Cigna Healthcare National Preferred 4-Tier Prescription Drug List

Coverage as of July 1, 2025

For the State of California
Health Maintenance Organization (HMO), Network, Network Point of Service (POS)

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: 05/01/2025. This drug list is subject to change and all prior versions are no longer in effect.

Offered by: Cigna Health and Life Insurance Company or its affiliates.
975750 d CA NPF 4-Tier Split Generics 05/25 © 2025 Cigna Healthcare.

cigna healthcare

View your drug list online

This document was last updated on 05/01/2025.* 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 4 Tier** from the dropdown menu. Then type in your medication name.

Questions?

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

* Drug list created: originally created 01/01/2023

Last updated: 05/01/2025, for changes starting 07/01/2025

Next planned update: 10/01/2025, for changes starting 01/01/2026

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 I and January I.
- **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 you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

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

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

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

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

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

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

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

Q. My medication was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?
A. You don't need to do anything. If your doctor continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval from Cigna Healthcare for the medication to be covered.

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

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (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.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

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

Your Step Therapy rights under California State law:

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

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

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

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

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

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

this law, certain preventive medications (including some over-the-counter products) may be available to you at no cost-share ($0), depending on your plan. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA No Cost-Share Preventive Medications drug list at **Cigna.com/PDL**. For more information about health care reform, go to **informedonreform.com** or **CignaHealthcare.com**.

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

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

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.[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. Can I fill my prescription at any pharmacy in my network?
A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

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

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo®'s 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 specially-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 specially-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 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**.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. I take a medication every day to treat diabetes. My plan requires me to fill my medication through Express Scripts® Pharmacy. How do I get started?
A. Some plans allow one or more fills at a retail pharmacy before switching to home delivery. Check your plan materials to find out if your plan allows retail fills. Here are three easy ways to get started.

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

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

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

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

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

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

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

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

Q. How can I find out my cost-share for each tier of the drug list?
A. Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the

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

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

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

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 4-Tier Prescription Drug List as of January 1, 2025. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

The drug list is updated on a regular basis, so this document doesn't show all of the medications your plan covers. Also, your plan may not cover every medication on this list. Log in to the **myCigna App** or **myCigna.com** to see the most up-to-date list of covered medications.

How to read this drug list

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

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

Tiers

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

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

* 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
In this drug list, some medications have **letters (acronyms)** next to them 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 you meet coverage requirements for the medication.
QL	**Quantity Limit*** – 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	This is a **specialty medication**, which is used to treat a complex medical condition. 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	Health care reform under the **Patient Protection and Affordable Care Act (PPACA)** requires plans to cover this preventive medication/product 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 understand how medications are covered.*

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 4-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
ALLZITAL	T4	PA
butalbital/acetaminophen	T2	
butalbital/acetaminophen (Bupap)	T2	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital/aspirin/caffeine	T2	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB		
butalb/acetaminophen/caffeine	T2	
butalb/acetaminophen/caffeine (Esgic)	T2	
butalb/acetaminophen/caffeine (Fioricet)	T2	
ESGIC *(butalb/acetaminophen/caffeine)*	T4	PA
FIORICET *(butalb/acetaminophen/caffeine)*	T4	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T2	HD
diflunisal	T2	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(3 auto-injs/90 days)
AJOVY SYRINGE	T3	PA QL(1 syringe/30 days)
almotriptan malate 6.25 mg tab	T2	ST QL (6 tabs/30 days)
almotriptan malate 12.5 mg tab	T2	ST QL (12 tabs/30 days)
AMERGE *(naratriptan hcl)*	T4	ST QL(9 tabs/fill)
CAMBIA	T4	ST QL(9 packs/fill)
dihydroergotamine 1 mg/ml amp	T2	ST QL (9 pkts/30 days)
dihydroergotamine 4 mg/ml spry (Migranal)	T2	ST QL(8 mls/fill)
eletriptan hydrobromide (Relpax)	T2	QL(6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T3	PA QL(1 syringe/30 days)
EMGALITY PEN	T3	PA QL(1pen/30 days)
ERGOMAR	T4	
ergotamine tartrate/caffeine	T2	
FROVA *(frovatriptan succinate)*	T4	ST QL(9 tabs/fill)
frovatriptan succinate (Frova)	T2	ST QL (9 tabs/30 days)
MIGRANAL (*dihydroergotamine mesylate*)	T4	ST QL(8 mls/fill)
naratriptan hcl (Amerge)	T2	QL(9 tabs/fill)

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIMIGRAINE PREPARATIONS (cont.)		
NURTEC ODT	T3	PA QL(16 tabs/fill)
QULIPTA	T3	PA QL(30 tabs/30 days)
REYVOW	T4	PA QL(8 tabs/treatment)
rizatriptan benzoate (Maxalt)	T2	QL(18 tabs/fill)
sumatriptan	T2	QL (6 units/30 days)
sumatriptan (Imitrex)	T2	QL(6 units/fill)
sumatriptan 4 mg/0.5 ml cart (Imitrex)	T2	QL(1 ml/fill)
sumatriptan 4 mg/0.5 ml inject (Imitrex)	T2	QL(2 pens/fill)
sumatriptan 6 mg/0.5 ml cart (Imitrex)	T2	QL(1 ml/fill)
sumatriptan 6 mg/0.5 ml inject (Imitrex)	T2	QL(2 pens/fill)
sumatriptan 6 mg/0.5 ml vial	T2	QL(2 vials/fill)
sumatriptan succ/naproxen sod (Treximet)	T2	ST QL(9 tabs/fill)
TOSYMRA	T4	ST QL(6 units/fill)
UBRELVY 50MG TABLET	T3	PA QL(10 tabs/treatment)
UBRELVY 100MG TABLET	T3	PA QL(10 tabs/treatment)
ZEMBRACE SYMTOUCH	T4	ST QL(4 pens/fill)
zolmitriptan	T2	QL (6 tabs/30 days)
ZOLMITRIPTAN 2.5 MG NASAL SPRAY	T4	ST QL (6 units/30 days)
zolmitriptan 5 mg nasal spray (Zomig)	T2	ST QL(6 units/fill)
zolmitriptan 2.5 mg tablet (Zomig)	T2	QL(6 tabs/fill)
zolmitriptan 5 mg tablet (Zomig)	T2	QL(6 tabs/fill)
ZOMIG 2.5 MG NASAL SPRAY	T4	ST QL(6 units/fill)
ZOMIG 5 MG NASAL SPRAY (*zolmitriptan*)	T4	ST QL(6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T4	ST QL(5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
diclofenac pot 25mg tablet	T2	ST HD
diclofenac pot 50 mg tablet	T2	HD
diclofenac pot powder pack (Cambia)	T2	ST QL (9 pkts/30 days)
diclofenac potassium	T2	ST HD
diclofenac potassium 25 mg cap (Zipsor)	T2	HD
FENORTHO 200 MG CAPSULE	T4	ST HD
ketorolac 10 mg tablet	T2	QL(20 tabs/fill)
ketorolac 15 mg/ml carpuject	T2	HD

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
ketorolac 15 mg/ml syr	T2	HD
ketorolac 15 mg/ml syringe	T2	
ketorolac 15 mg/ml vial	T2	
ketorolac 30 mg/ml syr	T2	HD
ketorolac 30 mg/ml syringe	T2	
ketorolac 30 mg/ml vial	T2	
ketorolac 300 mg/10 ml vial	T2	
ketorolac 60 mg/2 ml syringe	T2	
ketorolac 60 mg/2 ml vial	T2	
mefenamic acid	T2	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen with codeine	T2	PA QL
hydrocodone-acetamin 10-300 mg	T2	PA QL
hydrocodone-acetamin 10-325 mg	T2	PA QL
hydrocodone-acetamin 10-325/15	T2	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T4	PA QL
hydrocodone-acetamin 2.5-325	T2	PA QL (12 ds/60 days)
HYDROCODONE-ACETAMIN 5-217/10	T4	PA QL
hydrocodone-acetamin 5-300 mg	T2	PA QL
hydrocodone-acetamin 5-325 mg	T2	PA QL
hydrocodone-acetamin 7.5-300	T2	PA QL
hydrocodone-acetamin 7.5-325/15	T2	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T4	PA QL
LORTAB	T4	PA QL
NALOCET	T4	PA QL
oxycodone hcl/acetaminophen	T2	PA QL
oxycodone hcl/acetaminophen (Percocet)	T2	PA QL
prolate 10-300 mg tablet	T2	PA QL
prolate 5-300 mg tablet	T2	PA QL
prolate 7.5-300 mg tablet	T2	PA QL
tramadol hcl/acetaminophen	T2	PA QL(12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T2	PA QL

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
acetaminophen/caff/dihydrocod	T2	PA QL
TREZIX	T2	PA QL
OPIOID ANALGESICS		
ABSTRAL	T4	PA QL
ACTIQ (*fentanyl citrate*)	T4	PA QL
BELBUCA	T3	PA QL (60 films/30 days)
buprenorphine (Butrans)	T2	PA
butorphanol tartrate	T2	PA QL (12 ds/180 days)
codeine sulfate	T2	PA QL
DILAUDID *(hydromorphone hcl)*	T4	PA QL
fentanyl	T2	PA QL (15 patches/30 days)
fentanyl cit otfc 1,200 mcg	T2	PA QL(90 lozs/30 days)
fentanyl cit otfc 1,600 mcg (Actiq)	T2	PA QL
fentanyl citrate otfc 200 mcg	T2	PA QL(90 lozs/30 days)
fentanyl citrate otfc 400 mcg (Actiq)	T2	PA QL
fentanyl citrate otfc 600 mcg	T2	PA QL(90 lozs/30 days)
fentanyl citrate otfc 800 mcg	T2	PA QL (90 lozs/30 days)
hydrocodone er 10 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 15 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 20 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 30 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 40 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 50 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 20 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 30 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 40 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 60 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 80 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 100 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 120 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydromorphone hcl	T2	PA QL
hydromorphone hcl	T2	PA QL (60 tabs/30 days)
hydromorphone hcl (Dilaudid)	T2	PA QL
HYSINGLA ER *(hydrocodone bitartrate)*	T3	PA QL (60 tabs/30 days)

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC (cont.)		
KADIAN	T4	ST QL(90 caps/30 days)
KADIAN (*morphine sulfate*)	T4	ST QL(90 caps/30 days)
LAZANDA 100 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
levorphanol tartrate	T2	PA QL
methadone hcl	T2	
methadone hcl	T1	
morphine sulfate er 10 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 20 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 30 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 30 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 45 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 50 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 60 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 60 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 75 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 80 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 90 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 100 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 120 mg cap	T2	PA QL (60 caps/30 days)
*morphine sulfate er 10 mg cap (*Kadian*)*	T2	PA QL (60 caps/30 days)
*morphine sulfate er 50 mg cap (*Kadian*)*	T2	ST QL(90 caps/30 days)
*morphine sulfate er 60 mg cap (*Kadian*)*	T2	ST QL(90 caps/30 days)
*morphine sulfate er 80 mg cap (*Kadian*)*	T2	ST QL(90 caps/30 days)
*morphine sulfate er 100 mg cap (*Kadian*)*	T2	ST QL(90 caps/30 days)
*morphine sulf er 15 mg tablet (*Ms Contin*)*	T2	PA QL (120 tabs/30 days)
morphine sulf er 30 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
*morphine sulf er 60 mg tablet (*Ms Contin*)*	T2	PA QL (120 tabs/30 days)
morphine sulf er 100 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulf er 200 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
MS CONTIN (*morphine sulfate*)	T4	PA QL (120 tabs/30 days)
opium/belladonna alkaloids	T2	PA QL
oxycodone hcl (ir) 10 mg tab	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T2	PA QL (12 ds/60 days)

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC (cont.)		
oxycodone hcl (ir) 20 mg tab	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg cap	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T2	PA QL (12 ds/60 days)
oxycodone hcl 100 mg/5 ml conc	T2	PA QL (12 ds/60 days)
oxycodone hcl 5 mg/5 ml cup	T2	PA QL (12 ds/60 days)
oxycodone hcl 5 mg/5 ml soln	T2	PA QL (12 ds/60 days)
OXYCONTIN	T3	PA QL (90 tabs/30 days)
oxymorphone hcl	T2	PA QL (90 tabs/30 days)
pentazocine hcl/naloxone hcl	T2	PA QL
ROXICODONE (*oxycodone hcl*)	T4	PA QL
SUBSYS	T4	PA QL(90 units/30 days)
tramadol hcl 100 mg tablet	T2	PA QL (12 ds/60 days)
tramadol er 100 mg tablet	T2	PA QL (30 tabs/30 days)
tramadol er 200 mg tablet	T2	PA QL (30 tabs/30 days)
tramadol er 300 mg tablet	T2	PA QL (30 tabs/30 days)
tramadol hcl er 100 mg tablet	T2	PA QL (30 tabs/30 days)
tramadol hcl er 200 mg tablet	T2	PA QL (30 tabs/30 days)
tramadol hcl er 300 mg tablet	T2	PA QL (30 tabs/30 days)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T2	PA QL
OPIOID, NON-SALICYL.ANALGESIC, BARBITURATE, XANTHINE		
butalbit/acetamin/caff/codeine	T2	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T2	PA QL
FIORICET WITH CODEINE *(butalbit/acetamin/caff/codeine)*	T4	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T2	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T4	

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

List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL ANESTHETICS, INHALANT		
desflurane	T2	
isoflurane	T2	
sevoflurane (Ultane)	T2	
SUPRANE	T4	
ULTANE (*sevoflurane*)	T4	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
LOCAL ANESTHETICS		
lidocaine hcl	T2	QL(60 mls/30 days)
lidocaine hcl	T2	
lidocaine hcl 2% jel urojet ac	T2	QL(60 mls/30 days)
lidocaine hcl 2% jelly uro-jet	T2	QL(60 mls/30 days)
lidocaine hcl 4% solution	T2	
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T4	
L.E.T. (LIDO-EPINEPH-TETRA)	T4	
lidocaine (Lidocan li)	T2	PA
lidocaine 5% ointment	T2	QL(50 gms/28 days)
lidocaine 5% patch (Lidocan li)	T2	PA
lidocaine 5% patch (Lidoderm)	T2	PA
lidocaine hcl	T2	
lidocaine hcl 4% solution	T2	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T4	
lidocaine-prilocaine cream	T2	QL(30 gms/30 days)
lidocaine-prilocaine cream	T2	
LIDOCAN II *(lidocaine)*	T4	PA
NOLIRA	T4	
SYNERA	T4	PA
ZTLIDO	T3	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T2	

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

List of Prescription Medications

ANTIALLERGY (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T2	
GASTROCROM (*cromolyn sodium*)	T4	
ANTIARTHRITICS (Pain Relief And Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T4	HD
salsalate (Disalcid)	T2	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T4	PA SP
penicillamine (Cuprimine)	T2	PA SP
penicillamine (Depen)	T2	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T3	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T4	QL(30 tabs/fill) HD
leflunomide (Arava)	T2	QL(30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL(60 tabs/30 days) SP HD
COLCHICINE		
colchicine 0.6 mg capsule (Mitigare)	T2	ST
colchicine 0.6 mg tablet (Colcrys)	T2	HD
GLOPERBA	T4	HD
MITIGARE (*colchicine*)	T3	ST
GOLD SALTS		
AURANOFIN	T3	
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol	T1	HD
allopurinol (Zyloprim)	T1	HD
febuxostat (Uloric)	T2	ST HD
ZYLOPRIM (*allopurinol*)	T4	HD

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG, 30 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T4	PA ST QL(56 tabs/365 days) SP HD
RINVOQ LQ	T4	PA QL (360 mls/30 days) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL(300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
XELJANZ XR	T4	PA QL(30 tabs/fill) SP HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
ibuprofen/famotidine	T2	ST HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T4	
COMFORT PAC-MELOXICAM	T4	
COMFORT PAC-NAPROXEN	T4	
NSAID,COX INHIBITOR-TYPE AND PROTON-PUMP INHIBITOR		
naproxen/esomeprazole mag	T2	ST HD
naproxen/esomeprazole mag (Vimovo)	T2	ST HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium/misoprostol*)	T4	ST HD
ARTHROTEC 75 (*diclofenac sodium/misoprostol*)	T4	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T2	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T2	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium*)	T4	ST HD
DAYPRO (*oxaprozin*)	T4	ST HD
diclofenac sod dr 25 mg tab	T2	HD
diclofenac sod dr 50 mg tab	T2	HD
diclofenac sod dr 75 mg tab	T2	HD
diclofenac sod ec 25 mg tab	T2	HD
diclofenac sod ec 50 mg tab	T2	HD
diclofenac sod ec 75 mg tab	T2	HD
diclofenac sodium	T2	HD
EC-NAPROSYN (*naproxen*)	T4	ST HD
etodolac	T2	HD
etodolac (Lodine)	T2	HD

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
FELDENE (*piroxicam*)	T4	ST HD
fenoprofen 400 mg capsule (Nalfon)	T2	ST HD
fenoprofen 600 mg tablet (Nalfon)	T2	ST HD
flurbiprofen	T2	HD
ibuprofen	T1	HD
ibuprofen	T2	HD
indomethacin	T2	HD
INDOMETHACIN 20 MG CAPSULE	T4	ST QL(90 caps/30 days) HD
indomethacin 25 mg capsule	T2	HD
indomethacin 25 mg/5 ml susp (Indocin)	T2	ST HD
indomethacin 50 mg capsule	T2	HD
indomethacin 50 mg suppository (Indocin)	T2	HD
ketoprofen	T2	ST HD
ketoprofen 25 mg capsule	T2	ST HD
ketoprofen 50 mg capsule	T2	HD
ketoprofen 75 mg capsule	T2	HD
ketoprofen er 200 mg capsule	T2	ST HD
LODINE (*etodolac*)	T4	ST HD
meclofenamate sodium	T2	HD
meloxicam 10 mg capsule (Vivlodex)	T2	ST QL(30 caps/fill) HD
meloxicam 5 mg capsule (Vivlodex)	T2	ST QL(30 caps/fill) HD
MOBIC (*meloxicam*)	T4	ST QL(30 tabs/fill) HD
nabumetone (Relafen)	T2	HD
NALFON 600 MG TABLET (*fenoprofen calcium*)	T4	ST HD
NAPRELAN	T4	ST HD
NAPRELAN (*naproxen sodium*)	T4	ST HD
NAPROSYN (*naproxen*)	T4	ST HD
naproxen (Ec-Naprosyn)	T2	HD
naproxen 125 mg/5 ml suspen (Naprosyn)	T2	ST HD
naproxen 250 mg tablet	T1	HD
naproxen 375 mg tablet	T1	HD
naproxen 500 mg kit (Naprosyn)	T1	HD
naproxen 500 mg tablet (Naprosyn)	T1	HD
naproxen dr 375 mg tablet (Ec-Naprosyn)	T2	HD

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
naproxen dr 500 mg tablet (Ec-Naprosyn)	T2	HD
naproxen er 750mg tablet	T2	ST
naproxen sodium	T2	ST HD
naproxen sodium	T2	HD
naproxen sodium (Anaprox Ds)	T2	HD
naproxen sodium (Naprelan)	T2	ST HD
oxaprozin 600 mg caplet (Daypro)	T2	HD
oxaprozin 600 mg tablet (Daypro)	T2	HD
piroxicam	T2	HD
piroxicam (Feldene)	T2	HD
RELAFEN (*nabumetone*)	T4	ST HD
sulindac	T1	HD
TOLECTIN 600 *(tolmetin sodium)*	T4	ST HD
tolmetin sodium 200 mg tab	T2	HD
tolmetin sodium 400 mg cap	T2	ST HD
tolmetin sodium 600 mg tab (Tolectin 600)	T2	ST HD
NSAIDS,CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib	T2	HD
URICOSURIC AGENTS		
probenecid	T2	HD
probenecid/colchicine	T2	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T2	PA HD
ZYFLO	T4	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T3	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T4	QL(60 mls/fill) HD
LONHALA MAGNAIR STARTER	T4	QL(60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP *(tiotropium bromide)*	T4	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T3	QL(1 inhaler/fill) HD
YUPELRI	T3	QL(30 vls/fill) HD

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T4	QL(2 inhalers/fill) HD
ipratropium br 0.02% soln	T2	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T2	HD
albuterol 8 mg/20 ml syrup cup	T2	HD
albuterol sulf 2 mg/5 ml syrup	T2	HD
albuterol sulfate 2 mg tab	T2	HD
albuterol sulfate 4 mg tab	T2	HD
albuterol sulfate er 4 mg tab	T2	HD
albuterol sulfate er 8 mg tab	T2	HD
metaproterenol sulfate	T2	HD
terbutaline sulfate	T2	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T2	
albuterol 2.5 mg/0.5 ml sol	T2	
albuterol 5 mg/ml solution	T2	
albuterol 15 mg/3 ml solution	T2	
albuterol 75 mg/15 ml soln	T2	
albuterol hfa 90 mcg inhaler (Proair Hfa)	T2	QL(2 inhalers/fill)
albuterol hfa 90 mcg inhaler	T2	QL (2 inhalers/30 days)
albuterol sul 0.63 mg/3 ml sol	T2	
albuterol sul 1.25 mg/3 ml sol	T2	
albuterol sul 2.5 mg/3 ml soln	T2	
levalbuterol hcl (Xopenex Concentrate)	T2	
levalbuterol hcl (Xopenex)	T2	
XOPENEX (*levalbuterol hcl*)	T4	
XOPENEX CONCENTRATE (*levalbuterol hcl*)	T4	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T3	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED,LONG ACTING		
arformoterol tartrate (Brovana)	T2	QL(120 mls/fill) HD
BROVANA (*arformoterol tartrate*)	T4	QL(120 mls/fill) HD
formoterol fumarate (Perforomist)	T2	QL(120 mls/fill) HD
FORMOTEROL FUMARATE-NEBULIZER	T3	QL (120 mls/30 days) HD

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T3	QL(1 inhaler/fill) HD
COMBIVENT INHALER	T3	
COMBIVENT RESPIMAT	T3	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T4	HD
STIOLTO RESPIMAT	T3	QL(1 inhaler/fill) HD
UMECLIDINIUM-VILANTEROL	T4	
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T4	HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T4	HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T3	PA QL(1 inhaler/fill) HD
AIRDUO DIGIHALER	T4	PA QL(1 inhaler/fill) HD
AIRSUPRA	T3	HD
BREO ELLIPTA 50-25 MCG INHALER	T3	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(28 blisters/fill) HD
BREO ELLIPTA 200-25 MCG INH	T3	PA QL(1 inhaler/fill) HD
breyna 80-4.mcg, 160-4.5 mcg inhaler	T2	PA
budesonide-formoterol 160-4.5, 80-4.5	T2	PA HD QL (1 inhaler/30 days)
DULERA 100 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T3	PA QL(13 gms/fill) HD
fluticasone propion/salmeterol (Advair Diskus)	T2	PA QL(1 inhaler/30 days)
fluticasone-salmeterol 100-50 (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
SYMBICORT *(budesonide/formoterol fumarate)*	T4	PA QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T3	QL(1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(28 blisters/fill)
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO 160 MCG INHALER	T4	QL(2 inhalers/fill) HD

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
ALVESCO 80 MCG INHALER	T4	QL(1 inhaler/fill) HD
ARNUITY ELLIPTA 100 MCG INH	T3	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 200 MCG INH	T3	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 50 MCG INH	T3	QL (30 blisters/30 days)
ASMANEX	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 100 MCG, 200 MCG INHALER	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T3	QL(13 gms/fill) HD
budesonide 0.25 mg/2 ml susp (Pulmicort)	T2	
budesonide 0.5 mg/2 ml susp (Pulmicort)	T2	
budesonide 1 mg/2 ml inh susp (Pulmicort)	T2	QL(60 mls/fill) HD
FLOVENT 100 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T3	QL(4 inhalers/fill) HD
FLOVENT 50 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT HFA 110 MCG INHALER	T3	QL(12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T3	QL(24 gms/fill) HD
FLOVENT HFA 44 MCG INHALER	T3	QL(11 gms/fill) HD
QVAR REDIHALER 40 MCG	T3	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T3	QL (22 gms/30 days)
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 100 MG/ML AUTO-INJECTOR	T4	PA QL(1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T4	PA QL(1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T4	PA QL(1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA QL(1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T4	HD
montelukast sodium (Singulair)	T2	HD
zafirlukast (Accolate)	T2	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T2	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 75 MG/0.5 ML AUTOINJECT	T4	
XOLAIR 150 MG/ML AUTOINJECTOR	T4	
XOLAIR 150 MG/1.2 ML POWDER VL	T4	PA QL(6 vls/28 days) SP HD

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE) (cont.)		
XOLAIR 300 MG/2 ML AUTOINJECT	T4	
XOLAIR 300 MG/2 ML SYRINGE	T4	
MUCOLYTICS		
acetylcysteine	T2	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T2	PA QL(30 tabs/fill) HD
roflumilast 500 mcg tablet (Daliresp)	T2	PA HD
XANTHINES		
ELIXOPHYLLIN	T4	HD
THEO-24	T4	HD
theophylline anhydrous	T2	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T2	
CORTISPORIN-TC	T4	
neomycin/polymyxin b/hydrocort	T2	
ofloxacin	T2	
OTIPRIO	T4	QL(1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T2	
OTOVEL	T4	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T4	
MAXITROL *(neomycin/polymyxin b/dexametha)*	T4	
neomycin/bacit/p-myx/hydrocort	T2	
neomycin/polymyxin b/dexametha (Maxitrol)	T2	
neomycin/polymyxin b/hydrocort	T2	
PRED-G	T4	
PREDNISOLONE ACET-GATIFLOXACIN	T4	
PREDNISOLONE ACET-MOXIFLOXACIN	T4	
PREDNISOLONE PHOS-GATIFLOXACIN	T4	
PREDNISOLONE PHOS-MOXIFLOXACIN	T4	

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

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS (cont.)		
TOBRADEX	T4	
tobramycin/dexamethasone	T2	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T4	
PREDNISOLONE AC-MOXIFLOX-BROMF	T4	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T4	
PREDNISOLONE PHOS-GATIFLO-BROM	T4	
PREDNISOLONE PHOS-MOXIFLO-BROM	T4	
EYE SULFONAMIDES		
BLEPH-10 (*sulfacetamide sodium*)	T4	
BLEPHAMIDE S.O.P.	T4	
sulfacetamide sodium	T2	
sulfacetamide sodium (Bleph-10)	T2	
sulfacetamide/prednisolone sp	T2	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T3	
bacitracin	T2	
bacitracin/polymyxin b sulfate	T2	
CEFUROXIME SODIUM-0.9% NACL	T4	PA
CILOXAN 0.3% EYE DROPS (*ciprofloxacin hcl*)	T4	
ciprofloxacin hcl (Ciloxan)	T2	
erythromycin base	T2	
gatifloxacin	T2	
gentamicin 0.3% eye drop	T2	
gentamicin sulfate	T2	
KLARITY-A(AZITHROMYCIN-CHONDR)	T4	
levofloxacin	T2	
moxifloxacin	T2	
moxifloxacin (Vigamox)	T2	
neomycin/bacitracin/polymyxinb	T2	
neomycin/polymyxn b/gramicidin	T2	
OCUFLOX (*ofloxacin*)	T4	
ofloxacin (Ocuflox)	T2	
polymyxin b sulf/trimethoprim (Polytrim)	T2	

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

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS (cont.)		
POLYTRIM (*polymyxin b sulf/trimethoprim*)	T4	
tobramycin 0.3% eye drop (Tobrex)	T2	
TOBREX	T4	
TOBREX (*tobramycin*)	T4	
VIGAMOX *(moxifloxacin hcl)*	T4	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T3	QL(1 pack/fill)
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole/trimethoprim*)	T4	
BACTRIM DS (*sulfamethoxazole/trimethoprim*)	T4	
sulfadiazine	T2	
sulfamethoxazole/trimethoprim	T2	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
BETHKIS *(tobramycin)*	T4	PA QL(224 mls/fill) SP HD
gentamicin 20 mg/2 ml vial	T2	PA
gentamicin 80 mg/2 ml vial	T2	PA
gentamicin 800 mg/20 ml vial	T2	PA
gentamicin ped 20 mg/2 ml vial	T2	PA
KITABIS PAK	T4	PA QL(280 mls/fill) SP HD
neomycin sulfate	T2	
TOBI PODHALER	T4	PA QL(224 caps/fill) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T2	PA QL(224 mls/fill) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T2	PA QL(280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL(280 mls/fill) SP HD
tobramycin sulfate	T2	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T4	
metronidazole 250 mg tablet	T2	
metronidazole 375 mg capsule (Flagyl)	T2	
metronidazole 500 mg tablet	T2	

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T2	
meth/meblue/sod phos/psal/hyos	T2	
methen/mblue/sal/sod phos/hyos	T2	
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T2	
methenam/sod phos/mblue/hyoscy	T2	
methenamine hippurate	T2	
methenamine mandelate	T2	
PRIMSOL	T4	
trimethoprim	T2	
TRIMPEX	T4	
URELLE	T4	
URIBEL	T4	
URIBEL TABS *(methenam/m.blue/salicyl/hyoscy)*	T4	
ANTILEPROTICS		
dapsone	T2	
THALOMID 100 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD
THALOMID 150 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T2	HD
isoniazid	T2	HD
MYCOBUTIN (*rifabutin*)	T4	HD
PASER	T4	HD
pyrazinamide	T2	HD
rifabutin (Mycobutin)	T2	HD
TRECATOR	T4	HD
ANTITUBERCULAR ANTIBIOTICS		
PRETOMANID	T4	PA
PRIFTIN	T3	
rifampin	T2	
SIRTURO	T4	PA SP
BETALACTAMS		
CAYSTON	T4	PA QL(84 mls/fill) SP HD

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T2	
cephalexin	T2	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T2	
cefprozil	T2	
cefuroxime axetil	T2	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T2	
cefditoren pivoxil (Spectracef)	T2	
cefixime (Suprax)	T2	
cefpodoxime proxetil	T2	
ceftriaxone sodium	T2	PA
SPECTRACEF (*cefditoren pivoxil*)	T4	
SUPRAX (*cefixime*)	T4	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (*clindamycin hcl*)	T4	
CLEOCIN PEDIATRIC (*clindamycin palmitate hcl*)	T4	
clindamycin hcl (Cleocin Hcl)	T2	
clindamycin palmitate hcl (Cleocin Pediatric)	T2	
MACROLIDE ANTIBIOTICS		
azithromycin	T2	
azithromycin (Zithromax Tri-Pak)	T2	
azithromycin (Zithromax)	T2	
clarithromycin	T2	
DIFICID 200 MG TABLET	T4	QL(20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T4	QL(1 bottle/fill)
E.E.S. 200 *(erythromycin ethylsuccinate)*	T4	
ERYPED 200 *(erythromycin ethylsuccinate)*	T4	
ERYPED 400 *(erythromycin ethylsuccinate)*	T4	
ery-tab dr 250 mg tablet	T2	
ery-tab dr 333 mg tablet	T2	
ERY-TAB DR 500 MG TABLET *(erythromycin base)*	T4	
erythromycin base	T2	
erythromycin base (Ery-Tab)	T2	

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS (cont.)		
erythromycin ethylsuccinate	T2	
erythromycin ethylsuccinate (E.E.S. 200)	T2	
erythromycin ethylsuccinate (Eryped 200)	T2	
erythromycin ethylsuccinate (Eryped 400)	T2	
erythromycin stearate	T2	
ZITHROMAX *(azithromycin)*	T4	
ZITHROMAX TRI-PAK (*azithromycin*)	T4	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T4	
MACROBID (*nitrofurantoin monohyd/m-cryst*)	T4	
nitrofurantoin (Furadantin)	T2	
nitrofurantoin mcr 25 mg cap	T2	
nitrofurantoin mcr 50 mg cap	T2	
nitrofurantoin mcr 100 mg cap	T2	
nitrofurantoin monohyd/m-cryst (Macrobid)	T2	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T2	PA
ZYVOX (*linezolid*)	T4	PA
PENICILLIN ANTIBIOTICS		
amoxicillin	T2	
amoxicillin/potassium clav	T2	
amoxicillin/potassium clav (Augmentin Xr)	T2	
amoxicillin/potassium clav (Augmentin)	T2	
ampicillin trihydrate	T2	
AUGMENTIN 125-31.25 MG/5 ML	T3	
AUGMENTIN 250-62.5 MG/5 ML *(amoxicillin/potassium clav)*	T4	
AUGMENTIN XR *(amoxicillin/potassium clav)*	T4	
dicloxacillin sodium	T2	
MOXATAG	T4	
penicillin v potassium	T2	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T4	
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	QL(28 tabs/fill)

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
QUINOLONE ANTIBIOTICS (cont.)		
CIPRO (*ciprofloxacin hcl*)	T4	
CIPRO (*ciprofloxacin*)	T4	
ciprofloxacin (Cipro)	T2	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
FACTIVE	T4	
levofloxacin	T2	
moxifloxacin hcl	T2	
ofloxacin	T2	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T4	QL(12 tabs/fill)
XIFAXAN 200 MG TABLET	T3	QL(9 tabs/fill)
XIFAXAN 550 MG TABLET	T3	QL(60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE *(doxycycline hyclate)*	T4	ST
AVIDOXY DK	T4	ST
demeclocycline hcl	T2	
doxycycline 25 mg/5 ml susp (Vibramycin)	T2	
doxycycline 50 mg tablet (Targadox)	T2	ST
doxycycline hyc dr 100 mg tab	T2	ST
doxycycline hyc dr 150 mg tab	T2	ST
doxycycline hyc dr 200 mg tab (Doryx)	T2	ST
doxycycline hyc dr 50 mg tab	T2	ST
doxycycline hyc dr 75 mg tab	T2	ST
doxycycline hyclate 100 mg cap	T2	
doxycycline hyclate 100 mg tab (Lymepak)	T2	
doxycycline hyclate 150 mg tab (Acticlate)	T2	ST
doxycycline hyclate 50 mg cap	T2	
doxycycline hyclate 75 mg tab (Acticlate)	T2	ST
doxycycline mono 100 mg cap	T2	
doxycycline mono 100 mg tablet	T2	
doxycycline mono 150 mg cap	T2	ST
doxycycline mono 150 mg tablet	T2	
doxycycline mono 50 mg cap	T2	

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS (cont.)		
doxycycline mono 50 mg tablet	T2	
doxycycline mono 75 mg capsule	T2	
doxycycline mono 75 mg tablet	T2	
doxycycline monohydrate	T2	
doxycycline monohydrate (Monodox)	T2	
doxycycline monohydrate (Oracea)	T2	ST
LYMEPAK *(doxycycline hyclate)*	T4	
minocycline hcl	T2	
minocycline hcl	T2	ST
minocycline hcl (Solodyn)	T2	ST
MINOLIRA ER	T4	ST
MORGIDOX 1X100 MG KIT	T4	ST
MORGIDOX 1X50 MG KIT	T4	ST
MORGIDOX 2X100 MG KIT	T4	ST
morgidox 50 mg capsule	T2	
NUZYRA	T4	QL(30 tabs/30 days) SP
SEYSARA	T4	ST
SOLODYN *(minocycline hcl)*	T4	ST
TARGADOX *(doxycycline hyclate)*	T4	ST
tetracycline 250 mg, 500 mg capsule	T2	
tetracycline 250 mg, 500 mg tablet	T2	ST
VIBRAMYCIN	T4	ST
VIBRAMYCIN (*doxycycline monohydrate*)	T4	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T4	
CLEOCIN (clindamycin phosphate)	T4	
clindamycin 2% vaginal cream (Cleocin)	T2	
CLINDESSE	T4	
METROGEL-VAGINAL (*metronidazole*)	T4	
metronidazole (Metrogel-Vaginal)	T2	
metronidazole vaginal 0.75% gl (Metrogel-Vaginal)	T2	
NUVESSA	T4	
XACIATO	T4	

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL 125 MG CAPSULE (*vancomycin hcl*)	T4	PA QL(40 caps/fill)
VANCOCIN HCL 250 MG CAPSULE *(vancomycin hcl)*	T4	PA QL(80 caps/fill)
vancomycin 250 mg/5 ml soln	T2	QL(450 mls/fill)
vancomycin 125 mg capsule	T2	PA QL(40 caps/30 days)
vancomycin 250 mg capsule	T2	PA QL(80 caps/30 days)
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T4	
TOPICAL ANTIBIOTICS		
AKTIPAK	T4	ST
AMZEEQ	T4	ST
BENZAMYCIN (*erythromycin/benzoyl peroxide*)	T4	ST
CENTANY	T4	ST QL(30 gms/fill)
CENTANY AT	T4	ST QL(1 kit/fill)
CLEOCIN T 1% LOTION (*clindamycin phosphate*)	T4	ST QL(120 mls/30 days)
CLEOCIN T 1% PLEDGETS *(clindamycin phosphate)*	T4	ST
*clindacin etz 1% pledget (*Cleocin T*)*	T2	
CLINDACIN ETZ KIT	T4	ST
CLINDACIN PAC	T4	ST
clindamycin ph 1% gel	T2	QL(120 gms/30 days)
clindamycin ph 1% solution	T2	QL(120 mls/30 days)
clindamycin phos 1% pledget (Cleocin T)	T2	
clindamycin phosp 1% lotion (Cleocin T)	T2	QL(120 mls/30 days)
clindamycin phosphate (Cleocin T)	T2	
clindamycin phosphate (Evoclin)	T2	ST QL(100 gms/30 days)
clindamycin phosphate 1% foam (Evoclin)	T2	ST QL(100 gms/30 days)
clindamycin phosphate 1% gel (Clindagel)	T2	QL(150 mls/30 days)
erythromycin base in ethanol	T2	
*erythromycin/benzoyl peroxide (*Benzamycin*)*	T2	
EVOCLIN *(clindamycin phosphate)*	T4	ST QL(100 gms/30 days)
gentamicin 0.1% cream, ointment	T2	QL(60 gms/fill)
mupirocin 2% cream	T2	ST QL(30 gms/fill)
mupirocin 2% ointment	T2	QL (1 treatment/30 days)
XEPI	T4	ST QL(30 gms/fill)

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

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL SULFONAMIDES		
AVAR LS	T4	ST
AVAR-E	T4	ST
AVAR-E GREEN	T4	ST
AVAR-E LS	T4	ST
mafenide acetate (Sulfamylon)	T2	
PLEXION	T4	ST
ROSULA 10%-4.5% WASH	T4	ST
rosula 10%-5% cloths	T2	
SILVADENE *(silver sulfadiazine)*	T4	
silver sulfadiazine (Silvadene)	T2	
sod sulface-sulf 9.8-4.8% clsr	T2	
sod sulface-sulfur 9-4.5% wash	T2	
sod sulfacet-sulfr 9.8-4.8%pad	T2	
sod sulfacet-sulfur 10-2% clsr	T2	
sod sulfacet-sulfur 10-4% pad (Sumaxin)	T2	
sod sulfacet-sulfur 10-5% clsr	T2	
sod sulfac-sulfur 9.8-4.8% crm	T2	
sod sulfac-sulfur 9.8-4.8% lot	T2	
sulfacetamide sodium/sulfur	T2	
sulfacetamide sodium/sulfur	T2	ST
sulfacetamide-sulfur 10-2% crm	T2	
sulfacetamide-sulfur 10-5% crm	T2	
sulfacetamide-sulfur 10-5% lot	T2	
sulfacetamide-sulfur 10-5% sus	T2	
sulfacetamide-sulfur 8-4% susp	T2	
sulfacetamide-sulfur 9-4% clsr	T2	
SULFAMYLON 8.5% CREAM	T3	
SULFAMYLON POWDER PACKET *(mafenide acetate)*	T4	
SUMADAN	T4	ST
SUMADAN XLT	T4	ST
SUMAXIN	T4	ST
SUMAXIN *(sulfacetamide sodium/sulfur)*	T4	ST
SUMAXIN CP	T4	ST
SUMAXIN TS	T4	ST

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

List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CITRATES AS ANTICOAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T4	
CITRATE PHOSPHATE DEXTROSE	T3	
CRRT TRISODIUM CITRATE	T4	
SODIUM CITRATE	T4	
TRISODIUM CITRATE CRRT	T4	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T3	PA
XARELTO	T3	PA
rivaroxaban	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (*fondaparinux sodium*)	T4	SP
enoxaparin sodium (Lovenox)	T2	SP
fondaparinux sodium (Arixtra)	T2	SP
FRAGMIN	T4	SP
heparin 10,000 unit/10 ml vial	T2	
heparin 2,000 unit/2 ml vial	T2	
heparin 30,000 unit/30 ml vial	T2	
heparin 40,000 unit/4 ml vial	T2	
heparin 5,000 unit/ml carpujct	T2	
heparin 50,000 unit/10 ml vial	T2	
heparin 50,000 unit/5 ml vial	T2	
heparin sod 1,000 unit/ml vial	T2	
heparin sod 10,000 unit/ml vl	T2	
heparin sod 20,000 unit/ml vl	T2	
heparin sod 5,000 unit/0.5 ml	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/0.5 ML	T4	
heparin sod 5,000 unit/ml syrg	T2	
HEPARIN SOD 5,000 UNIT/ML SYRG	T4	
heparin sod 5,000 unit/ml vial	T2	

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T3	QL(30 tabs/fill)
RELISTOR 12 MG/0.6 ML SYRINGE	T3	ST
RELISTOR 8 MG/0.4 ML SYRINGE	T3	ST
RELISTOR 12 MG/0.6 ML VIAL	T3	ST
SYMPROIC	T3	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
KLOXXADO	T3	QL(2 units/fill)
naloxone 0.4 mg/ml carpuject	T2	
naloxone 0.4 mg/ml syringe	T2	
naloxone 0.4 mg/ml vial	T2	
naloxone 2 mg/2 ml syringe	T2	
naloxone 4 mg/10 ml vial	T2	
naloxone hcl 4 mg nasal spray (Narcan)	T2	QL(2 units/fill)
naltrexone hcl	T1	
NARCAN (*naloxone hcl*)	T4	QL(2 units/30 days)
REXTOVY	T3	QL (2 units/30 days)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T4	
miconazole nitrate	T2	
terconazole	T2	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON	T4	PA
clotrimazole	T2	
CRESEMBA	T3	PA
DIFLUCAN 10 MG/ML SUSPENSION *(fluconazole)*	T4	
DIFLUCAN 100 MG TABLET *(fluconazole)*	T4	
DIFLUCAN 150 MG TABLET *(fluconazole)*	T4	QL(2 tabs/fill)

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

List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFUNGAL AGENTS (cont.)		
DIFLUCAN 200 MG TABLET *(fluconazole)*	T4	
DIFLUCAN 40 MG/ML SUSPENSION *(fluconazole)*	T4	
DIFLUCAN 50 MG TABLET *(fluconazole)*	T4	
fluconazole 10 mg/ml susp	T2	
fluconazole 100 mg tablet (Diflucan)	T2	
fluconazole 150 mg tablet (Diflucan)	T2	QL(2 tabs/fill)
fluconazole 200 mg tablet (Diflucan)	T2	
fluconazole 40 mg/ml susp (Diflucan)	T2	
fluconazole 50 mg tablet (Diflucan)	T2	
flucytosine (Ancobon)	T2	
itraconazole 10 mg/ml solution (Sporanox)	T2	QL(2 bottles/fill)
itraconazole 100 mg capsule (Sporanox)	T2	QL(30 caps/fill)
itraconazole 100 mg/10 ml cup (Sporanox)	T2	QL(2 bottles/fill)
ketoconazole 200 mg tablet	T2	
NOXAFIL	T3	PA
NOXAFIL 300 MG POWDERMIX SUSP	T4	PA
NOXAFIL 40 MG/ML SUSPENSION	T3	PA SP
ORAVIG	T4	
POSACONAZOLE 200 MG/5 ML SUSP	T3	PA
posaconazole dr 100 mg tablet (Noxafil)	T2	PA
SPORANOX 10 MG/ML SOLUTION (*itraconazole*)	T4	QL(2 bottles/fill)
SPORANOX 100 MG CAPSULE (*itraconazole*)	T4	QL(30 caps/fill)
terbinafine hcl	T2	
VFEND *(voriconazole)*	T4	PA
VIVJOA	T4	PA QL (18 caps/30 days) SP
voriconazole (Vfend)	T2	PA
ANTIFUNGAL ANTIBIOTICS		
BREXAFEMME	T4	ST QL(4 tabs/fill)
griseofulvin ultramicrosize	T2	
griseofulvin, microsize	T2	
nystatin 100,000 unit/ml susp	T2	
nystatin 500,000 unit oral tab	T2	
nystatin 500,000 unit/5 ml cup	T2	

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

List of Prescription Medications

ANTIFUNGALS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole-betamethasone crm	T2	QL(90 gms/28 days)
clotrimazole-betamethasone lot	T2	QL(60 mls/28 days)
TOPICAL ANTIFUNGALS		
ciclodan 0.77% cream (Loprox)	T2	QL(90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T4	
ciclodan 8% solution	T2	
ciclopirox 0.77% cream (Loprox)	T2	QL(90 gms/28 days)
ciclopirox 0.77% gel	T2	QL(100 gms/28 days)
ciclopirox 0.77% topical susp (Loprox)	T2	QL(60 mls/28 days)
ciclopirox 1% shampoo	T2	QL(120 mls/28 days)
ciclopirox 8% solution	T2	
econazole nitrate	T2	QL(85 gms/28 days)
EXELDERM 1% CREAM, SOLUTION	T4	QL(60 gms/28 days)
EXTINA *(ketoconazole)*	T4	ST QL(100 gms/28 days)
JUBLIA	T4	ST
ketoconazole 2% cream	T2	QL(60 gms/28 days)
ketoconazole 2% foam (Extina)	T2	ST QL(100 gms/28 days)
ketodan 2% foam (Extina)	T2	ST QL(100 gms/28 days)
ketodan 2% foam kit	T2	ST
LOPROX 0.77% CREAM (*ciclopirox olamine*)	T4	QL(90 gms/28 days)
LOPROX 0.77% CREAM KIT	T4	QL(544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T4	QL(1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (*ciclopirox olamine*)	T4	QL(60 mls/28 days)
naftifine hcl 1% cream	T2	QL (90 gms/28 days)
naftifine hcl 2% cream	T2	QL (60 gms/28 days)
naftifine hcl 2% gel (Naftin)	T2	QL (60 gms/28 days)
NAFTIN 1% GEL *(naftifine hcl)*	T4	QL (90 gms/28 days)
NAFTIN 2% GEL *(naftifine hcl)*	T4	QL (60 gms/28 days)
nystatin	T2	QL(180 gms/fill)
nystatin 100,000 unit/gm cream	T2	QL(60 gms/28 days)
nystatin 100,000 unit/gm oint	T2	QL(60 gms/28 days)
nystatin/triamcin	T2	QL(60 gms/28 days)
oxiconazole nitrate	T2	QL(60 gms/28 days)
tavaborole	T2	ST

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T2	
phenylephrine/chlor-tan	T2	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T4	QL(60 tabs/fill)
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T2	
carbinoxamine maleate 4 mg tab	T2	
carbinoxamine maleate 6 mg tab	T2	ST
clemastine fumarate	T2	
cyproheptadine 2 mg/5 ml soln	T2	
cyproheptadine 2 mg/5 ml syrup	T2	
cyproheptadine 4 mg tablet	T2	
CYPROHEPTADINE 4 MG/10 ML SYRP	T4	
dexchlorpheniramine maleate (Ryclora)	T2	
hydroxyzine hcl	T2	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T2	
RYCLORA *(dexchlorpheniramine maleate)*	T4	
RYVENT	T4	ST
VISTARIL (*hydroxyzine pamoate*)	T4	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T4	
desloratadine	T2	QL(30 tabs/fill) HD
desloratadine (Clarinex)	T2	QL(30 tabs/fill) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T2	
BEPREVE	T2	
epinastine hcl	T2	
LASTACAFT 0.25% EYE DROPS	T4	ST

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T4	ST QL(30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEP.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T4	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T4	PA HD QL (1 kit/28 days)
BYDUREON BCISE	T3	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T3	PA QL(4 pens/fill) HD
BYETTA	T3	PA QL (1 pen/30 days)
OZEMPIC	T3	PA QL(1 pen/28 days)
RYBELSUS 1.5 MG TABLET	T3	PA
RYBELSUS 14 MG TABLET	T3	PA QL (30 tabs/30 days)
RYBELSUS 3 MG TABLET	T3	PA QL (30 tabs/30 days)
RYBELSUS 4 MG TABLET	T3	PA
RYBELSUS 7 MG TABLET	T3	PA QL (30 tabs/30 days)
RYBELSUS 9 MG TABLET	T3	PA
TRULICITY	T3	PA QL (4 pens/28 days)
TRULICITY 0.75 MG/0.5 ML PEN	T3	PA QL(4 pens/fill) HD
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T3	QL(15 mls/fill) HD
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T4	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T3	PA QL(4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T2	HD
miglitol	T2	HD
PRECOSE *(acarbose)*	T4	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T3	PA QL(7 pens/fill) HD
SYMLINPEN 60	T3	PA QL (7 pens/30 days)
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
metformin er 1,000 mg gastr-tb (Glumetza)	T2	PA QL(60 tabs/fill) HD
metformin er 500 mg gastrc-tb (Glumetza)	T2	PA QL(120 tabs/fill) HD
metformin er 1,000 mg osm-tab	T2	PA QL (60 tabs/30 days) HD
metformin er 500 mg osmotic tb	T2	PA QL (30 tabs/30 days) HD

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
metformin hcl 500 mg, 750 mg tablet	T1	HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T2	ST HD
metformin hcl 850 mg tablet	T1	HD
metformin hcl er 500 mg tablet	T1	QL(120 tabs/fill) HD
metformin hcl er 750 mg tablet	T1	QL(60 tabs/fill) HD
RIOMET *(metformin hcl)*	T4	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T3	ST QL(30 tabs/fill) HD
saxagliptin hcl (Onglyza)	T2	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg, 2 mg, 4 mg tablet	T1	HD
glipizide	T1	HD
glipizide (Glucotrol XI)	T1	HD
GLUCOTROL XL (*glipizide*)	T4	HD
glyburide	T2	HD
glyburide,micronized	T2	HD
glyburide,micronized (Glynase)	T2	HD
GLYNASE *(glyburide,micronized)*	T4	HD
nateglinide	T2	HD
PRANDIN *(repaglinide)*	T4	HD
repaglinide	T2	HD
repaglinide (Prandin)	T2	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET *(pioglitazone hcl/metformin hcl)*	T4	QL (90 tabs/30 days) HD
ACTOPLUS MET XR 30 1000MG TABLET	T4	ST
pioglitazone hcl/metformin hcl	T2	QL(90 tabs/fill) HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T2	QL(90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T4	QL (30 tabs/30 days) HD
pioglitazone hcl/glimepiride (Duetact)	T2	QL(30 tabs/fill) HD

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T3	ST QL(60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T3	ST QL(30 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T3	ST QL(60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T3	ST QL(60 tabs/fill) HD
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T2	ST QL(30 tabs/30 days) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T2	ST QL(30 tabs/30 days) HD
saxagliptn-metform er 2.5-1000 (Kombiglyze Xr)	T2	ST QL(60 tabs/30 days) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T2	PA SP
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T2	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS *(pioglitazone hcl)*	T4	QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T3	ST QL(60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T3	ST QL(30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T3	ST QL(60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T3	ST QL(30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T3	ST QL(30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T3	ST QL(30 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T3	ST QL (30 tabs/30 days)
JARDIANCE	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T3	ST HD
INSULINS		
HUMALOG 100 unit/ML CARTRIDGE	T3	HD
HUMALOG JUNIOR KWIKPEN	T3	HD
HUMALOG KWIKPEN U-100	T3	HD

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS (cont.)		
HUMALOG KWIKPEN U-200	T3	HD
HUMALOG MIX 50-50 KWIKPEN	T3	HD
HUMALOG MIX 75-25	T3	HD
HUMALOG MIX 75-25 KWIKPEN	T3	HD
HUMULIN 70/30 KWIKPEN	T3	HD
HUMULIN 70-30	T3	HD
HUMULIN N	T3	HD
HUMULIN N KWIKPEN	T3	HD
HUMULIN R	T3	HD
HUMULIN R U-500	T3	HD
HUMULIN R U-500 KWIKPEN	T3	HD
INSULIN GLARGINE-YFGN	T3	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T3	HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	HD
INSULIN LISPRO KWIKPEN U-100	T3	HD
INSULIN LISPRO PROTAMINE MIX	T3	HD
LYUMJEV	T3	HD
LYUMJEV KWIKPEN U-100	T3	HD
LYUMJEV KWIKPEN U-200	T3	HD
MYXREDLIN	T4	
SEMGLEE (YFGN)	T3	HD
SEMGLEE (YFGN) PEN	T3	HD
TOUJEO MAX SOLOSTAR	T3	HD
TOUJEO SOLOSTAR	T3	HD
TRESIBA	T3	HD
TRESIBA FLEXTOUCH U-100, U-200	T3	HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T4	
ANTIINFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T2	

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

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T2	
RELAGARD *(acetic acid/oxyquinoline)*	T4	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole 250 mg tablet	T2	QL(40 tabs/30 days)
tinidazole 500 mg tablet	T2	QL(20 tabs/30 days)
AMEBICIDES		
HUMATIN	T4	
paromomycin sulfate	T2	
ANTHELMINTICS		
albendazole (Albenza)	T2	QL(120 tabs/30 days)
ALBENZA (*albendazole*)	T4	QL(120 tabs/30 days)
BILTRICIDE (*praziquantel*)	T4	
ANTHELMINTICS		
EMVERM	T3	QL(6 tabs/30 days)
ivermectin 6 mg tablet	T2	PA
praziquantel (Biltricide)	T2	
STROMECTOL (*ivermectin*)	T4	PA QL(14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T4	QL(16 tabs/fill)
atovaquone-proguanil 250-100 (Malarone)	T2	QL(60 tabs/180 days)
atovaquone-proguanil 62.5-25 (Malarone)	T2	QL(180 tabs/180 days)
chloroquine phosphate	T2	
COARTEM	T3	QL(24 tabs/30 days)
DARAPRIM *(pyrimethamine)*	T4	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T4	
hydroxychloroquine 200 mg tab (Plaquenil)	T2	
HYDROXYCHLOROQUINE 300 MG, 400 MG TAB	T4	
KRINTAFEL	T4	QL(2 tabs/30 days)
MALARONE 250-100 MG TABLET *(atovaquone/proguanil hcl)*	T4	QL(60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB *(atovaquone/proguanil hcl)*	T4	QL(180 tabs/180 days)
mefloquine hcl	T2	QL(13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T3	QL(120 tabs/180 days)

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
ANTIMALARIAL DRUGS (cont.)		
primaquine 26.3 mg tablet	T2	QL(120 tabs/180 days)
pyrimethamine 25 mg tablet (Daraprim)	T2	PA
pyrimethamine 25 mg tablet (Daraprim)	T2	PA SP
QUALAQUIN (*quinine sulfate)*	T4	QL(42 caps/30 days)
quinine sulfate (Qualaquin)	T2	QL(42 caps/30 days)
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T2	
BENZNIDAZOLE	T3	QL(360 tabs/fill)
IMPAVIDO	T3	PA QL(84 caps/30 days)
MEPRON (*atovaquone*)	T4	
NEBUPENT *(pentamidine isethionate)*	T4	QL(1 vl/28 days)
pentamidine isethionate (Nebupent)	T2	QL(1 vl/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
glycine urologic solution	T2	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T4	
CVS ISOPROPYL ALCOHOL 91% SPRY	T4	
GS ISOPROPYL ALCOHOL 70% SPRAY	T4	
ISOPROPYL ALCOHOL 70% SPRAY	T4	
MEDI-FIRST ISOPROPYL ALCOHOL	T4	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T2	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T4	ST
ciclopirox 8% treatment kit	T2	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ(CF)	T4	PA QL(2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T4	PA QL (2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL (2 srnge kits/28 days) SP HD

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T4	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL (4 pens/365 days) SP HD
ENBREL 25 MG KIT	T4	PA QL(8 vls/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL(8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL(8 vials/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL SP HD
ENBREL MINI	T4	PA QL SP HD
ENBREL SURECLICK	T4	PA QL SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL(1pen/30 days) SP HD
SIMLANDI(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL(1 syringe/30 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T2	PA SP HD CSL
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA QL(6 caps/fill) CSL
ZOLINZA	T4	PA QL(120 caps/fill) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (*melphalan*)	T4	SP CSL
cyclophosphamide 25 mg capsule	T2	SP HD CSL
cyclophosphamide 50 mg capsule	T2	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	SP HD CSL
GLEOSTINE	T3	CSL
HYDREA *(hydroxyurea)*	T4	CSL
hydroxyurea (Hydrea)	T2	CSL
LEUKERAN	T3	CSL
MYLERAN	T3	CSL
temozolomide	T2	PA SP HD CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T2	PA QL (120 tabs/30 days) CSL
bicalutamide (Casodex)	T2	CSL
CASODEX (*bicalutamide*)	T4	CSL
ERLEADA 240 MG TABLET	T4	PA SP HD QL (30 tabs/30 days) CSL
EULEXIN *(flutamide)*	T4	CSL
flutamide (Eulexin)	T2	CSL
NILANDRON *(nilutamide)*	T4	PA CSL
nilutamide (Nilandron)	T2	PA CSL
NUBEQA	T4	PA QL(120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE	T4	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 40 MG TABLET	T4	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T4	PA QL(60 tabs/fill) SP HD CSL
YONSA	T4	PA QL (120 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
LONSURF	T4	PA SP HD CSL
mercaptopurine 20 mg/ml suspen	T2	SP CSL
mercaptopurine 50 mg tablet	T2	CSL
methotrexate 2.5 mg tablet	T2	CSL
methotrexate 250 mg/10 ml vial	T2	
methotrexate 50 mg/2 ml vial	T2	
methotrexate sodium/pf	T2	
PURIXAN	T4	SP CSL
TABLOID	T4	CSL
TREXALL	T4	CSL
XELODA 150 MG TABLET (*capecitabine*)	T4	PA SP HD QL (56 tabs/30 days) CSL
XELODA 500 MG TABLET (*capecitabine*)	T4	PA SP HD QL (140 tabs/30 days)CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T2	HD PPACA CSL
AROMASIN (*exemestane*)	T4	HD CSL
exemestane (Aromasin)	T2	HD PPACA CSL
FEMARA *(letrozole)*	T4	HD CSL
letrozole (Femara)	T2	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA QL (180 caps/30 days) SP HD CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - BRAF KINASE INHIBITORS (cont.)		
OJEMDA	T4	PA SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	SP PA HD QL (840ml/30 days) CSL
ZELBORAF	T4	PA QL(240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 100 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
DAURISMO 25 MG TABLET	T4	PA QL(60 tabs/fill) SP HD CSL
ERIVEDGE	T4	PA QL(30 caps/fill) SP HD CSL
ODOMZO	T4	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T4	PA SP HD CSL
ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA QL(63 tabs/fill) SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO	T4	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA SP HD QL (108ml/30 days) CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
MEKTOVI	T4	PA QL (180 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus 2 mg tab for susp (Afinitor Disperz)	T2	PA QL(30 tabs/fill) SP CSL
everolimus (Afinitor)	T2	PA QL (30 tabs/30 days) SP CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T2	PA QL(30 tabs/fill) SP CSL
*everolimus 5 mg tab for susp (*Afinitor Disperz*)*	T2	PA QL(30 tabs/fill) SP CSL
everolimus 5 mg tablet (Torpenz)	T2	PA QL (30 tabs/30 days) SP HD CSL
everolimus 7.5 mg tablet (Torpenz)	T2	PA QL (30 tabs/30 days) SP HD CSL
everolimus 10 mg tablet (Torpenz)	T2	PA QL (30 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA 200 MG CO-PACK	T4	PA QL (49 tabs/30 days) SP CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT (cont.)		
KISQALI FEMARA 400 MG CO-PACK	T4	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T4	PA QL (91 tabs/30 days) SP CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T2	PA QL(30 caps/fill) SP HD CSL
POMALYST	T4	PA SP HD CSL
REVLIMID	T4	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T4	PA QL(30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(240 caps/fill) SP HD CSL
ALUNBRIG 180 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(60 tabs/fill) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(30 tabs/fill) SP CSL
AUGTYRO	T4	PA SP HD CSL
AYVAKIT	T4	PA QL(30 tabs/fill) SP CSL
BALVERSA	T4	PA SP CSL
BOSULIF 50 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T4	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 400 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
BOSULIF 500 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
BRUKINSA	T4	PA SP CSL
CALQUENCE	T4	PA QL(60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL(60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL(56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL(112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL(84 caps/fill) SP HD CSL
COPIKTRA	T4	PA QL(56 caps/fill) SP CSL
DANZITEN	T4	PA SP CSL
dasatinib 20 mg tablet (Sprycel)	T2	PA QL (90 tabs/30 days) SP CSL
dasatinib 20 mg tablet (Sprycel)	T2	PA QL (90 tabs/30 days) SP HD CSL
dasatinib 50 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
dasatinib 50 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP HD CSL
dasatinib 70 mg tablet (Sprycel)	T2	PA QL (60 tabs/30 days) SP CSL
dasatinib 70 mg tablet (Sprycel)	T2	PA QL (60 tabs/30 days) SP HD CSL
dasatinib 80 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP CSL
dasatinib 80 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP HD CSL
dasatinib 100 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP CSL
dasatinib 100 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP HD CSL
dasatinib 140 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP CSL
dasatinib 140 mg tablet (Sprycel)	T2	PA QL (30 tabs/30 days) SP HD CSL
erlotinib hcl 100 mg tablet (Tarceva)	T2	PA QL(30 tabs/fill) SP HD CSL
erlotinib hcl 150 mg tablet	T2	PA QL (30 tabs/30 days) SP HD CSL
FRUZAQLA	T4	PA SP CSL
GAVRETO	T4	PA QL (120 caps/30 days) SP CSL
GILOTRIF	T4	PA QL(30 tabs/fill) SP HD CSL
IBRANCE	T4	PA QL (21 tabs/caps/30 days) SP HD CSL
ICLUSIG	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL(120 caps/fill) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL(30 caps/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL(3 bottles/fill) SP CSL
IMKELDI	T4	PA SP CSL
INLYTA 1 MG TABLET	T4	PA QL(180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T4	PA QL(120 tabs/fill) SP HD CSL
IRESSA (*gefitinib*)	T4	PA QL(30 tabs/30 days) SP HD CSL
IWILFIN	T4	PA SP CSL
KISQALI	T4	PA SP HD QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T4	PA SP HD QL (1 pack/28 days) CSL
lapatinib ditosylate (Tykerb)	T2	PA QL(180 tabs/fill) SP HD CSL
LAZCLUZE	T4	PA SP CSL
LENVIMA 10 MG DAILY DOSE	T4	PA QL(30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LENVIMA 18 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
LYNPARZA	T4	PA QL(120 tabs/fill) SP HD CSL
LYTGOBI	T4	PA SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (*sorafenib tosylate*)	T4	PA QL(120 tabs/fill) SP HD CSL
NINLARO	T4	PA QL(3 caps/fill) SP HD CSL
OGSIVEO	T4	PA SP CSL
pazopanib hcl (Votrient)	T2	PA QL(120 tabs/30 days) SP HD CSL
PEMAZYRE	T4	PA QL(28 tabs/30 days) SP CSL
PIQRAY	T4	PA SP HD CSL
RETEVMO 40 MG CAPSULE	T4	PA QL(180 caps/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T4	PA QL(120 caps/fill) SP HD CSL
RETEVMO 40 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 120 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T4	PA SP CSL
ROMVIMZA	T4	PA SP CSL
ROZLYTREK 100 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T4	PA QL(90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T4	PA QL(42 packs/fill) SP HD CSL
RYDAPT	T4	PA QL(224 caps/fill) SP HD CSL
SCEMBLIX 20 MG TABLET	T4	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T4	PA QL (120 tabs/fill) SP CSL
sorafenib tosylate (Nexavar)	T2	PA QL(120 tabs/fill) SP HD CSL
SPRYCEL 100 MG TABLET *(dasatinib)*	T4	PA QL (30 tabs/30 days) SP HD CSL
SPRYCEL 140 MG TABLET*(dasatinib)*	T4	PA QL (30 tabs/30 days) SP HD CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
SPRYCEL 20 MG TABLET *(dasatinib)*	T4	PA QL (90 tabs/30 days) SP HD CSL
SPRYCEL 50 MG TABLET *(dasatinib)*	T4	PA QL (30 tabs/30 days) SP HD CSL
SPRYCEL 70 MG TABLET *(dasatinib)*	T4	PA QL (60 tabs/30 days) SP HD CSL
SPRYCEL 80 MG TABLET *(dasatinib)*	T4	PA QL (30 tabs/30 days) SP HD CSL
STIVARGA	T4	PA QL(84 tabs/fill) SP HD CSL
sunitinib malate 12.5 mg cap (Sutent)	T2	PA QL(90 caps/fill) SP HD CSL
sunitinib malate 25 mg capsule (Sutent)	T2	PA QL(30 caps/fill) SP HD CSL
sunitinib malate 37.5 mg cap (Sutent)	T2	PA QL(30 caps/fill) SP HD CSL
sunitinib malate 50 mg capsule (Sutent)	T2	PA QL(30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (*sunitinib malate*)	T4	PA QL(90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (*sunitinib malate*)	T4	PA QL(30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (*sunitinib malate*)	T4	PA QL(30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (*sunitinib malate*)	T4	PA QL(30 caps/fill) SP HD CSL
TABRECTA	T4	PA SP HD CSL
TAGRISSO	T4	PA QL(30 tabs/fill) SP HD CSL
TALZENNA	T4	PA QL(30 caps/fill) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TARCEVA (*erlotinib hcl*)	T4	PA QL (30 tabs/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE	T4	PA QL(120 caps/fill) SP HD CSL
TASIGNA 150 MG, 200 MG CAPSULE	T4	PA QL(112 caps/fill) SP HD CSL
TRUQAP	T4	PA SP CSL
TUKYSA 150 MG TABLET	T4	PA QL(120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T4	PA QL(300 tabs/fill) SP CSL
TURALIO	T4	PA QL(120 caps/fill) SP CSL
TYKERB (*lapatinib ditosylate*)	T4	PA QL(180 tabs/fill) SP HD CSL
VERZENIO	T4	PA QL(60 tabs/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T4	PA QL(300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T4	PA QL(180 caps/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD CSL

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
VIZIMPRO	T4	PA QL(30 tabs/fill) SP HD CSL
VONJO	T4	PA QL(120 caps/fill) SP CSL
VOTRIENT *(pazopanib hcl)*	T4	PA QL(120 tabs/30 days) SP HD CSL
XALKORI 200MG CAPSULE	T4	PA QL(60 caps/30 days) SP HD CSL
XALKORI 250MG CAPSULE	T4	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XALKORI 50MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XALKORI 150MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XOSPATA	T4	PA QL(90 tabs/fill) SP CSL
ZEJULA 100MG, 200MG, 300MG TABLET	T3	SP PA
ZYDELIG	T4	PA QL(60 tabs/fill) SP HD CSL
ZYKADIA	T4	PA QL(90 tabs/caps/fill) SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T4	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T4	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T4	PA QL(180 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T4	PA QL(28 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T4	PA QL(42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T4	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA QL(30 tabs/fill) SP HD CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T4	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
etoposide	T2	SP HD CSL
LYSODREN	T3	CSL
MATULANE	T4	SP CSL
tretinoin 10 mg capsule	T2	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T4	HD CSL
SOLTAMOX	T4	HD PPACA CSL

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS (Cancer) (cont.)		
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) (cont.)		
tamoxifen citrate	T2	HD PPACA CSL
toremifene citrate (Fareston)	T2	HD CSL
STEROID ANTINEOPLASTICS		
megestrol 20 mg, 40 mg tablet	T2	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T2	PA SP HD
diclofenac sodium 3% gel	T2	PA QL(100 gms/28 days)
EFUDEX *(fluorouracil)*	T4	
FLUOROPLEX	T4	
fluorouracil 2% topical soln	T2	
fluorouracil 5% cream (Efudex)	T2	
fluorouracil 5% topical soln	T2	
PANRETIN	T4	PA SP HD
TARGRETIN 1% GEL (*bexarotene*)	T4	PA SP HD
TOLAK	T4	
VALCHLOR	T4	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (*phentermine hcl*)	T4	PA QL(30 tabs/30 days)
benzphetamine hcl	T2	PA QL(90 tabs/fill)
diethylpropion hcl	T2	PA QL(90 tabs/fill)
diethylpropion hcl	T2	PA QL(30 tabs/fill)
LOMAIRA	T4	PA QL(90 tabs/fill)
phendimetrazine tartrate	T2	PA QL(30 caps/fill)
phendimetrazine tartrate	T2	PA QL(180 tabs/fill)
phentermine 15 mg, 30 mg capsule	T2	PA QL(30 caps/fill)
phentermine 37.5 mg capsule	T2	PA QL(30 caps/30 days)
phentermine 37.5 mg tablet (Adipex-P)	T2	PA QL(30 tabs/fill)
QSYMIA	T4	PA QL(30 caps/fill)

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

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T3	PA QL (2 mls/28 days)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T4	PA QL(6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEP AGONIST		
SAXENDA	T4	PA QL (5 pens/30 days)
WEGOVY 0.25 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T3	PA QL(4 pens/28 days)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T4	PA
BELVIQ XR	T4	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T4	PA QL(120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T4	PA QL(90 caps/fill)
XENICAL	T4	PA QL(90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	QL(10 mgs/30 days) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	QL(180ml/30 days)
TOPICAL ANTIPARASITICS		
crotamiton	T2	
ELIMITE (*permethrin*)	T4	
EURAX	T4	
permethrin (Elimite)	T2	
spinosad (Natroba)	T2	
ULESFIA	T4	

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

List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T2	HD
ANTIPARKINSONISM DRUGS, OTHER		
amantadine hcl	T2	HD
apomorphine hcl	T2	PA QL(30 mls/30 days) SP
AZILECT (*rasagiline mesylate*)	T4	ST HD
bromocriptine mesylate	T2	HD
carbidopa/levodopa	T2	HD
carbidopa/levodopa (Sinemet)	T2	HD
carbidopa/levodopa/entacapone	T2	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T2	HD
carbidopa/levodopa/entacapone (Stalevo 50)	T2	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T2	HD
CREXONT	T4	ST HD
DUOPA	T4	PA SP HD
entacapone	T2	HD
INBRIJA	T4	PA QL(300 caps/fill) SP HD
KYNMOBI	T3	PA QL(150 films/30 days) HD
NEUPRO	T4	HD
NOURIANZ	T4	PA QL(30 tabs/fill) SP HD
ONGENTYS	T4	PA QL (30 caps/30 days) HD
pramipexole di-hcl	T2	HD
rasagiline mesylate (Azilect)	T2	HD
ropinirole hcl	T2	HD
RYTARY	T4	ST HD
selegiline hcl	T2	HD
SINEMET (*carbidopa/levodopa*)	T4	HD
STALEVO 100 (*carbidopa/levodopa/entacapone*)	T4	HD
STALEVO 50 (*carbidopa/levodopa/entacapone*)	T4	HD
STALEVO 75 (*carbidopa/levodopa/entacapone*)	T4	HD
TASMAR (*tolcapone*)	T4	PA HD
tolcapone (Tasmar)	T2	PA HD

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

List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T2	PA
LODOSYN *(carbidopa)*	T4	PA
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T2	HD
BRILINTA	T3	HD
cilostazol	T2	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T2	HD
EFFIENT *(prasugrel hcl)*	T4	HD
prasugrel hcl (Effient)	T2	HD
ticagrelor	T2	HD
ZONTIVITY	T4	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN *(anagrelide hcl)*	T4	
anagrelide hcl	T2	
anagrelide hcl (Agrylin)	T2	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T4	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T4	SP
DOVATO	T4	SP
TRIUMEQ	T4	SP
TRIUMEQ PD	T4	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	SP
darunavir (Prezista)	T2	SP
PREZISTA 600MG, 800MG TABLET (*darunavir*)	T4	SP

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	SP
DESCOVY	T4	SP
*emtricitabine-tenofv 100-150mg (*Truvada*)*	T2	SP
*emtricitabine-tenofv 133-200mg (*Truvada*)*	T2	SP
*emtricitabine-tenofv 167-250mg (*Truvada*)*	T2	SP
*emtricitabine-tenofv 200-300mg (*Truvada*)*	T2	SP PPACA
TEMIXYS	T4	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
*abacavir sulfate/lamivudine (*Epzicom*)*	T2	SP
COMBIVIR *(lamivudine/zidovudine)*	T4	SP
EPZICOM *(abacavir sulfate/lamivudine)*	T4	SP
*lamivudine/zidovudine (*Combivir*)*	T2	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T2	SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	SP
SELZENTRY 25 MG TABLET	T4	SP
SELZENTRY 75 MG TABLET	T4	SP
SELZENTRY 150 MG TABLET (*maraviroc*)	T4	SP
SELZENTRY 300 MG TABLET (*maraviroc*)	T4	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	SP QL (60 vials/30 days)
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	SP
*efavirenz (*Sustiva*)*	T2	SP
*etravirine (*Intelence*)*	T2	SP
INTELENCE 100 MG TABLET *(etravirine)*	T4	SP
INTELENCE 200 MG TABLET *(etravirine)*	T4	SP
INTELENCE 25 MG TABLET	T4	SP
nevirapine	T2	SP
*nevirapine (*Viramune Xr*)*	T2	SP
SUSTIVA *(efavirenz)*	T4	SP
VIRAMUNE XR (*nevirapine*)	T4	SP

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T2	SP
abacavir sulfate (Ziagen)	T2	SP
didanosine	T2	SP
emtricitabine (Emtriva)	T2	SP
EMTRIVA 10 MG/ML SOLUTION	T4	SP
EMTRIVA 200 MG CAPSULE (*emtricitabine*)	T4	SP
EPIVIR (*lamivudine*)	T4	SP
lamivudine (Epivir)	T2	SP
RETROVIR (zidovudine)	T4	SP
stavudine	T2	SP
ZIAGEN (*abacavir sulfate*)	T4	SP
zidovudine	T2	SP
zidovudine (Retrovir)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate (Viread)	T2	SP
VIREAD 150 MG TABLET	T4	SP
VIREAD 200 MG TABLET	T4	SP
VIREAD 250 MG TABLET	T4	SP
VIREAD 300 MG TABLET (*tenofovir disoproxil fumarate*)	T4	SP
VIREAD POWDER	T4	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA (*lopinavir/ritonavir*)	T4	SP
lopinavir/ritonavir (Kaletra)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate (Reyataz)	T2	SP
EVOTAZ	T4	SP
fosamprenavir calcium	T2	SP
NORVIR 100 MG TABLET (*ritonavir*)	T4	SP
REYATAZ 150 MG CAPSULE (*atazanavir sulfate*)	T4	SP
REYATAZ 200 MG CAPSULE (*atazanavir sulfate*)	T4	SP
REYATAZ 300 MG CAPSULE (*atazanavir sulfate*)	T4	SP
REYATAZ 50 MG POWDER PACKET	T4	SP
ritonavir (Norvir)	T2	SP
VIRACEPT	T4	SP

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-1 INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
efavirenz/emtricit/tenofovr df	T2	SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T2	SP
efavirenz/lamivu/tenofov disop (Symfi)	T2	SP
ODEFSEY	T4	SP
SYMFI *(efavirenz/lamivu/tenofov disop)*	T4	SP
SYMFI LO *(efavirenz/lamivu/tenofov disop)*	T4	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T2	
ZIRGAN	T4	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID 150-100 MG (MODERATE)	T3	QL (20 tabs/180 days)
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T3	PPACA
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T2	
acyclovir 200 mg/5 ml susp cup	T2	
acyclovir 800 mg/20ml susp cup	T2	
acyclovir 200 mg/5 ml susp (Zovirax)	T2	
acyclovir 400 mg tablet	T2	
acyclovir 800 mg tablet	T2	
famciclovir 125 mg tablet	T2	QL(21 tabs/fill)

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

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL (cont.)		
famciclovir 250 mg tablet	T2	QL(60 tabs/fill)
famciclovir 500 mg tablet	T2	QL(21 tabs/fill)
FLUMADINE (*rimantadine hcl*)	T4	
LIVTENCITY	T4	PA QL(112 tabs/28 days) SP
*oseltamivir 6 mg/ml suspension (*Tamiflu*)*	T2	QL(180 mls/30 days)
*oseltamivir phos 30 mgRINVOQ capsule (*Tamiflu*)*	T2	QL(20 caps/30 days)
*oseltamivir phos 45 mg capsule (*Tamiflu*)*	T2	QL(10 caps/30 days)
*oseltamivir phos 75 mg capsule (*Tamiflu*)*	T2	QL(10 caps/30 days)
PREVYMIS 120 MG PELLET PACKET	T4	SP
PREVYMIS 20 MG PELLET PACKET	T4	SP
PREVYMIS 240 MG TABLET	T4	QL (30 tabs/28 days) SP HD
PREVYMIS 480 MG TABLET	T4	QL (30 tabs/28 days) SP HD
RELENZA	T4	QL(20 blisters/10 days)
*rimantadine hcl (*Flumadine*)*	T2	
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T4	QL(20 caps/fill)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T4	QL(10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T4	QL(180 mls/fill)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T4	QL(10 caps/fill)
valacyclovir hcl (Valtrex)	T2	QL(30 tabs/fill)
VALCYTE *(valganciclovir hcl)*	T4	
*valganciclovir hcl (*Valcyte*)*	T2	
XOFLUZA	T4	QL(1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (*acyclovir*)	T4	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA QL(28 tabs/fill) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T4	PA QL(28 packs/fill) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(28 tabs/fill) SP HD
EPCLUSA 200-50 MG PELLET PACK	T4	PA SP HD QL (28 pkts/28 days)
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL(28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL(28 packs/fill) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL(56 packs/fill) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL(56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL(>= 18 yo 28 tabs/fill) SP HD

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

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T2	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
entecavir (Baraclude)	T2	SP HD
lamivudine	T2	SP
PEGASYS 180 MCG/0.5 ML SYRINGE KIT	T4	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T4	SP HD
ribasphere 200 mg capsule	T2	ST SP HD
ribasphere 600 mg tablet	T2	ST SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
ribavirin	T2	PA SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL(28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
acyclovir 5% cream (Zovirax)	T2	PA QL(5 gms/fill)
acyclovir 5% ointment (Zovirax)	T2	PA QL(30 gms/fill)
DENAVIR	T4	
penciclovir	T2	
ZOVIRAX 5% CREAM (*acyclovir*)	T4	PA QL(5 gms/fill)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T3	QL(2 auto-injs/30 days)
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T2	QL(2 auto-injs/fill)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T2	QL(2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T2	QL(2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen)	T2	QL(2 auto-injs/fill)
EPIPEN (*epinephrine*)	T3	PA QL(2 auto-injs/fill)
EPIPEN 2-PAK (*epinephrine*)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR (*epinephrine*)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR 2-PAK (*epinephrine*)	T3	PA QL(2 auto-injs/fill)
NEFFY 1 MG/0.1 ML NASAL SPRAY	T3	
NEFFY 2 MG/0.1 ML NASAL SPRAY	T3	QL (4 units/fill)

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTONOMIC DRUGS (Allergy/Nasal Sprays) (cont.)		
ANAPHYLAXIS THERAPY AGENTS (cont.)		
SYMJEPI	T3	QL(2 syringes/fill)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADLARITY	T4	ST HD
ARICEPT *(donepezil hcl)*	T4	ST HD
donepezil hcl	T1	HD
donepezil hcl 5mg, 10mg tablet (Aricept)	T1	HD
donepezil hcl 23 mg tablet (Aricept)	T1	ST HD
EXELON *(rivastigmine)*	T4	ST HD
galantamine hbr	T2	HD
galantamine hbr (Razadyne Er)	T2	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T2	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T4	HD
pyridostigmine br 60 mg tablet (Mestinon)	T2	HD
pyridostigmine bromide (Mestinon)	T2	HD
RAZADYNE ER (*galantamine hbr*)	T4	ST HD
rivastigmine (Exelon)	T2	HD
rivastigmine tartrate	T2	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS XR-ODT	T4	ST
amphetamine sulfate (Evekeo)	T2	
DESOXYN (*methamphetamine hcl*)	T4	
DEXEDRINE (*dextroamphetamine sulfate*)	T4	ST
dextroamphetamine sulfate	T2	
dextroamphetamine sulfate (Dexedrine)	T2	
dextroamphetamine sulfate (Zenzedi)	T2	
dextroamphetamine/amphetamine (Adderall Xr)	T2	
dextroamphetamine/amphetamine (Adderall)	T2	
dextroamphetamine/amphetamine (Mydayis)	T2	
EVEKEO ODT	T4	
methamphetamine hcl (Desoxyn)	T2	
MYDAYIS *(dextroamphetamine/amphetamine)*	T4	ST

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

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
zenzedi 10 mg tablet	T2	
ZENZEDI 15 MG TABLET *(dextroamphetamine sulfate)*	T4	
ZENZEDI 2.5 MG TABLET	T4	
ZENZEDI 20 MG TABLET *(dextroamphetamine sulfate)*	T4	
ZENZEDI 30 MG TABLET (*dextroamphetamine sulfate*)	T4	
zenzedi 5 mg tablet	T2	
ZENZEDI 7.5 MG TABLET *(dextroamphetamine sulfate)*	T4	
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T2	PA SP HD
midodrine hcl	T2	
DIBENZYLINE *(phenoxybenzamine hcl)*	T4	PA HD
phenoxybenzamine hcl (Dibenzyline)	T2	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T2	HD
bethanechol chloride (Urecholine)	T2	HD
cevimeline hcl (Evoxac)	T2	HD
EVOXAC (*cevimeline hcl*)	T4	HD
pilocarpine hcl (Salagen)	T2	HD
SALAGEN *(pilocarpine hcl)*	T4	HD
URECHOLINE (*bethanechol chloride*)	T4	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA
ODACTRA	T3	PA
ORALAIR	T3	PA
RAGWITEK	T3	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD

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

List of Prescription Medications

BIOLOGICALS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T4	PA QL(30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T4	PA QL(8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T4	PA QL(60 syringes/fill) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID EUA	T3	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T3	PPACA
NOVAVAX COVID (EUA)	T3	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T3	PPACA
PFIZER COVID EUA	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX	T3	PPACA
SPIKEVAX COVID (18Y UP) VACC	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	HD PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	
PREVNAR 20	T3	PPACA
VAXNEUVANCE	T3	PPACA

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES		
AUDENZ (NATIONAL STOCKPILE)	T3	
AFLURIA QUAD	T3	PPACA
AFLURIA TRIV	T3	PPACA
AFLURIA TRIVALENT	T3	PPACA
FLUAD	T3	PPACA
FLUAD QUAD	T3	PPACA
FLUAD TRIVALENT	T3	PPACA
FLUARIX QUAD	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUBLOK QUAD	T3	PPACA
FLUBLOK TRIVALENT	T3	PPACA
FLUCELVAX QUAD	T3	PPACA
FLUCELVAX TRIVALENT	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLULAVAL TRIVALENT	T3	PPACA
FLUMIST QUAD	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE HIGH-DOSE	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T3	PPACA
FLUZONE QUAD	T3	PPACA
FLUZONE QUAD PEDI	T3	PPACA
FLUZONE HIGH-DOSE TRIV	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T3	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	
HIBERIX	T3	PPACA

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000	T3	
AREXVY VIAL KIT	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA
HAVRIX	T3	PPACA
HEPLISAV-B	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	
PEDIARIX	T3	PPACA
PREHEVBRIO	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
VAQTA	T3	PPACA
VIMKUNYA	T3	

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

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T4	SP HD
aminocaproic acid (Amicar)	T2	SP HD
LYSTEDA (*tranexamic acid)*	T4	SP
tranexamic acid (Lysteda)	T2	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA SP
TAVNEOS	T4	PA QL (180 caps/30 days) SP
VOYDEYA	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T4	PA QL(56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T4	PA QL(14 tabs/365 days) SP
PYRUKYND 5 MG TABLET	T4	PA QL(56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T4	PA QL(7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T4	PA QL(56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T4	PA QL(14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T3	
ENDARI	T4	PA
glutamine	T2	PA
OXBRYTA	T4	SP
TOPICAL HEMOSTATICS		
ASTRINGYN	T4	
AVITENE	T4	
ENDO-AVITENE	T4	
EVICEL	T4	
GEL-FLOW	T4	
GEL-FLOW NT	T4	
GELFOAM	T4	
GELFOAM (*gelatin sponge,absorb/porcine*)	T4	
GELFOAM COMPRESSED	T4	
GELFOAM JMI	T4	

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
TOPICAL HEMOSTATICS (cont.)		
MONSEL'S	T3	
RECOTHROM	T4	
SURGICEL	T4	
SURGIFOAM SPONGE SIZE 100	T4	
SURGIFOAM SPONGE SIZE 100C	T4	
surgifoam sponge size 12-7 (Gelfoam)	T2	
SYRINGE AVITENE	T4	
THROMBI-GEL (*thrombin/cal/cmc/gel/dress,hem*)	T4	
THROMBIN-JMI	T4	
THROMBI-PAD	T4	
ULTRAFOAM	T4	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T2	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T2	HD
ranolazine (Ranexa)	T2	HD
RANEXA *(ranolazine)*	T4	ST HD
ANTIARRHYTHMICS		
amiodarone hcl	T2	HD
disopyramide phosphate (Norpace)	T2	HD
dofetilide (Tikosyn)	T2	HD
flecainide acetate	T2	HD
mexiletine hcl	T2	HD
MULTAQ	T3	HD
propafenone hcl	T2	HD
quinidine gluconate	T2	HD
quinidine sulfate	T2	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T4	
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate (Norvasc)	T1	HD

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
CALAN SR *(verapamil hcl)*	T4	ST HD
CARDIZEM (*diltiazem hcl*)	T4	HD
CARDIZEM CD (*diltiazem hcl*)	T4	HD
CARDIZEM LA	T4	HD
CARDIZEM LA (*diltiazem hcl*)	T4	HD
diltiazem hcl	T2	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem Cd)	T1	HD
diltiazem hcl (Cardizem La)	T2	HD
diltiazem hcl (Cardizem)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T2	HD
isradipine	T2	
nicardipine hcl	T2	HD
nifedipine	T2	HD
nifedipine (Procardia XL)	T2	HD
nifedipine (Procardia)	T2	HD
nimodipine 30 mg capsule	T2	HD
nimodipine 60 mg/20 ml soln	T2	
nisoldipine	T2	HD
nisoldipine (Sular)	T2	HD
NYMALIZE	T4	
PROCARDIA *(nifedipine)*	T4	ST HD
PROCARDIA XL *(nifedipine)*	T4	ST HD
SULAR *(nisoldipine)*	T4	ST HD
TIAZAC *(diltiazem hcl)*	T4	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T2	HD
verapamil hcl (Verelan)	T2	HD
VERELAN *(verapamil hcl)*	T4	ST HD
VERELAN *PM (verapamil hcl)*	T4	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	PA QL(30 caps/fill) SP HD

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIGITALIS GLYCOSIDES		
digoxin	T2	HD
digoxin (Lanoxin)	T2	HD
LANOXIN	T4	HD
LANOXIN *(digoxin)*	T4	HD
HEART RATE REDUCING,SA SELECTIVE I(F) CURRENT INH.		
ivabradine hcl (Corlanor)	T2	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T3	QL(30 tabs/fill)
VASODILATORS, CORONARY		
GONITRO	T4	HD
ISORDIL *(isosorbide dinitrate)*	T4	HD
ISORDIL TITRADOSE *(isosorbide dinitrate)*	T4	HD
isosorbide dinitrate	T2	HD
isosorbide dinitrate (Isordil Titradose)	T2	HD
isosorbide dinitrate (Isordil)	T2	HD
isosorbide mononitrate	T1	HD
MINITRAN	T4	HD
NITRO-DUR	T4	HD
nitroglycerin	T2	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T2	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T2	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T2	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T2	HD
NITROLINGUAL *(nitroglycerin)*	T4	HD
NITROMIST *(nitroglycerin)*	T4	HD
NITROSTAT *(nitroglycerin)*	T4	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA QL(90 tabs/fill) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (*sildenafil citrate*)	T4	PA QL(112 mls/fill) SP HD
REVATIO 20 MG TABLET (*sildenafil citrate*)	T4	PA QL(90 tabs/fill) SP HD
sildenafil 20 mg tablet (Revatio)	T2	PA QL(90 tabs/fill) SP HD
tadalafil (Adcirca)	T2	

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

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB (cont.)		
tadalafil 20 mg tablet (Adcirca)	T2	PA QL(60 tabs/fill) SP HD
WINREVAIR	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T2	PA QL(30 tabs/fill) SP HD
bosentan (Tracleer)	T2	PA QL(60 tabs/fill) SP HD
OPSUMIT	T4	PA QL(30 tabs/fill) SP HD
TRACLEER 125 MG TABLET *(bosentan)*	T4	PA QL(60 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA QL(120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T4	PA QL(60 tabs/fill) SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA QL(90 tabs/fill) SP HD
ORENITRAM TITRATION KT MONTH 1	T4	PA SP QL (168 tabs/28 days)
ORENITRAM TITRATION KT MONTH 2	T4	PA SP QL (336 tabs/28 days)
ORENITRAM TITRATION KT MONTH 3	T4	PA SP QL (252 tabs/28 days)
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 200 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 400 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
VENTAVIS	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
OPSYNVI	T4	PA QL (30 tabs/fill) SP HD

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD
PRESTALIA	T4	ST HD
trandolapril/verapamil hcl	T2	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (*quinapril/hydrochlorothiazide*)	T4	HD
benazepril/hydrochlorothiazide	T2	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T2	HD
captopril/hydrochlorothiazide	T2	HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T2	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT *(benazepril/hydrochlorothiazide)*	T4	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC *(enalapril/hydrochlorothiazide)*	T4	HD
ZESTORETIC *(lisinopril/hydrochlorothiazide)*	T4	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol phosphate (Coreg Cr)	T2	HD
COREG CR *(carvedilol phosphate)*	T4	ST HD
labetalol hcl 100 mg tablet	T2	HD
labetalol hcl 200 mg tablet	T2	HD
labetalol hcl 300 mg tablet	T2	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (*doxazosin mesylate*)	T4	ST QL(30 tabs/fill) HD
CARDURA 2 MG TABLET (*doxazosin mesylate*)	T4	ST QL(30 tabs/fill) HD
CARDURA 4 MG TABLET (*doxazosin mesylate*)	T4	ST QL(30 tabs/fill) HD
CARDURA 8 MG TABLET (*doxazosin mesylate*)	T4	ST QL(60 tabs/fill) HD
CARDURA XL	T4	ST QL(30 tabs/fill) HD
doxazosin mesylate 1 mg tab (Cardura)	T1	QL(30 tabs/fill) HD
doxazosin mesylate 2 mg tab (Cardura)	T1	QL(30 tabs/fill) HD
doxazosin mesylate 4 mg tab (Cardura)	T1	QL(30 tabs/fill) HD
doxazosin mesylate 8 mg tab (Cardura)	T1	QL(60 tabs/fill) HD

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-ADRENERGIC BLOCKING AGENTS (cont.)		
MINIPRESS (*prazosin hcl*)	T4	HD
prazosin hcl	T2	HD
prazosin hcl (Minipress)	T2	HD
terazosin 1 mg capsule	T1	QL(30 caps/fill) HD
terazosin 2 mg capsule	T1	QL(30 caps/fill) HD
terazosin 5 mg capsule	T1	QL(30 caps/fill) HD
terazosin 10 mg capsule	T1	QL(60 caps/fill) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T2	HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T2	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T3	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T3	QL (240 caps/fill) HD
sacubitril/valsartan	T2	QL (60 tabs/30 days) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid (Atacand Hct)	T2	HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
olmesartan/hydrochlorothiazide (Benicar Hct)	T1	HD
telmisartan/hydrochlorothiazid (Micardis Hct)	T2	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T2	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine bes/olmesartan med (Azor)	T2	HD
amlodipine besylate/valsartan (Exforge)	T2	HD
telmisartan/amlodipine	T2	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (*quinapril hcl*)	T4	HD
ALTACE (*ramipril*)	T4	HD
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T2	HD
enalapril maleate (Epaned)	T2	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril sodium	T1	HD

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)		
lisinopril (Zestril)	T1	HD
LOTENSIN (*benazepril hcl*)	T4	HD
moexipril hcl	T2	HD
perindopril erbumine	T1	HD
quinapril hcl (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC *(enalapril maleate)*	T4	HD
ZESTRIL *(lisinopril)*	T4	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T2	HD
eprosartan mesylate	T2	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
olmesartan medoxomil (Benicar)	T1	HD
telmisartan (Micardis)	T2	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 320 mg tablet (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T4	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (*metyrosine*)	T4	PA HD
metyrosine (Demser)	T2	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (*clonidine*)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 2 (*clonidine*)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 3 (*clonidine*)	T4	QL(4 patches/28 days) HD
clonidine (Catapres-Tts 1)	T2	QL(4 patches/28 days) HD
clonidine (Catapres-Tts 2)	T2	QL(4 patches/28 days) HD
clonidine (Catapres-Tts 3)	T2	QL(4 patches/28 days) HD
guanfacine hcl	T2	HD
methyldopa	T2	HD
methyldopa/hydrochlorothiazide	T2	HD

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, VASODILATORS		
hydralazine hcl	T2	HD
minoxidil	T2	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T2	HD
atenolol (Tenormin)	T1	HD
BETAPACE (*sotalol hcl*)	T4	ST HD
BETAPACE AF *(sotalol hcl)*	T4	ST HD
betaxolol hcl	T2	HD
bisoprolol fumarate	T2	HD
LOPRESSOR (*metoprolol tartrate*)	T4	ST HD
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
HEMANGEOL	T3	PA
nebivolol hcl (Bystolic)	T2	HD
pindolol	T2	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD
sotalol hcl (Betapace Af)	T2	HD
sotalol hcl (Betapace)	T2	HD
SOTYLIZE	T3	HD
TENORMIN *(atenolol)*	T4	ST HD
timolol maleate 10 mg tablet	T2	HD
timolol maleate 20 mg tablet		
timolol maleate 5 mg tablet	T2	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 50)	T2	HD
atenolol/chlorthalidone (Tenoretic 100)	T2	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T4	ST HD
metoprolol/hydrochlorothiazide	T2	HD
propranolol/hydrochlorothiazid	T2	HD
TENORETIC 50 *(atenolol/chlorthalidone)*	T4	ST HD
TENORETIC 100 *(atenolol/chlorthalidone)*	T4	ST HD
ZIAC (*bisoprolol/hydrochlorothiazide*)	T4	ST HD

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RENIN INHIBITOR, DIRECT		
aliskiren hemifumarate (Tekturna)	T2	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T3	HD
VASODILATORS, COMBINATION		
isosorbide dinit/hydralazine (Bidil)	T2	HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T2	
isoxsuprine hcl	T2	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/simvastatin (Vytorin)	T2	QL(30 tabs/fill) HD
ROSZET	T4	ST QL(30 tabs/fill) HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine/atorvastatin	T2	QL(30 tabs/fill) HD
amlodipine/atorvastatin (Caduet)	T2	QL(30 tabs/fill) HD
CADUET *(amlodipine/atorvastatin)*	T4	ST QL(30 tabs/fill) HD
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	PA SP
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T3	PA
ANTIHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T3	PA
REPATHA SURECLICK	T3	PA
REPATHA SYRINGE	T3	PA
ANTIHYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB		
NEXLIZET	T3	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
atorvastatin 10 mg tablet (Lipitor)	T1	
atorvastatin 20 mg tablet (Lipitor)	T1	
atorvastatin 40 mg tablet (Lipitor)	T1	
atorvastatin 80 mg tablet (Lipitor)	T1	
ezetimibe-atorvastatin tabs	T2	ST HD QL (30 tabs/30 days)

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
FLOLIPID	T4	ST QL(150 mls/fill) HD
fluvastatin sodium (Lescol XL)	T2	QL(30 tabs/fill) HD PPACA
fluvastatin sodium 20 mg cap	T2	QL(30 caps/fill) HD PPACA
fluvastatin sodium 40 mg cap	T2	QL(60 caps/fill) HD PPACA
LESCOL XL *(fluvastatin sodium)*	T4	ST QL(30 tabs/fill) HD
LIVALO (*pitavastatin calcium*)	T4	ST QL(30 tabs/30 days) HD
lovastatin 10 mg tablet	T2	QL(30 tabs/fill) HD PPACA
lovastatin 20 mg tablet	T2	QL(60 tabs/fill) HD PPACA
lovastatin 40 mg tablet	T2	QL(60 tabs/fill) HD PPACA
pitavastatin (Livalo)	T2	QL(30 tabs/30 days) HD PPACA
pravastatin sodium	T2	QL(30 tabs/fill) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T4	ST QL(150 mls/fill) HD
simvastatin 40 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
simvastatin 5 mg tablet	T1	QL(30 tabs/fill) HD PPACA
simvastatin 80 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD
ZYPITAMAG	T4	ST QL(30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
cholestyramine	T2	HD
cholestyramine (Questran Light)	T2	HD
cholestyramine (with sugar) (Questran)	T2	HD
cholestyramine/aspartame	T2	HD
colesevelam hcl (Welchol)	T2	HD
COLESTID	T4	ST HD
COLESTID (*colestipol hcl)*	T4	ST HD
colestipol hcl	T2	HD
colestipol hcl (Colestid)	T2	HD
QUESTRAN (*cholestyramine (with sugar))*	T4	ST HD
QUESTRAN LIGHT *(cholestyramine)*	T4	ST HD
LIPOTROPICS		
ANTARA	T4	ST HD
ezetimibe (Zetia)	T2	HD
fenofibrate 120 mg tablet (Fenoglide)	T2	ST HD

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOTROPICS (cont.)		
fenofibrate 130 mg capsule	T2	ST HD
fenofibrate 134 mg capsule	T2	HD
fenofibrate 145 mg tablet (Tricor)	T2	HD
fenofibrate 160 mg tablet	T2	HD
fenofibrate 200 mg capsule	T2	HD
fenofibrate 40 mg tablet (Fenoglide)	T2	ST HD
fenofibrate 43 mg capsule	T2	HD
fenofibrate 48 mg tablet (Tricor)	T2	HD
fenofibrate 54 mg tablet	T2	HD
fenofibrate 67 mg capsule	T2	HD
fenofibric acid	T2	HD
fenofibric acid (choline) (Trilipix)	T2	HD
fenofibric acid (Fibricor)	T2	HD
FENOGLIDE (*fenofibrate*)	T4	ST HD
FIBRICOR (*fenofibric acid*)	T4	ST HD
gemfibrozil (Lopid)	T1	HD
LOPID (*gemfibrozil*)	T4	HD
niacin	T2	HD
niacin 500 mg tablet	T2	HD
NIACOR	T4	HD
TRILIPIX *(fenofibric acid (choline))*	T4	ST HD
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
MEMANTINE 5-10 MG TITRATION PK	T4	HD
memantine hcl 10 mg/5 ml cup	T2	HD
memantine hcl	T2	HD
memantine hcl (Namenda Xr)	T2	HD
memantine hcl 2 mg/ml solution	T2	HD
memantine hcl 5 mg tablet	T2	HD
memantine hcl 10 mg tablet	T2	HD
NAMENDA	T4	HD
NAMENDA XR TITRATION PACK	T4	HD
NAMZARIC	T3	ST HD

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

List of Prescription Medications

CNS DRUGS (Alzheimer's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB		
memantine hcl/donepezil hcl (Namzaric)	T2	ST HD
NAMZARIC *(memantine hcl/donepezil hcl)*	T3	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS	T4	PA SP HD
RILUTEK (*riluzole*)	T4	PA SP HD
riluzole (Rilutek)	T2	PA SP HD
TEGLUTIK	T4	PA SP
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
AUSTEDO 9 MG , 12 MG TABLET	T4	PA QL(120 tabs/fill) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA SP HD QL (210 tabs/30 days)
AUSTEDO XR 12 MG TABLET	T4	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 18 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITR KT(6-12-24 MG)	T4	PA QL (42 tabs/30 days) SP HD
AUSTEDO XR TITR(12-18-24-30MG)	T4	PA QL (28 tabs/fill) SP HD
AUSTEDO XR 24MG TABLET	T4	PA SP HD QL (60 tabs/30 days)
AUSTEDO XR 30 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
HORIZANT	T4	ST
INGREZZA	T4	PA QL(30 caps/fill) SP
INGREZZA INITIATION PK(TARDIV)	T4	PA QL (28 caps/30 days) SP
INGREZZA SPRINKLE	T4	PA QL (30 caps/fill) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T2	PA QL(120 tabs/fill) SP HD
tetrabenazine 25 mg tablet (Xenazine)	T2	PA QL(60 tabs/fill) SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	PA
XANTHINES		
caffeine citrate	T2	HD

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

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T4	PA QL (1 kit/28 days) SP HD
AVONEX PEN (4 PACK)	T4	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T4	PA QL(120 caps/fill) SP HD
BETASERON	T4	PA QL(14 kits/30 days) SP HD
glatiramer 20 mg/ml syringe (Copaxone)	T2	PA QL(30 syringes/30 days) SP HD
glatiramer 40 mg/ml syringe (Copaxone)	T2	PA QL(12 syringes/30 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T2	PA QL(30 syringes/30 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T2	PA QL(12 syringes/30 days) SP HD
KESIMPTA PEN	T4	PA QL(1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T4	PA QL(10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T4	PA QL(4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T4	PA QL(5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T4	PA QL(6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T4	PA QL(7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T4	PA QL(8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T4	PA QL(9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T4	PA QL(7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T4	PA QL(12 tabs/fill) SP HD
MAYZENT 1 MG, 2 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T4	PA QL(1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRING	T4	PA QL(1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T4	PA QL(1 ml/365 days) SP HD
PLEGRIDY SYRINGE STARTER PACK	T4	PA QL(1 ml/365 days) SP HD
PONVORY 14-DAY STARTER PACK	T4	PA QL (14 tabs/365 days) SP HD
PONVORY 20 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T4	PA QL(6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T4	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T4	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T4	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T4	PA QL(4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T4	PA QL(4.2 mls/28 days) SP HD
VUMERITY	T4	PA QL(120 caps/fill) SP HD

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

List of Prescription Medications

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS		
APTIOM	T4	HD
BRIVIACT	T4	ST HD
carbamazepine (Carbatrol)	T2	HD
carbamazepine (Tegretol Xr)	T2	HD
carbamazepine (Tegretol)	T4	HD
carbamazepine 100 mg/5 ml cup	T2	HD
carbamazepine 200 mg/10 ml cup	T2	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T2	HD
carbamazepine 100 mg tab chew	T2	HD
CARBAMAZEPINE 200 MG TAB CHEW	T4	HD
carbamazepine 200 mg tablet (Tegretol)	T2	HD
CARBATROL (*carbamazepine*)	T3	HD
CELONTIN (methsuximide)	T4	HD
DEPAKOTE *(divalproex sodium)*	T4	ST HD
DEPAKOTE ER *(divalproex sodium)*	T4	ST HD
DEPAKOTE SPRINKLE *(divalproex sodium)*	T4	ST HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (*phenytoin sodium extended*)	T4	HD
DILANTIN 30 MG CAPSULE	T3	HD
DILANTIN 50 MG INFATAB (*phenytoin*)	T4	HD
DILANTIN-125 (*phenytoin*)	T4	HD
divalproex sodium (Depakote Er)	T2	HD
divalproex sodium (Depakote Sprinkle)	T2	HD
divalproex sodium (Depakote)	T2	HD
ELEPSIA XR	T4	ST HD
ethosuximide (Zarontin)	T2	HD
felbamate (Felbatol)	T2	HD
FELBATOL *(felbamate)*	T4	HD
FYCOMPA	T3	HD
gabapentin	T2	HD
gabapentin (Neurontin)	T1	HD
gabapentin (Neurontin)	T2	HD
lacosamide (Vimpat)	T2	HD
LAMICTAL XR (BLUE)	T4	ST HD

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS (cont.)		
LAMICTAL XR (GREEN)	T4	ST HD
LAMICTAL XR (ORANGE)	T4	ST HD
lamotrigine (Lamictal (Blue))	T2	HD
lamotrigine (Lamictal (Green))	T2	HD
lamotrigine (Lamictal (Orange))	T2	HD
lamotrigine (Lamictal Odt (Blue))	T2	HD
lamotrigine (Lamictal Odt (Green))	T2	HD
lamotrigine (Lamictal Odt (Orange))	T2	HD
lamotrigine (Lamictal Odt)	T2	HD
lamotrigine (Lamictal Xr)	T2	HD
lamotrigine (Lamictal)	T1	HD
lamotrigine (Lamictal)	T2	HD
levetiracetam (Keppra Xr)	T2	HD
levetiracetam (Keppra)	T2	HD
levetiracetam 1,000 mg tablet (Keppra)	T2	HD
levetiracetam 1,000mg/10ml cup (Keppra)	T2	HD
levetiracetam 100 mg/ml soln (Keppra)	T2	HD
LEVETIRACETAM 250 MG TAB SUSP	T4	ST HD
levetiracetam 250 mg tablet (Keppra)	T2	HD
levetiracetam 500 mg tablet (Keppra)	T2	HD
levetiracetam 500 mg/5 ml cup, soln	T2	HD
levetiracetam 750 mg tablet (Keppra)	T2	HD
MYSOLINE (*primidone*)	T4	HD
oxcarbazepine (Oxtellar Xr)	T2	HD
oxcarbazepine (Trileptal)	T2	HD
OXTELLAR XR *(oxcarbazepine)*	T4	ST HD
PHENYTEK *(phenytoin sodium extended)*	T4	HD
phenytoin	T2	HD
phenytoin (Dilantin)	T2	HD
phenytoin (Dilantin-125)	T2	HD
phenytoin sodium extended (Dilantin)	T2	HD
phenytoin sodium extended (Phenytek)	T2	HD
pregabalin (Lyrica)	T2	HD

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS (cont.)		
primidone (Mysoline)	T2	HD
QUDEXY XR (*topiramate*)	T4	ST HD
rufinamide (Banzel)	T2	PA HD
SPRITAM	T4	ST HD
TEGRETOL (*carbamazepine*)	T4	HD
TEGRETOL XR (*carbamazepine*)	T4	HD
tiagabine hcl	T2	HD
topiramate (Qudexy Xr)	T2	ST HD
topiramate 100 mg tablet (Topamax)	T1	HD
topiramate 15 mg sprinkle cap (Topamax)	T2	HD
topiramate 200 mg tablet (Topamax)	T1	HD
topiramate 25 mg sprinkle cap (Topamax)	T2	HD
topiramate 25 mg tablet (Topamax)	T1	HD
topiramate 50 mg tablet (Topamax)	T1	HD
topiramate er 25mg, 50mg, 100mg	T2	ST HD
TROKENDI XR	T4	ST HD
valproic acid	T2	HD
valproic acid (as sodium salt)	T2	HD
vigabatrin (Sabril)	T2	PA QL(150 packs/30 days) SP HD
VIGADRONE	T2	PA SP HD QL (150 pkts/30 days)
XCOPRI 250 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
XCOPRI 25 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 50 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 100 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 150 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 200 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T4	QL(28 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T4	QL(28 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T4	QL(28 tabs/fill) HD
ZARONTIN (*ethosuximide*)	T4	HD
zonisamide	T2	HD
zonisamide (Zonegran)	T2	HD

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

List of Prescription Medications

CNS DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA QL(1.2 mls/30 days) SP
LEUKINE	T4	PA SP
NIVESTYM	T4	PA SP HD
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA QL(15 tabs/fill) SP HD
PROMACTA	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	PA SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T4	ST QL(1 ring/365 days) PPACA
etonogestrel/ethinyl estradiol (Nuvaring)	T2	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (*medroxyprogesterone acetate*)	T4	QL(1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T4	QL(1 ml/90 days) PPACA
medroxyprogesterone 150 mg/ml (Depo-Provera)	T2	QL(1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (*drospir/eth estra/levomefol ca*)	T4	ST HD PPACA
desog-e.estradiol/e.estradiol	T2	HD PPACA
desog-e.estradiol/e.estradiol	T2	PPACA
desogestrel-ethinyl estradiol	T2	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T2	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T2	HD PPACA
ELLA	T3	QL(1 tab/fill) HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T2	PPACA
ethinyl estradiol/drospirenone (Yaz)	T2	HD PPACA
ethynodiol d-ethinyl estradiol	T2	HD PPACA
levonorgestrel/ethin.estradiol	T2	HD PPACA

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

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
l-norgest/e.estradiol-e.estrad	T2	HD PPACA
norelgestromin/ethin.estradiol	T2	PPACA
noreth-ethinyl estradiol/iron	T2	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T2	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T2	HD PPACA
norethindrone	T2	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T2	HD PPACA
norethindrone-e.estradiol-iron	T2	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T2	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T2	HD PPACA
norethindrone-ethin. estradiol	T2	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T2	HD PPACA
norgestimate-ethinyl estradiol	T2	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T2	HD PPACA
YAZ (*ethinyl estradiol/drospirenone*)	T4	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T2	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (*pseudoephed/chlor-mal/bell alk*)	T4	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
benzonatate	T2	
DECONGESTANT-EXPECTORANT COMBINATIONS		
guaifenesin/phenylephrine hcl	T2	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (*brompheniramine/pseudoephed/dm*)	T4	
brompheniramine/pseudoephed/dm (Bromfed Dm)	T2	

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

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T2	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T4	
HISTEX-AC	T4	
MAXI-TUSS CD	T4	
POLY-TUSSIN AC	T4	
promethazine/phenyleph/codeine	T2	
ZODRYL DAC 25	T4	
ZODRYL DAC 30	T4	
ZODRYL DAC 35	T4	
ZODRYL DAC 40	T4	
ZODRYL DAC 50	T4	
ZODRYL DAC 60	T4	
ZODRYL DAC 80	T4	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T2	
promethazine hcl/codeine	T2	
TUSSICAPS	T4	PA
TUXARIN ER	T4	
TUZISTRA XR	T4	PA
ZODRYL AC 25	T4	
ZODRYL AC 30	T4	
ZODRYL AC 35	T4	
ZODRYL AC 40	T4	
ZODRYL AC 50	T4	
ZODRYL AC 60	T4	
ZODRYL AC 80	T4	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T4	
HYCODAN *(hydrocodone bit/homatrop me-br)*	T4	
hydrocodone bit/homatrop me-br	T2	
hydrocodone bit/homatrop me-br (Hycodan)	T2	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T4	

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

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB (cont.)		
pseudoephed/codeine/guaifen	T2	
ZODRYL DEC 25	T4	
ZODRYL DEC 30	T4	
ZODRYL DEC 35	T4	
ZODRYL DEC 40	T4	
ZODRYL DEC 50	T4	
ZODRYL DEC 60	T4	
ZODRYL DEC 80	T4	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T2	
CODITUSSIN AC	T4	
GUAIFEN-CODEINE 100-10 MG/5 ML	T4	
guaifen-codeine 100-10 mg/5 ml	T2	
GUAIFEN-CODEINE 200-20 MG/10ML	T4	
MAR-COF CG	T4	
NINJACOF-XG	T4	
OBREDON	T4	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T3	
FREESTYLE INSULINX TEST STRIPS	T3	
FREESTYLE LITE TEST STRIP	T3	
FREESTYLE PRECISION NEO	T3	
FREESTYLE TEST STRIPS	T3	
ONETOUCH ULTRA TEST STRIP	T3	
ONETOUCH VERIO TEST STRIP	T3	
PRECISION XTRA	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T3	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T4	
GOJJI BLOOD KETONE TEST STRIP	T4	

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BLOOD TESTING PREPARATIONS (cont.)		
NOVAMAX PLUS	T3	
PRECISION XTRA	T3	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T4	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T4	
METHACHOLINE CHLORIDE	T4	
PROVOCHOLINE	T4	
TC 99M SULFUR COLLOID PREP	T4	
TOXICOLOGY SALIVA COLLECTION	T4	
VUEBLU	T4	
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T2	
ful-glo 1 mg opth strip	T2	
FUL-GLO EYE STRIPS	T4	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T4	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T2	
ENTERO VU	T4	
E-Z DISK	T4	
E-Z-HD	T4	
E-Z-PAQUE	T4	
E-Z-PASTE	T4	
GASTROGRAFIN (*diatrizoate meglumine, sodium*)	T4	
GASTROMARK	T4	
LIQUID E-Z PAQUE	T4	
LIQUID POLIBAR PLUS	T4	
NEULUMEX	T4	
POLIBAR ACB	T4	
READI-CAT 2	T4	
SITZMARKS	T4	
SITZMARKS FOR KIDS	T4	
TAGITOL	T4	

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
VANILLA SILQ	T4	
VARIBAR HONEY	T4	
VARIBAR NECTAR	T4	
VARIBAR PUDDING	T4	
VARIBAR THIN HONEY	T4	
VARIBAR THIN LIQUID	T4	
VOLUMEN	T4	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T4	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T4	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T4	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T4	
CYSTOGRAFIN	T4	
CYSTOGRAFIN-DILUTE	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T3	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINE MULTIPLE TEST AIDS (cont.)		
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T2	PA QL(30 tabs/fill) SP
tolvaptan 30 mg tablet (Samsca)	T2	PA QL(60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T2	HD
methazolamide	T2	HD
LOOP DIURETICS		
bumetanide	T2	HD
EDECRIN *(ethacrynic acid)*	T4	ST
ethacrynic acid (Edecrin)	T2	
furosemide	T1	HD
furosemide (Lasix)	T1	HD
LASIX (*furosemide*)	T4	ST HD
torsemide	T2	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 15 MG TABLET	T4	PA QL(120 tabs/fill) SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA QL(56 tabs/fill) SP
JYNARQUE 30 MG TABLET	T4	PA QL(120 tabs/fill) SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA QL(56 tabs/fill) SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA QL(56 tabs/fill) SP

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

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG (cont.)		
JYNARQUE 60 MG-30 MG TABLET	T4	PA QL(56 tabs/fill) SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA QL(56 tabs/fill) SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (*spironolactone*)	T4	HD
amiloride hcl	T2	HD
DYRENIUM (*triamterene*)	T4	HD
eplerenone (Inspra)	T2	HD
INSPRA *(eplerenone)*	T4	HD
KERENDIA	T4	PA QL(30 tabs/30 days)
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T2	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T2	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride/hydrochlorothiazide	T2	HD
DYAZIDE (*triamterene/hydrochlorothiazid*)	T4	HD
spironolact/hydrochlorothiazid	T2	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T2	HD
DIURIL	T4	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T2	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T2	QL(60 mls/fill) HD
azelastine 0.15% nasal spray	T2	HD
olopatadine hcl (Patanase)	T2	QL(31 gms/fill) HD
PATANASE (*olopatadine hcl*)	T4	QL(31 gms/fill) HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone (Dymista)	T2	ST QL(23 gms/fill) HD
RYALTRIS	T4	ST QL(1 bottle/fill) HD

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

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T2	ST QL(50 mls/fill) HD
fluticasone prop 50 mcg spray	T2	QL(16 gms/fill) HD
mometasone furoate 50 mcg spry (Nasonex)	T2	ST QL(17 gms/fill) HD
XHANCE	T3	ST QL (32 mls/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T4	
GOPRELTO	T4	
ipratropium 0.03% spray	T2	QL(30 mls/fill) HD
ipratropium 0.06% spray	T2	QL(30 mls/fill) HD
NUMBRINO	T4	
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T4	
epinephrine hcl	T2	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T4	
fluocinolone acetonide oil (Dermotic)	T2	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T2	
CORTANE-B *(hydrocort/pramoxine/chloroxyl)*	T4	
hydrocortisone/acetic acid	T2	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T4	
PHOTREXA VISCOUS	T4	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T4	
LACRISERT	T4	PA QL(60 inserts/fill)
MIEBO	T3	PA QL (3 mls/fill)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T4	
povidone-iodine	T2	

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (*ketorolac tromethamine*)	T4	ST
ACULAR LS (*ketorolac tromethamine*)	T4	ST
bromfenac sodium	T2	
bromfenac sodium (Bromsite)	T2	
bromfenac sodium (Prolensa)	T2	
dexamethasone sodium phosphate	T2	
DEXTENZA	T4	
diclofenac 0.1% eye drops	T2	
difluprednate (Durezol)	T2	
EYSUVIS	T3	PA QL (8.3 mls/30 days)
fluorometholone (FmI)	T2	
flurbiprofen sodium	T2	
FML *(fluorometholone)*	T4	ST
ILEVRO	T4	
INVELTYS	T4	ST
ketorolac 0.4% ophth solution (Acular Ls)	T2	
ketorolac 0.5% ophth solution (Acular)	T2	
KLARITY-B(BETAMETHASONE-CHOND)	T4	
KLARITY-L *(LOTEPREDNOL-CHONDR)*	T4	
LOTEMAX 0.5% EYE DROPS *(loteprednol etabonate)*	T4	
LOTEMAX 0.5% EYE OINTMENT	T4	ST
LOTEMAX 0.5% OPHTHALMIC GEL (*loteprednol etabonate*)	T4	ST
LOTEMAX SM	T4	ST
loteprednol 0.5% ophthalmc gel (Lotemax)	T2	
loteprednol etabonate 0.2% drp (Alrex)	T2	ST
loteprednol etabonate 0.5% drp (Lotemax)	T2	
PRED FORTE (*prednisolone acetate*)	T4	
prednisolone ac 1% eye drop (Pred Forte)	T2	
PREDNISOLONE ACET 1% EYE DROP	T4	
prednisolone sod ph/bromfenac	T2	
prednisolone sodium phosphate	T2	
PREDNISOLONE-BROMFENAC	T4	
PREDNISOLONE-NEPAFENAC	T4	
PROLENSA (*bromfenac sodium)*	T4	ST

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS		
AKTEN	T4	
ALCAINE (*proparacaine hcl*)	T4	
ALTAFLUOR BENOX (*benoxinate hcl/fluorescein sod*)	T4	
FLUORESCEIN-BENOXINATE	T4	
proparacaine hcl (Alcaine)	T2	
proparacaine/fluorescein sod	T2	
tetracaine 0.5% eye drop	T2	
TETRACAINE 0.5% STERI-UNIT SOL	T4	
tetracaine hcl	T2	
TETRAVISC	T4	
TETRAVISC FORTE	T4	
EYE MAST CELL STABILIZERS		
ALOCRIL	T4	ST
cromolyn 4% eye drops	T2	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T4	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T4	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T2	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T4	ST HD
ALPHAGAN P (*brimonidine tartrate*)	T4	ST HD
apraclonidine hcl	T2	HD
betaxolol hcl	T2	HD
BETOPTIC S	T4	HD
bimatoprost	T2	PA HD
brimonidine tartrate	T2	HD
brimonidine tartrate (Alphagan P)	T2	HD
brimonidine tartrate/timolol (Combigan)	T2	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T4	
BRIMONIDINE 0.15%-DORZOLAM 2%	T4	HD
brinzolamide (Azopt)	T2	HD
carteolol hcl	T2	HD

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
COMBIGAN *(brimonidine tartrate/timolol)*	T4	ST HD
DORZOLAMIDE	T4	HD
dorzolamide hcl	T2	HD
dorzolamide hcl/timolol maleat (Cosopt)	T2	*HD*
dorzolamide/timolol/pf (Cosopt Pf)	T2	HD
IOPIDINE	T4	ST HD
ISOPTO CARPINE *(pilocarpine hcl)*	T4	HD
LATANOPROST 0.005% EYE DROP	T4	HD
latanoprost 0.005% eye drops (Xalatan)	T2	PA HD
levobunolol hcl	T2	HD
PHOSPHOLINE IODIDE	T4	SP HD
pilocarpine hcl	T2	HD
pilocarpine hcl (Isopto Carpine)	T2	HD
RHOPRESSA	T4	
ROCKLATAN	T4	PA
SIMBRINZA	T4	HD
timolol (Betimol)	T2	ST HD
timolol 0.25% gel-solution (Timoptic-Xe)	T2	ST HD
timolol 0.5% eye drop (Istalol)	T2	ST HD
timolol 0.5% gel-solution (Timoptic-Xe)	T2	ST HD
timolol 0.5% gfs gel-solution (Timoptic-Xe)	T2	ST HD
timolol maleate 0.25% eye drop	T2	ST HD
timolol maleate 0.25% eye drop (Timoptic)	T1	HD
timolol maleate 0.5% eye drop (Timoptic Ocudose)	T2	ST HD
timolol maleate 0.5% eye drops (Timoptic)	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T4	HD
TIMOLOL-BRIMONI-DORZOL-BIMATOP	T4	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T4	HD
TIMOLOL-DORZOLAMIDE	T4	HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T4	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T4	HD
TIMOLOL-LATANOPROST	T4	HD
TIMOPTIC (*timolol maleate*)	T4	ST HD
TIMOPTIC-XE (*timolol maleate*)	T4	ST HD
travoprost (Travatan Z)	T2	PA HD

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MYDRIATICS		
atropine 1% eye drops	T2	HD
atropine 1% eye ointment	T2	HD
ATROPINE SULF 0.25% EYE DROP	T4	HD
ATROPINE SULFATE 0.01% EYE DRP	T4	HD
ATROPINE SULFATE 0.05% EYE DRP	T4	HD
ATROPINE SULFATE-0.9% NACL	T4	HD
CYCLOGYL	T4	HD
CYCLOGYL (cyclopentolate hcl)	T4	HD
CYCLOMYDRIL	T4	HD
cyclopentolat/tropic/phenyleph	T2	HD
cyclopentolate hcl (Cyclogyl)	T2	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T4	HD
homatropine hbr	T2	HD
MYDCOMBI	T4	HD
MYDRIACYL (*tropicamide*)	T4	HD
PAREMYD	T4	HD
tropicamide	T2	HD
tropicamide (Mydriacyl)	T2	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T4	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T4	
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T4	HD
tropicamide 1%-phenylephr 2.5%	T2	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T4	
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T4	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T4	
MITOMYCIN -WATER	T4	
MITOSOL	T4	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T4	PA QL (60 vls/30 days)
cyclosporine 0.05% eye emuls (Restasis)	T2	PA QL(60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T4	HD
RESTASIS (cyclosporine)	T4	PA QL(60 vials/fill) HD

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EENT PREPS (Eye Conditions) (cont.)		
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE (cont.)		
RESTASIS MULTIDOSE	T3	PA QL(6 mls/fill) HD
XIIDRA	T3	PA QL(60 vls/fill) HD
VEVYE	T4	PA QL(2 mls/fill) HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T4	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T4	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
FLORIVA	T4	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FRAICHE 5000 PREVI	T4	
PREVIDENT KIDS	T4	
FLUORIDEX	T4	
FLUORIDEX SENSITIVITY RELIEF	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (fluoride (sodium))	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ENAMEL PROTECT	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (fluoride (sodium))	T4	
PREVIDENT 5000 SENSITIVE	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
*sodium fluoride 1.1% cream (*Prevident 5000 Plus*)*	T2	
*sodium fluoride 1.1% gel (*Prevident*)*	T2	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS (cont.)		
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	
sodium fluoride 5000 ppm paste	T2	
sodium fluoride/potassium nit	T2	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T2	PPACA
FLURA-DROPS	T4	
sodium fluoride 0.25 (0.55) mg	T2	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T2	PPACA
sodium fluoride 0.5 mg/ml drop	T2	PPACA
sodium fluoride 1 mg (2.2 mg)	T2	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
cvs glucose 4 gram tablet chew (Trueplus Glucose)	T2	
CVS GLUCOSE LIQUID SHOT	T4	
DEX4 GLUCOSE 15 GM GEL PACKET	T4	
dex4 glucose 4 gm tablet chew (Trueplus Glucose)	T2	
DEX4 GLUCOSE LIQUID	T4	
DEX4 GLUCOSE LIQUID BLAST	T4	
dex4 glucose tab pouch pack (Trueplus Glucose)	T2	
dex4 quick dissolve tab chew (Trueplus Glucose)	T2	
dextrose	T2	
dextrose (Glutose-15)	T2	
dextrose (Glutose-45)	T2	
dextrose/vitamin d3	T2	
diazoxide (Proglycem)	T2	
drug mart glucose 4 gm tab chw (Trueplus Glucose)	T2	
GLUCO SHOT	T4	
glucose 3.75 gram tablet chew (Trueplus Glucose)	T2	
GLUCOSE 2 GRAM GUMMY	T4	
glucose 4 gram tablet chew (Trueplus Glucose)	T2	
GLUCOSE LIQUID	T4	
GLUTOSE-15 (*dextrose*)	T3	
GLUTOSE-45 (*dextrose*)	T3	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
gnp glucose 3.75 gram tab chew (Trueplus Glucose)	T2	
gnp glucose 4 gram tablet chew (Trueplus Glucose)	T2	
gnp quick dissolve glucose tab (Trueplus Glucose)	T2	
gs glucose 4 gram tablet chew (Trueplus Glucose)	T2	
GVOKE	T3	QL(2 vials/fill)
GVOKE HYPOPEN 1-PACK	T3	QL(2 auto-injs/fill)
GVOKE HYPOPEN 2-PACK	T3	QL(2 auto-injs/fill)
GVOKE PFS 1-PACK SYRINGE	T3	QL(2 syringes/fill)
GVOKE PFS 2-PACK SYRINGE	T3	QL(2 syringes/fill)
INSTA-GLUCOSE	T4	
kro glucose 4 gram tablet chew (Trueplus Glucose)	T2	
kroger glucose 4 gram tab chew (Trueplus Glucose)	T2	
leader glucose 4 gm tab chew (Trueplus Glucose)	T2	
leader quick dissolve gluc tab (Trueplus Glucose)	T2	
longs glucose 4 gram tab chew (Trueplus Glucose)	T2	
meijer glucose 4 gram tab chew (Trueplus Glucose)	T2	
ms glucose 4 gram tablet chew (Trueplus Glucose)	T2	
ms quick dissolve glucose tab (Trueplus Glucose)	T2	
preferred plus glucose tab chw (Trueplus Glucose)	T2	
PROGLYCEM (*diazoxide*)	T4	
pub glucose 4 gram tablet chew (Trueplus Glucose)	T2	
ra glucose 4 gram tablet chew (Trueplus Glucose)	T2	
relion glucose 4 gram tab chew (Trueplus Glucose)	T2	
reli-on glucose 4 gram tab chw (Trueplus Glucose)	T2	
RELION GLUCOSE LIQUID	T4	
sm glucose 4 gram tab chew (Trueplus Glucose)	T2	
smart sense glucose 4 gram tab (Trueplus Glucose)	T2	
TRUEPLUS GLUCOSE	T4	
TRUEPLUS GLUCOSE (*dextrose*)	T4	
upup glucose 4 gram tab chew (Trueplus Glucose)	T2	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T4	
calcium acetate 667 mg capsule	T2	QL(360 caps/fill)
calcium acetate 667 mg gelcap	T2	QL(360 caps/fill)
calcium acetate 667 mg tablet	T2	QL(360 tabs/fill)
lanthanum carbonate (Fosrenol)	T2	QL(90 tabs/fill)
LOKELMA	T3	QL(30 packs/fill)
RENVELA 0.8 GM POWDER PACKET (*sevelamer carbonate*)	T4	QL(180 packs/fill)
RENVELA 2.4 GM POWDER PACKET (*sevelamer carbonate*)	T4	QL(90 packs/fill)
RENVELA 800 MG TABLET (sevelamer carbonate)	T4	QL(270 tabs/fill)
sevelamer hcl 800 mg tablet	T2	
VELTASSA 1 GM POWDER PACKET	T3	
VELTASSA 16.8 GM POWDER PACKET	T3	QL (30 packs/30 days)
VELTASSA 25.2 GM POWDER PACKET	T3	QL (30 packs/30 days)
VELTASSA 8.4 GM POWDER PACKET	T3	QL (30 packs/30 days)
sodium polystyrene sulfon/sorb	T2	
sodium polystyrene sulfonate	T2	
VELPHORO	T3	QL(120 tabs/fill)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FLUORIDEX	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT *(fluoride (sodium))*	T4	
PREVIDENT KIDS	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS *(fluoride (sodium))*	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T2	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS (cont.)		
sodium fluoride 1.1% gel (Prevident)	T2	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	
sodium fluoride 5000 ppm paste	T2	
IODINE CONTAINING AGENTS		
potassium iodide	T2	
potassium iodide/iodine	T2	
SSKI	T4	
IRON REPLACEMENT		
ABATRON	T4	
ABATRON AF	T4	
ACCRUFER	T4	
ACTIVE FE	T4	
APETIGEN-PLUS	T3	
BENTIVITE BX	T4	
CHROMAGEN	T4	
CITRANATAL BLOOM	T4	
CORVITE 150	T4	
CORVITE FE	T4	
cvs iron 27 mg tablet (Fergon)	T2	
cvs iron 65 mg tablet	T2	
CVS SLOW RELEASE IRON 45 MG TB	T4	
cvs slow release iron 45 mg tb	T2	
cvs slow release iron tablet	T2	
eql iron 65 mg tablet	T2	
eql slow release iron 45 mg tab	T2	
eql slow release iron 50 mg tb	T2	
FEOSOL 45 MG CAPLET (*iron,carbonyl*)	T3	
feosol 65 mg tablet	T2	
FEOSOL BIFERA 28 MG CAPLET	T3	
FERAHEME (*ferumoxytol*)	T4	PA
FERGON 27 MG TABLET	T4	
FERGON 27 MG TABLET (*ferrous gluconate*)	T3	
FERGON TABLET	T4	
FER-IN-SOL (*ferrous sulfate*)	T3	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
FERIVA 21-7	T4	
FERIVA FA	T4	
FERRACTIV IRON	T4	
FERRALET 90	T4	
FERRETTS IPS 18 MG CAP	T4	
FERRETTS IPS 40 MG/15 ML LIQ	T3	
FERRIMIN 150	T3	
FERRLECIT (*sodium ferric gluconat/sucrose*)	T4	PA
FERRO-SEQUELS	T4	
ferrous fum/vit c/b12-if/folic	T2	PPACA
ferrous fumarate	T2	
ferrous fumarate (Hemocyte)	T2	
FERROUS FUMARATE 29 MG TAB	T4	
ferrous fumarate 324 mg tab (Hemocyte)	T2	
ferrous fumarate/folic acid (Hemocyte-F)	T2	
ferrous gluconate	T2	
ferrous gluconate (Fergon)	T2	
ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)	T2	
FERROUS SULF 300 MG/5 ML CUP	T4	
ferrous sulf 220 mg/5 ml elix	T2	
ferrous sulf 220 mg/5 ml liq	T2	
ferrous sulf 300 mg/5 ml cup	T2	
ferrous sulf 300 mg/6.8ml soln	T2	
ferrous sulf 44 mg iron/5ml lq	T2	
ferrous sulf ec 324 mg tablet	T2	
ferrous sulf ec 325 mg tablet	T2	
true ferrous sulf ec 324 mg tb	T2	
ferrous sulfate	T2	
ferrous sulfate (Fer-In-Sol)	T2	
ferrous sulfate 325 mg tablet	T2	
ferrous sulfate/vit c/folic ac	T2	PPACA
ferumoxytol (Feraheme)	T2	PA
FT IRON 45 MG TABLET	T2	
ft iron 65 mg tablet	T2	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
FUSION	T4	
FUSION PLUS	T4	
FUSION SPRINKLES	T4	
GENTLE IRON	T4	
gnp iron 45 mg tablet	T2	
gnp iron 65 mg tablet	T2	
HEMATEX	T4	
HEMATEX (*iron polysaccharide complex*)	T4	
HEMATOGEN	T4	
HEMATRON-AF	T4	
HEMAX	T4	
HEMOCYTE (*ferrous fumarate*)	T3	
HEMOCYTE PLUS (*iron fum/folic acid/mv,min 15*)	T4	
HEMOCYTE-F (*ferrous fumarate/folic acid*)	T4	
hm iron 65 mg tablet	T2	
hm slow release iron tablet	T2	
I.L.X. B-12	T3	
ICAR	T3	
ICAR-C (*iron,carbonyl/ascorbic acid*)	T3	
ICAR-C PLUS (*iron,carb/vit c/vit b12/folic*)	T4	
INFED	T3	PA
INJECTAFER	T4	PA
INTEGRA	T3	
INTEGRA F (*iron fum,ps/folic acid/vitc/b3*)	T4	
INTEGRA PLUS (*iron fum,ps/folic/bcomp,c no.9*)	T4	
iron aspgly,ps/c/b12/fa/ca/suc	T2	
iron aspgly,ps/c/succinic acid	T2	
iron aspgly/c/b12/fa/ca-th/suc	T2	
iron bg,ps/vitc/b12/fa/calcium	T2	
IRON BISGLYCINATE	T4	
*iron fm,ps no.1/folic/mv no.18 (*Tandem Plus*)*	T2	
iron fum,ag/c/b12/folic/ca/suc	T2	
*iron fum,ps/folic acid/vitc/b3 (*Integra F*)*	T2	
*iron fum,ps/folic/bcomp,c no.9 (*Integra Plus*)*	T2	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
iron fum/folic acid/mv,min 15 (Hemocyte Plus)	T2	
iron fumarate/vit c/vit b12/fa	T2	
iron polysaccharide complex	T2	
iron polysaccharide complex (Nu-Iron 150)	T2	
iron ps complex/b12/folic acid	T2	
iron,carb/vit c/vit b12/folic (Icar-C Plus)	T2	
iron,carbonyl	T2	
iron,carbonyl (Feosol)	T2	
iron,carbonyl/ascorbic acid (Icar-C)	T2	
iron/c/b12/calciu/stomach conc	T2	
iron/c/folic acd/mv cmb11/calc	T2	
iron/folic ac/vit bcomp,c/min	T2	
iron/folic acid/b12/c/docusate	T2	
iron/folic acid/c/b6/b12/zinc	T2	
iron/vit c/fructooligosacchard	T2	
iron 27 mg tablet	T2	
iron 27 mg tablet (Fergon)	T2	
iron 28 mg tablet	T2	
iron 45 mg tablet	T2	
iron 65 mg tablet	T2	
IRONUP	T4	
IRO-PLEX	T4	
IROSPAN	T4	
LIQUID IRON	T4	
LYDIA PINKHAM HERBAL	T4	
MAXFE	T4	
MONOFERRIC	T4	PA
NEONATAL FE	T4	
NIFEREX	T4	
NOVAFERRUM 125 MG/5 ML LIQUID	T4	
NOVAFERRUM 15 MG/ML DROPS	T3	
NOVAFERRUM 50	T4	
NUFERA	T4	
NU-IRON 150 (*iron polysaccharide complex*)	T3	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
PARVLEX	T4	
PERFECT IRON	T4	
PRO FE	T3	
PROFERRIN	T3	
PROFERRIN-FORTE	T4	
PROTECT IRON	T4	
ra high potency iron 27 mg tab	T2	
RA HIGH POTENCY IRON 27 MG TAB	T4	
ra iron 65 mg tablet	T2	
RA SLOW RELEASE IRON 45 MG TAB	T3	
SIDEROL	T4	
SLOW FE	T3	
slow release iron 160 mg tab	T2	
SLOW RELEASE IRON 45 MG TAB	T3	
SLOW RELEASE IRON 45 MG TABLET	T3	
slow release iron 45 mg tablet	T2	
SLOW RELEASE IRON 45 MG TABLET	T4	
SLOW RELEASE IRON TABLET	T3	
sm iron 160 mg tablet sa	T2	
sm iron 65 mg tablet	T2	
sm iron 325 mg tablet	T2	
SM SLOW RELEASE IRON 45 MG TAB	T3	
sodium ferric gluconat/sucrose (Ferrlecit)	T2	PA
sv iron 65 mg tablet	T2	
SV SLOW RELEASE IRON 45 MG TAB	T3	
TANDEM DUAL ACTION	T3	
TANDEM PLUS (*iron fm,ps no.1/folic/mv no.18*)	T4	
TL-HEM 150	T4	
TRIFERIC	T4	
true ferrous sulf ec 324 mg tb	T2	
TULIVITE	T4	
VENOFER	T3	PA
VIRT-FEFA PLUS CAPSULE	T4	
virt-fefa plus capsule (Integra Plus)	T2	

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
VITABEX IRON	T4	
VITAFOL	T4	
VITRON-C	T3	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T2	PPACA
FLURA-DROPS	T4	
sodium fluoride 0.25 (0.55) mg	T2	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T2	PPACA
sodium fluoride 0.5 mg/ml drop	T2	PPACA
sodium fluoride 1 mg (2.2 mg)	T2	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T4	
EFFER-K 20 MEQ TABLET EFF	T4	
effer-k 25 meq tablet eff	T2	
K-TAB ER 20 MEQ TABLET (*potassium chloride*)	T4	
k-tab er 8 meq tablet	T1	
potassium bicarbonate/cit ac	T2	
potassium chloride	T1	
potassium chloride	T2	
potassium cl 10% (20 meq/15ml)	T2	
potassium cl 10% (40 meq/30ml)	T2	
potassium cl 20 meq packet	T2	
potassium cl 20% (40 meq/15ml)	T2	
potassium cl er 10 meq capsule	T1	
potassium cl er 10 meq tablet	T1	
potassium cl er 15 meq tablet	T1	
potassium cl er 20 meq tablet	T1	
potassium cl er 20 meq tablet (K-Tab Er)	T1	
potassium cl er 8 meq capsule	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T2	
potassium cl10%(40meq/30ml)cup	T2	
potassium cl20%(40meq/15ml)cup	T2	
POTASSIUM CL ER 15 MEQ TABLET	T4	

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T4	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T2	HD
K-PHOS NO.2	T4	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T4	HD
potassium citrate	T2	HD
potassium citrate (Urocit-K)	T2	HD
RENACIDIN	T3	HD
UROCIT-K (*potassium citrate*)	T4	HD
UROQID-ACID NO.2	T4	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T2	PA HD
omega-3 acid ethyl esters (Lovaza)	T2	PA HD
VASCEPA *(icosapent ethyl)*	T3	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (*sodium phenylbutyrate*)	T4	PA SP HD
lactulose	T2	HD
lactulose 10 gm/15 ml solution	T2	HD
LITHOSTAT	T4	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T4	SP PA HD
RAVICTI	T4	PA SP HD
sodium phenylbutyrate (Buphenyl)	T2	PA SP HD
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br (Librax)	T2	
GLYCATE	T4	
glycopyrrolate	T2	
glycopyrrolate (Cuvposa)	T2	

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICHOLINERGICS, QUATERNARY AMMONIUM (cont.)		
glycopyrrolate (Robinul Forte)	T2	
glycopyrrolate (Robinul)	T2	
ROBINUL *(glycopyrrolate)*	T4	
ROBINUL FORTE *(glycopyrrolate)*	T4	
ANTICHOLINERGICS/ANTISPASMODICS		
dicyclomine hcl	T2	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA QL(84 tabs/28 days) SP
ANTIDIARRHEALS		
diphenoxylate hcl/atropine	T2	
diphenoxylate hcl/atropine (Lomotil)	T2	
LOMOTIL (*diphenoxylate hcl/atropine*)	T4	
MOTOFEN	T4	
opium tincture	T2	
paregoric	T2	
ANTIEMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T2	PA
MARINOL *(dronabinol)*	T4	PA
SYNDROS	T4	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
aprepitant 125 mg capsule	T2	QL(1 cap/fill)
aprepitant 125-80-80 mg pack (Emend)	T2	QL(3 caps/fill)
aprepitant 40 mg capsule (Emend)	T2	QL(1 cap/fill)
aprepitant 80 mg capsule (Emend)	T2	QL(2 caps/fill)
COMPAZINE *(prochlorperazine maleate)*	T4	
COMPAZINE *(prochlorperazine)*	T4	
DICLEGIS (*doxylamine succinate/vit b6*)	T4	QL(120 tabs/fill)
fosaprepitant dimeglumine (Emend)	T2	
granisetron hcl 0.1 mg/ml vial	T2	
granisetron hcl 1 mg tablet	T2	QL(6 tabs/fill)
granisetron hcl 1 mg/ml vial	T2	
granisetron hcl 4 mg/4 ml vial	T2	
meclizine 50 mg tablet	T2	
ondansetron 4 mg/2 ml	T2	

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
ondansetron 40 mg/20 ml vial	T2	
ondansetron hcl 4 mg tablet	T2	QL(9 tabs/fill)
ondansetron hcl 4 mg/2 ml syr	T2	
ondansetron hcl 4 mg/2 ml vial	T2	
ondansetron hcl 8 mg tablet	T2	QL(9 tabs/fill)
ondansetron odt 4 mg tablet	T2	QL (9 tabs/30 days)
ondansetron odt 8 mg tablet	T2	QL(9 tabs/30 days)
prochlorperazine (Compazine)	T2	
prochlorperazine maleate (Compazine)	T2	
promethazine hcl	T2	
SANCUSO	T4	QL(1 patch/fill)
scopolamine (Transderm-Scop)	T2	
trimethobenzamide hcl	T2	
VARUBI	T3	QL(2 tabs/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (*misoprostol*)	T4	HD
misoprostol (Cytotec)	T2	HD
sucralfate (Carafate)	T2	HD
ANTI-ULCER-H.PYLORI AGENTS		
lansoprazole/amoxiciln/clarith	T2	QL(112 units/fill)
OMECLAMOX-PAK	T4	QL(80 units/fill)
TALICIA	T3	QL(168 caps/fill)
VOQUEZNA DUAL PAK	T4	
VOQUEZNA TRIPLE PAK	T4	
BELLADONNA ALKALOIDS		
DONNATAL	T4	HD
DONNATAL (*phenobarb/hyoscy/atropine/scop*)	T4	HD
hyoscyamine sulfate	T2	HD
hyoscyamine sulfate (Levbid)	T2	HD
hyoscyamine sulfate (Levsin)	T2	HD
hyoscyamine sulfate (Levsin-SL)	T2	HD
hyoscyamine sulfate (Nulev)	T2	HD
LEVBID (*hyoscyamine sulfate*)	T4	HD
LEVSIN (*hyoscyamine sulfate*)	T4	HD

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS (cont.)		
LEVSIN-SL *(hyoscyamine sulfate)*	T4	HD
methscopolamine bromide	T2	HD
NULEV *(hyoscyamine sulfate)*	T4	HD
phenobarb/hyoscy/atropine/scop	T2	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T2	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)	T2	HD
PHENOBARBITAL-BELLADONNA *(phenobarb/hyoscy/atropine/scop)*	T4	HD
SYMAX DUOTAB	T4	HD
BILE SALTS		
CHENODAL	T4	PA SP HD
CHOLBAM 250 MG CAPSULE	T4	PA SP HD
CHOLBAM 50 MG CAPSULE	T4	PA QL(120 caps/fill) SP HD
CTEXLI	T4	PA SP
URSO FORTE (*ursodiol*)	T4	HD
ursodiol	T2	HD
ursodiol (Urso Forte)	T2	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T2	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T2	
mesalamine 4 gm/60 ml kit (Rowasa)	T2	
ROWASA *(mesalamine w/cleansing wipes)*	T4	
SFROWASA (*mesalamine*)	T4	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine*)	T4	HD
ASACOL HD (mesalamine)	T4	HD
AZULFIDINE (*sulfasalazine*)	T4	HD
balsalazide disodium (Colazal)	T2	HD
COLAZAL *(balsalazide disodium)*	T4	HD
mesalamine (Apriso)	T2	HD
mesalamine (Delzicol)	T2	HD
mesalamine (Pentasa)	T2	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T2	HD
mesalamine dr 1.2 gm tablet (Lialda)	T2	HD
PENTASA 250 MG CAPSULE	T3	HD

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (cont.)		
PENTASA 500 MG CAPSULE (*mesalamine*)	T4	HD
sulfasalazine (Azulfidine)	T2	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA QL(30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T4	SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T2	HD
cimetidine hcl	T2	HD
famotidine	T2	HD
famotidine (Pepcid)	T1	HD
nizatidine	T2	HD
PEPCID *(famotidine)*	T4	HD
ranitidine hcl	T2	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T3	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T3	QL(30 caps/fill)
TRULANCE	T3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T4	PA QL(60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T4	PA QL(120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T4	PA QL(150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T4	PA QL(30 pellets/fill) SP HD
LIVMARLI	T4	PA SP
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
prucalopride succinate	T2	QL (30 tabs/30 days)
REGLAN (*metoclopramide hcl*)	T4	
IRRITABLE BOWEL SYND. AGENT,5-HT4 PARTIAL AGONIST		
ZELNORM	T4	

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T2	SP HD
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T2	PPACA
bisac/nacl/nahco3/kcl/peg 3350	T2	PPACA
GIALAX	T4	PPACA
GOLYTELY *(peg3350/sod sulf,bicarb,cl/kcl)*	T4	
KRISTALOSE	T4	
lactulose	T2	
lactulose 10 gm packet	T2	
lactulose 10 gm/15 ml solution	T2	
lactulose 20 gm/30 ml solution	T2	
lubiprostone	T2	QL (60 caps/30 days)
NULYTELY	T4	
NULYTELY WITH FLAVOR PACKS *(sodium chloride/nahco3/kcl/peg)*	T4	
OSMOPREP	T4	PPACA
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T2	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T2	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T2	PPACA
sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)	T2	PPACA
sodium, potassium,mag sulfates (Suprep)	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T2	
RECTIV *(nitroglycerin)*	T3	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
alvimopan	T2	
ENTEREG	T4	
PANCREATIC ENZYMES		
CREON	T3	HD
PANCREAZE	T3	HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T4	ST

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 60 mg cap	T2	ST HD
dexlansoprazole dr 30 mg cap (Dexilant)	T2	ST QL(30 caps/30 days)
dexlansoprazole dr 60 mg cap (Dexilant)	T2	ST HD
esomeprazole dr 10 mg packet (Nexium)	T2	ST QL(30 packs/fill) HD
esomeprazole dr 2.5 mg packet (Nexium)	T2	ST QL (30 packs/30 days) HD
esomeprazole dr 5 mg packet (Nexium)	T2	ST QL (30 packs/30 days) HD
esomeprazole dr 40 mg packet (Nexium)	T2	ST HD
ESOMEPRAZOLE DR 49.3 MG CAP	T4	ST HD
esomeprazole mag dr 40 mg cap (Nexium)	T2	HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	HD
lansoprazole odt 15 mg tablet (Prevacid)	T2	ST QL(30 tabs/fill) HD
lansoprazole odt 30 mg tablet (Prevacid)	T2	ST HD
omeprazole dr 10 mg, 20 mg capsule	T1	QL(30 caps/fill) HD
omeprazole dr 40 mg capsule	T1	HD
omeprazole/sodium bicarbonate (Zegerid)	T2	PA HD
omeprazole-bicarb 20-1,680 pkt (Zegerid)	T2	ST QL (30 packs/30 days) HD
omeprazole-bicarb 40-1,100 cap (Zegerid)	T2	ST HD
omeprazole-bicarb 40-1,680 pkt (Zegerid)	T2	ST HD
pantoprazole 40 mg suspension (Protonix)	T2	ST HD
pantoprazole sod dr 40 mg tab (Protonix)	T1	HD
rabeprazole sod dr 20 mg tab (Aciphex)	T2	HD
RECTAL PREPARATIONS		
hydrocortisone acetate (Anusol-Hc)	T2	
hydrocortisone acetate (Proctocort)	T2	
PROCTOCORT *(hydrocortisone acetate)*	T4	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T4	
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM *(hydrocortisone/pramoxine)*	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE *(hydrocortisone/pramoxine)*	T4	ST
hydrocort-pramoxine 1%-1% crm	T2	

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

List of Prescription Medications

GASTROINTESTINAL (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET (cont.)		
hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)	T2	ST
hydrocort-pramoxine 2.5-1% crm (Analpram Hc)	T2	ST
lidocaine-hc 2.8-0.55% gel	T2	
lidocaine-hc 2-2% cream kit	T2	
lidocaine-hc 3-0.5% cream	T2	
lidocaine-hc 3-0.5% cream kit	T2	
lidocaine-hc 3-1% cream kit	T2	
lidocaine-hc 3-2.5% gel kit	T2	
LIDOCAINE-HC 3-2.5% GEL KIT	T4	
LIDOCAINE-HYDROCORT 3-2.5% GEL	T4	
PROCORT	T4	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (*hydrocortisone*)	T4	
hydrocortisone (Cortenema)	T2	
UCERIS *(budesonide)*	T4	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T4	PA SP HD
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T4	PA
DEPO-TESTOSTERONE (*testosterone cypionate)*	T4	PA
JATENZO 158 MG, 198 MG CAPSULE	T4	PA QL(120 caps/30 days)
METHITEST	T3	
methyltestosterone	T2	
oxandrolone	T2	
testosterone 1% (25mg/2.5g) pk (Androgel)	T2	PA QL(75 gms/fill)
testosterone 1% (50 mg/5 g) pk (Androgel)	T2	PA QL(300 gms/fill)
testosterone 1.62% (2.5 g) pkt (Androgel)	T2	PA QL(60 packs/fill)
testosterone 1.62% gel pump (Androgel)	T2	PA QL(150 gms/fill)
testosterone 1.62%(1.25 g) pkt (Androgel)	T2	PA QL(30 packs/fill)
testosterone 10 mg gel pump	T2	QL (120 gms/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T4	PA QL(300 gms/fill)

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANDROGENIC AGENTS (cont.)		
testosterone 12.5 mg/1.25 gram	T2	PA QL(300 gms/fill)
testosterone 30 mg/1.5 ml pump	T2	PA QL(180 mls/fill)
testosterone 50 mg/5 gram gel (Testim)	T2	PA QL(60 tubes/fill)
testosterone 50 mg/5 gram gel (Vogelxo)	T2	PA QL(60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T4	PA QL(300 gms/fill)
testosterone cypionate	T2	PA
testosterone cypionate (Depo-Testosterone)	T2	PA
testosterone enanthate	T2	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T4	PA QL(300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (*testosterone*)	T4	PA QL(60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKT	T4	PA QL(60 packs/fill)
XYOSTED	T3	QL(2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (*desmopressin (nonrefrigerated)*)	T4	
DDAVP 0.1 MG TABLET *(desmopressin acetate)*	T4	HD
DDAVP 0.2 MG TABLET *(desmopressin acetate)*	T4	HD
desmopressin 0.01% solution	T2	HD
DESMOPRESSIN 1.5 MG/ML SPRAY	T3	HD
desmopressin 10 mcg/0.1 ml spr	T2	HD
desmopressin acetate 0.1 mg tb (Ddavp)	T2	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T2	HD
NOCDURNA	T4	PA QL(30 tabs/fill)
NOCTIVA	T4	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen,ester/me-testosterone (Estratest F.S.)	T2	HD
estrogen,ester/me-testosterone (Estratest H.S.)	T2	HD
ESTRATEST F.S. *(estrogen,ester/me-testosterone)*	T4	HD
ESTRATEST H.S. *(estrogen,ester/me-testosterone)*	T4	HD
ESTROGENIC AGENTS		
ACTIVELLA (*estradiol/norethindrone acet*)	T4	HD
CLIMARA (*estradiol*)	T4	QL(4 patches/28 days) HD
COMBIPATCH	T3	
DELESTROGEN	T4	HD
DELESTROGEN (*estradiol valerate*)	T4	HD

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS (cont.)		
DEPO-ESTRADIOL	T3	HD
ESTRACE 0.5 MG TABLET (*estradiol*)	T4	HD
ESTRACE 1 MG TABLET (*estradiol*)	T4	HD
ESTRACE 2 MG TABLET (*estradiol*)	T4	HD
estradiol (Climara)	T2	QL(4 patches/28 days) HD
estradiol 0.1% (0.25mg) gel pk (Divigel)	T2	QL(30 packs/fill) HD
estradiol 0.1% (0.75mg) gel pk (Divigel)	T2	QL(30 packs/fill) HD
estradiol 0.1% (1 mg) gel pkt (Divigel)	T2	QL(30 packs/fill) HD
estradiol 0.1% (1.25mg) gel pk	T2	QL(30 packs/fill) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T2	QL (50 gms/30 days) HD
estradiol 0.5 mg tablet (Estrace)	T2	HD
estradiol 1 mg tablet (Estrace)	T2	HD
estradiol 2 mg tablet (Estrace)	T2	HD
estradiol valerate (Delestrogen)	T2	HD
estradiol/norethindrone acet	T2	HD
estradiol/norethindrone acet (Activella)	T2	HD
EVAMIST	T4	QL (17 mls/30 days) HD
MENOSTAR	T4	QL(4 patches/28 days) HD
norethind-eth estrad 0.5-2.5	T2	HD
norethindrone ac/eth estradiol	T2	HD
norethin-eth estrad 1 mg-5 mcg	T2	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T4	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T3	
GLUCOCORTICOIDS		
ASMALPRED PLUS	T4	
budesonide	T2	
budesonide (Uceris)	T2	
CORTEF (*hydrocortisone*)	T4	
cortisone acetate	T2	
deflazacort	T2	PA SP HD
deflazacort (Emflaza)	T2	PA SP HD
dexamethasone	T2	PA

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS (cont.)		
dexamethasone	T2	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T2	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 10 day 1.5 mg tb	T2	PA
dexamethasone 13 day 1.5 mg tb	T2	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 day 1.5 mg tab	T2	PA
dexamethasone 6 mg tablet	T1	
DEXONTO	T4	
DXEVO	T4	PA
hydrocortisone (Cortef)	T2	
MEDROL	T4	
MEDROL (*methylprednisolone)*	T4	
methylprednisolone	T2	
methylprednisolone (Medrol)	T2	
ORAPRED ODT (*prednisolone sodium phosphate*)	T4	
prednisolone	T2	
prednisolone sodium phosphate	T2	
*prednisolone sodium phosphate (*Orapred Odt*)*	T2	
prednisone	T2	
prednisone	T1	
RAYOS	T4	PA
TAPERDEX	T4	PA
TARPEYO	T4	PA QL(28 caps/30 days) SP
UCERIS *(budesonide)*	T4	
ZCORT	T4	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T4	PA SP HD

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

List of Prescription Medications

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS		
CRINONE 8% GEL	T3	
medroxyprogesterone 2.5 mg tab (Provera)	T2	HD
medroxyprogesterone 5 mg tab (Provera)	T2	HD
medroxyprogesterone 10 mg tab (Provera)	T2	HD
norethindrone acetate	T2	HD
progesterone, micronized (Prometrium)	T2	HD
PROMETRIUM *(progesterone, micronized)*	T4	HD
PROVERA (*medroxyprogesterone acetate*)	T4	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T4	PA SP
MYCAPSSA DR 20MG CAPSULE	T4	PA SP QL (56 caps/28 days)
SIGNIFOR	T4	PA SP
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T2	
estradiol 0.01% cream (Estrace)	T2	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T2	HD
PREMARIN VAGINAL CREAM-APPL	T3	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T2	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	ST SP
GONAL-F	T4	ST SP
GONAL-F RFF	T4	ST SP
GONAL-F RFF REDI-JECT	T4	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	ST QL(3 vials/30 days) SP
CHORIONIC GONAD 50,000 UNIT VL	T4	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T4	ST SP
NOVAREL	T4	QL (6 vls/30 days) SP
OVIDREL	T4	SP
PREGNYL	T4	ST QL (3 vials/30 days) SP

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

List of Prescription Medications

HORMONES (Infertility) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T4	
ENDOMETRIN	T4	ST
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL(1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
calcitonin,salmon,synthetic	T2	HD
calcitonin,salmon,synthetic (Miacalcin)	T2	HD
MIACALCIN (*calcitonin,salmon,synthetic*)	T4	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI 45 MG/0.5 ML SYRINGE	T4	PA SP
SELARSDI 90 MG/ML SYRINGE	T4	PA SP
STELARA	T4	PA QL SP HD
USTEKINUMAB	T4	
USTEKINUMAB-TTWE	T4	
YESINTEK	T4	
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T4	PA QL (2 mls/28 days) SP HD
OMVOH 100 MG/ML PEN	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA SP HD
TREMFYA PEN INDUCTION PK-CROHN	T4	PA QL (200 mgs/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 auto-inj/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL (200 mgs/28 days) SP HD
TREMFYA PEN	T4	PA QL (200 mgs/28 days) SP HD
SKYRIZI ON-BODY	T4	PA QL(1 cartridge/56 days) SP HD

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T4	PA QL(2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T4	PA QL(400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T4	PA QL(400 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML PEN	T4	PA QL(600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T4	PA QL(600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL(3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL(2 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
TYENNE	T4	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T4	PA QL (2 pens/28 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T4	T4 PA QL (2 pens/28 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T4	PA SP
pimecrolimus (Elidel)	T2	ST QL(120 gms/30 days)
tacrolimus 0.03% ointment	T2	ST QL (120 gms/30 days)
tacrolimus 0.1% ointment	T2	ST QL (120 gms/30 days)
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	PA SP HD
AZASAN (*azathioprine*)	T4	SP HD
azathioprine (Azasan)	T2	SP HD
azathioprine (Imuran)	T2	SP HD
CELLCEPT *(mycophenolate mofetil)*	T4	SP HD
cyclosporine 100 mg capsule (Sandimmune)	T2	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T2	SP HD
cyclosporine, modified	T2	SP HD
cyclosporine, modified (Neoral)	T2	SP HD
everolimus 0.25 mg tablet (Zortress)	T2	SP HD
everolimus 0.5 mg tablet (Zortress)	T2	SP HD

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES (cont.)		
everolimus 0.75 mg tablet (Zortress)	T2	SP HD
everolimus 1 mg tablet (Zortress)	T2	SP HD
IMURAN (*azathioprine*)	T4	SP HD
LUPKYNIS	T4	PA SP QL (180 caps/30 days)
mycophenolate mofetil (Cellcept)	T2	SP HD
mycophenolate sodium (Myfortic)	T2	SP HD
MYFORTIC (*mycophenolate sodium*)	T4	SP HD
MYHIBBIN	T4	SP
NEORAL (*cyclosporine, modified*)	T4	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (*tacrolimus*)	T4	SP HD
PROGRAF 1 MG CAPSULE (*tacrolimus*)	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (*tacrolimus*)	T4	SP HD
RAPAMUNE (*sirolimus*)	T4	SP HD
SANDIMMUNE 100 MG CAPSULE (*cyclosporine*)	T4	SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (*cyclosporine*)	T4	SP HD
sirolimus	T2	SP HD
sirolimus (Rapamune)	T2	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T2	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T2	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T2	SP HD
ZORTRESS (*everolimus*)	T4	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK	T4	
ACCU-CHEK	T4	
ACCU-CHEK COMPACT PLUS CONTROL	T4	
ACCU-CHEK FASTCLIX LANCING DEV	T3	
ACCU-CHEK GUIDE CONTROL SOLN	T4	
ACCU-CHEK SMARTVIEW CONTRL SOL	T4	
ACCU-CHEK SOFTCLIX	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
ACCUTREND GLUCOSE CONTROL	T4	
ADJUSTABLE LANCING DEVICE	T3	
ADVANCED LANCING DEVICE	T3	
ADVOCATE CONTROL SOLUTION	T4	
ADVOCATE LANCING DEVICE	T3	
ADVOCATE RAPID-SAFE LANCING DV	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T4	
AGAMATRIX CONTROL	T4	
AGAMATRIX CONTROL SOLUTION	T4	
ALKALINE BATTERIES	T4	
ALTERNATE SITE LANCING DEVICE	T3	
AQUA LANCE LANCING DEVICE	T3	
ASSURE 4 CONTROL SOLUTION	T4	
ASSURE DOSE	T4	
ASSURE PRISM	T4	
AT HOME A1C	T4	
AUTOLET LITE	T3	
AUTOJECT 2	T3	
AUTO-LANCET MINI	T3	
AUTOLET IMPRESSION	T3	
AUTOLET LANCING DEVICE	T3	
AUTOLET LITE	T3	
AUTOLET PLUS	T3	
AUTOPEN	T3	
AUTOSOFT 30	T3	
AUTOSOFT 90	T3	
AUTOSOFT 30 INFUSION SET PACK	T4	
AUTOSOFT XC INFUSION SET PACK	T4	
AUTOSOFT XC	T3	
BLOOD GLUCOSE CONTROL	T4	
BLOOD-GLUCOSE CONTROL	T4	
BREEZE 2	T4	
CAREONE	T3	
CARESENS	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
CARETOUCH CONTROL SOLUTION	T4	
CARETOUCH LANCING DEVICE	T3	
CEQUR SIMPLICITY	T3	
CEQUR SIMPLICITY INSERTER	T3	
CHEMSTRIP BG DIARY	T4	
CHOSEN LANCING DEVICE	T3	
CLEVER CHOICE CONTROL SOLUTION	T4	
CONTOUR	T4	
CONTOUR NEXT CONTROL SOLUTION	T4	
CONTROL SOLUTION	T4	
COOL CONTROL SOLUTION	T4	
DEXCOM G6 RECEIVER	T3	PA QL (1 unit/365 days)
DEXCOM G6 SENSOR	T3	PA QL (3 kits/30 days)
DEXCOM G6 TRANSMITTER	T3	PA QL (1 kit/90 days)
DEXCOM G7 RECEIVER	T3	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T3	PA QL (3 units/30 days)
DEXCOM G4 RECEIVER	T3	PA
DEXCOM G4 TRANSMITTER	T3	PA QL (1 kit/180 days)
DEXCOM G5 RECEIVER	T3	PA
DEXCOM G5 TRANSMITTER	T3	PA QL (1 kit/90 days)
DEXCOM G5-G4 SENSOR	T3	PA
DEXCOM RECEIVER	T3	PA
DIATRUE	T4	
DROPLET GENTEEL LANCING DEVICE	T3	
DROPLET LANCING DEVICE	T3	
EASY MINI EJECT LANCING DEVICE	T3	
EASY PLUS II CONTROL SOLN HIGH	T4	
EASY PLUS II CONTROL SOLN LOW	T4	
EASY STEP CONTROL SOLUTION	T4	
EASY TALK CONTROL SOLN LOW	T4	
EASY TALK HIGH CONTROL SOLN	T4	
EASY TALK PLUS II HIGH CONTROL	T4	
EASY TALK PLUS II LOW CTRL SLN	T4	
EASY TOUCH BLULINK CTRL SOLN	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
EASY TOUCH CONTROL SOLUTION	T4	
EASY TOUCH LANCING DEVICE	T3	
EASY TRAK CONTROL SOLN HIGH	T4	
EASY TRAK CONTROL SOLN LOW	T4	
EASY TRAK II CONTROL SOLUTION	T4	
EASYGLUCO PLUS CONTROL NORMAL	T4	
EASYMAX 15 LEVEL 2 SOLUTION	T4	
EASYMAX NORMAL CONTROL SOLN	T4	
ELEMENT COMPACT CONTROL SOLN	T4	
ELEMENT CONTROL SOLUTION	T4	
EMBRACE EVO LEVEL 1 CTRL SOLN	T4	
EMBRACE GLUC CONTROL SOLN HIGH	T4	
EMBRACE GLUCOSE CONTROL SOLN	T4	
EMBRACE LANCING DEVICE	T3	
EMBRACE PRO	T4	
EMBRACE TALK CONTROL SOLUTION	T4	
ENLITE SERTER	T4	
EVENCARE G2 CONTROL SOLUTION	T4	
EVENCARE G3 CONTROL SOLUTION	T4	
EVOLUTION CONTROL SOLUTION	T4	
FORA CONTROL SOLUTION	T4	
FORA GTEL MULTIFUNCTN MONITOR	T4	
FORA KETONE CONTROL SOLUTION	T4	
FORA LANCING DEVICE	T3	
FORA TN'GO ADV MOBILE MULT MTR	T4	
FORA TN'G ADVANCE PRO MONITOR	T4	
FORA TN'GO ADVANCE MULTIFN MTR	T4	
FORACARE GDH	T4	
FORTISCARE	T4	
FREESTYLE CONTROL SOLUTION	T3	
FREESTYLE LIBRE 2 READER	T3	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 SENSOR	T3	ST QL (2 sensors/28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	T3	PA QL (2 units/30 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T3	PA QL (2 units/30 days)

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
FREESTYLE LIBRE 3 READER	T3	PA QL (1 unit/365 days)
FREESTYLE LIBRE 3 SENSOR	T3	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T3	PA
FREESTYLE LIBRE 10 DAY SENSOR	T3	PA QL (2 kits/30 days)
FREESTYLE LIBRE 14 DAY READER	T3	PA
FREESTYLE LIBRE 14 DAY SENSOR	T3	PA QL (2 sensors/28 days)
FREESTYLE NAVIGATOR SENSOR KIT	T3	
GE100 CONTROL SOLUTION NORMAL	T4	
GENTEEL VACUUM LANCING DEVICE	T4	
GLUCOCARD 01 CONTROL	T4	
GLUCOCARD EXPRESSION CNTRL SLN	T4	
GLUCOCARD SHINE CONTROL SOLN	T4	
GLUCOCOM AUTOLINK	T4	
GLUCOCOM CONTROL SOLUTION	T4	
GLUCOSE CONTROL	T4	
GLUCOSE CONTROL SOLUTION	T4	
GOJJI GLUCOSE CONTROL SOLUTION	T4	
GOJJI KETONE CONTROL SOLUTION	T4	
GOJJI LANCING DEVICE	T3	
GOJJI MULTI-FUNCTIONAL METER	T4	
GUARDIAN 4 TRANSMITTER	T4	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T4	PA QL (5 sensors/30 days)
GUARDIAN LINK 3 TRANSMITTER	T4	PA QL (1 transmitter/273 days)
GUARDIAN RT CHARGER	T4	
GUARDIAN RT STARTER KIT	T4	
GUARDIAN TEST PLUG	T4	
GUARDIAN TRANSMITTER TAPE	T4	
HEALTHPRO GLUCOSE CONTROL SOLN	T4	
HEALTHY ACCENTS AUTOLET	T3	
HYPOLANCE	T3	
IHEALTH CONTROL SOLN LEVEL 2	T4	
ILET INFUSION-CONTACT DETACH	T3	
ILET INFUSION KIT-INSET	T3	
ILET STARTER KIT-INSET	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
INCONTROL LANCING DEVICE	T3	
INFINITY CONTROL SOLUTION	T4	
INFINITY VOICE CONTROL SOLN	T4	
INPEN (FOR HUMALOG)	T4	
INPEN (FOR NOVOLOG OR FIASP)	T4	
INSUL-CAP	T4	
INSUL-EZE	T3	
LANCING DEVICE	T3	
LANCING SYSTEM	T3	
LANZO	T3	
LITE TOUCH LANCING PEN	T3	
MEDISENSE	T3	
MEDISENSE GLUCOSE KETONE	T3	
MEDISENSE GLUCOSE KETONE CONTR	T3	
MEDTRONIC EXT INFUSION SET	T3	
MEDTRONIC REMOTE CONTROL	T4	
MICRODOT HIGH-LOW CONTROL SOL	T4	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T3	
MICROLET NEXT LANCING DEVICE	T3	
MINI LANCING DEVICE	T2	
MINIMED	T3	
MINIMED MIO ADVANCE	T3	
MINIMED QUICK SET	T3	
MINIMED QUICK-SERTER	T4	
MINIMED QUICK-SERTER	T3	
MINIMED SILHOUETTE	T3	
MINIMED SURE T	T3	
MULTI-LANCET	T3	
MYGLUCOHEALTH CONTROL SOLUTION	T4	
NOVA MAX PLUS GLUC-KETON METER	T4	
NOVAMAX PLUS GLU-KET	T4	
NOVOPEN 3	T3	
NOVOPEN ECHO	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T3	
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T3	QL (1 kit/720 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T3	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T3	QL (15 pods/28 days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T3	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T3	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T3	QL (15 crtgs/30 days)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T3	
OMNIPOD CLASSIC PODS (GEN 3)	T3	QL(15 pods/28 days)
OMNIPOD DASH INTRO KIT (GEN 4)	T3	QL(1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T3	QL(15 pods/28 days)
OMNIPOD GO PODS	T3	QL(10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T4	
ON CALL LANCING DEVICE	T3	
ON CALL PLUS CONTROL	T4	
ON CALL PLUS LANCING DEVICE	T3	
ON CALL VIVID CONTROL	T4	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANC DEV	T3	
ONETOUCH ULTRA CONTROL SOLN	T3	
ONETOUCH VERIO HIGH CNTRL SOLN	T3	
ONETOUCH VERIO MID CNTRL SOLN	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T4	
OVAL TAPE	T4	
PIP GLUCOSE CONTROL SOLUTION	T4	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T4	
PRODIGY LANCING DEVICE	T3	
QUICK RELEASE SOFT TEFLON	T3	
REFUAH PLUS GLUCOSE CONTROL	T4	
RELIAMED MINI LANCING DEVICE	T3	
REPLACEMENT PEDIATRIC MONITOR	T4	
RIGHTEST CONTROL SOLUTION	T4	
RIGHTEST GD500	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
SAFE-CLIP	T3	
SEN-SERTER	T4	
SILHOUETTE	T3	
SIL-SERTER	T3	
SMARTDIABETES VANTAGE	T3	
SMARTEST	T4	
SOF-SERTER	T3	
SOF-SET	T3	
SOF-SET MICRO	T3	
SOLUS V2 CONTROL SOLUTION	T4	
SOLUS V2 LANCING DEVICE	T3	
SURE COMFORT LANCING PEN	T3	
SUREFLEX	T3	
SURE-PEN	T3	
SURE-TEST EASYPLUS MINI SOLN	T4	
T:FLEX	T3	
T:SLIM X2	T3	
TANDEM MOBI AUTOSOFT 30 SUPPLY	T3	
TANDEM MOBI AUTOSOFT XC SUPPLY	T3	
TANDEM MOBI CARTRIDGE	T3	
TANDEM MOBI TRUSTEEL SUPPLY	T3	
TELCARE CONTROL SOLUTION	T4	
TRUE METRIX	T4	
TRUECONTROL	T4	
TRUEDRAW	T3	
TRUSTEEL INFUSION SET	T3	
TRUSTEEL INFUSION SET PACK	T4	
TWIIST REFILL KT(CSST-NDL-SYR)	T3	
TWIIST RFL(INFUS-CSST-NDL-SYR)	T3	
TWIIST STARTER KIT	T3	
ULTI-LANCE	T3	
ULTRATRAK CONTROL SOL NORMAL	T4	
ULTRATRAK CONTROL SOLUTION	T4	
ULTRATRAK ULTIMATE CNTRL SOLN	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
UNISTIK 2	T3	
UNISTRIP	T4	
VARISOFT INFUSION SET	T3	
V-GO 20	T3	
V-GO 30	T3	
V-GO 40	T3	
VIVAGUARD INO CONTROL SOLUTION	T4	
VIVAGUARD LANCING DEVICE	T3	
WAVESENSE CONTROL SOLUTION	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
acti-lance lite 28g lancets	T2	
acti-lance special 17g lancets	T2	
acti-lance univers 23g lancets	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
CARETOUCH SAFETY LANCETS	T3	
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
CHOSEN LANCET	T3	
CHOSEN SAFETY LANCET	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
COMFORT TOUCH PLUS SAFETY LANC	T3	
COMFORT TOUCH ULT THIN LANCET	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST & CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
lancets	T2	
LANCETS	T3	
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
medlance plus 21g lancets	T2	
MEDLANCE PLUS 21G LANCETS	T3	
medlance plus 30g lancets	T2	
MEDLANCE PLUS 30G LANCETS	T3	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
medlance plus lite 25g lancets	T2	
MEDLANCE PLUS LITE 25G LANCETS	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MOBILE LANCETS	T3	
MONOLET LANCETS	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ONETOUCH ULTRASOFT 2 LANCET	T3	
ON-THE-GO	T3	
PERFECT POINT SAFETY LANCETS	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRO COMFORT SAFETY LANCET	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCE SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTEST LANCET	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUE COMFORT SAFETY LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	
ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK 3 NORMAL	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VERIFINE SAFETY LANCET MINI	T3	
VERIFINE UNIVERSAL LANCET	T3	
VIVAGUARD LANCET	T3	
VIVAGUARD SAFETY LANCET	T3	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T3	
BD ECLIPSE NEEDLE 18G 40MM	T4	
BD ECLIPSE NEEDLE 21GX1"	T3	
BD ECLIPSE NEEDLE 22GX1"	T3	
BD ECLIPSE NEEDLE 23GX1"	T4	
BD ECLIPSE NEEDLE 25G 16MM	T4	
BD ECLIPSE NEEDLE 25G 25MM	T4	
BD ECLIPSE NEEDLE 25GX1"	T3	
BD ECLIPSE NEEDLE 25GX1.5"	T3	
BD ECLIPSE NEEDLE 25GX5/8"	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
BD ECLIPSE NEEDLE 27GX1/2"	T4	
BD ECLIPSE NEEDLES 21GX1.5"	T3	
BD SAFETYGLIDE NEEDLE	T3	
BD SAFETYGLIDE NEEDLE 18GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 21GX1"	T3	
BD SAFETYGLIDE NEEDLE 21GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 22GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 23G 40MM	T4	
BD SAFETYGLIDE NEEDLE 25GX1"	T3	
BD SAFETYGLIDE NEEDLE 27GX5/8"	T3	
BLUNT NEEDLE	T3	
CAREPOINT PRECISION NEEDLE	T4	
CARETOUCH HYPODERMIC NEEDLE	T4	
CHEMO TRANSFER PIN	T3	
DROPSAFE SICURA SAFETY NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLES	T4	
EASY TOUCH HYPODERMIC NEEDLE	T4	
EASYPOINT NEEDLE	T4	
EXEL HUBER NEEDLE	T3	
EXEL HYPODERMIC NEEDLE	T3	
EXEL MTI DRAWING NEEDLE	T3	
FILTER ASPIRATOR NEEDLE	T3	
FILTER NEEDLE	T3	
FLOW-EZE	T3	
HURRICAINE LUER-LOCK	T3	
HYPODERMIC NEEDLE	T3	
INTEGRA NEEDLE	T3	
INTEGRA PRECISIONGLIDE NEEDLE	T4	
LIFESHIELD BLUNT CANNULA	T3	
MINI TRANSFER PIN	T3	
MONOJECT BLOOD COLLECTION	T3	
MONOJECT FILTER NEEDLE	T4	
NANO 2ND GEN PEN NEEDLE	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
NANO PEN NEEDLE	T3	
NEEDLES	T3	
needles,safety huber,disposabl	T2	
NOKOR ADMIX NEEDLE	T3	
NOKOR NEEDLE	T3	
PEN NEEDLE 30G X 8MM	T4	
PERFECT POINT SAFETY NEEDLE	T4	
PHASEAL PROTECTOR	T4	
POLY HUB NEEDLE	T3	
PRECISIONGLIDE	T3	
PRECISIONGLIDE NEEDLE	T3	
QUINCE SPINAL NEEDLE	T3	
RAYA SURE PEN NEEDLE 29G 12MM	T4	
RAYA SURE PEN NEEDLE 31G 5MM	T4	
RAYA SURE PEN NEEDLE 31G 6MM	T4	
REGULAR BEVEL NEEDLES	T3	
SAFETYGLIDE NEEDLE	T3	
SHORT BEVEL NEEDLES	T3	
SPECIALTY USE NEEDLES	T3	
TERUMO SURGUARD2	T3	
THIN WALL NEEDLES	T3	
TRANSFER NEEDLE	T3	
TRANSFER PIN	T3	
ULTRA-FINE MICRO PEN NEEDLE	T3	
ULTRA-FINE MINI PEN NEEDLE	T3	
ULTRA-FINE NANO PEN NEEDLE	T3	
ULTRA-FINE ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE PEN NEEDLE	T3	
ULTRA-FINE SHORT PEN NEEDLE	T3	
YALE NEEDLE	T3	
YALE NEEDLES	T3	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
ALLERGIST TRAY SYR-DETACH NDL	T3	
ALLERGIST TRAY SYR-PERM NEEDLE	T3	
ALLERGY SYRINGE 1 ML 27GX1/2"	T4	
ALLERGY SYRINGE 1 ML 27GX3/8"	T4	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 3 ML	T3	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T4	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T3	
BD INS SYR UF 0.3ML 12.7MMX30G	T3	
BD INS SYR UF 0.5ML 12.7MMX30G	T3	
BD INS SYRN UF 1 ML 12.7MMX30G	T3	
BD INS SYRNG 0.3 ML 29GX12.7MM	T3	
BD INS SYRNG 0.5 ML 29GX12.7MM	T3	
BD INS SYRNG UF 0.3 ML 8MMX31G	T3	
BD INS SYRNG UF 0.5 ML 8MMX31G	T3	
BD INSULIN SYR 0.5 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 25GX1"	T3	
BD INSULIN SYR 1 ML 25GX5/8"	T3	
BD INSULIN SYR 1 ML 26GX1/2"	T3	
BD INSULIN SYR 1 ML 27GX12.7MM	T3	
BD INSULIN SYR 1 ML 27GX5/8"	T3	
BD INSULIN SYR 1 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX12.7MM	T3	
BD INSULIN SYR UF 1 ML 8MMX31G	T3	
BD INSULIN SYRINGE 1 ML	T3	
BD SAFETYGLIDE 3 ML SYRINGE	T3	
BD SAFETYGLIDE SYR 22GX1.5"	T3	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T4	
BD SAFETYGLIDE SYRINGE 27GX5/8	T3	
BD SAFETYGLIDE TB 1 ML SYR	T3	
BD SAFETYGLIDE TB 1ML 27G 10MM	T4	
BD SAFETYGLIDE TUBERCULIN SYR	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
BD SYRINGE-SAFETY GLIDE	T3	
BD UF INS SYR 1 ML 30GX1/2"	T3	
BULK SYRINGE	T3	
CANNULA	T3	
CAREPOINT LUER LOCK SYRINGE	T4	
CAREPOINT LUER LOCK SYRING-NDL	T3	
CAREPOINT PRECISION LUER LOCK	T4	
CAREPOINT PRECISION SAFETY	T3	
CAREPOINT SAFETY LUER LOCK SYR	T3	
CAREPOINT LUER SLIP SYRINGE	T4	
CAREPOINT LUER SLIP SYRING-NDL	T4	
CARETOUCH LUER LOCK	T3	
CARETOUCH LUER LOCK SYRINGE	T4	
CARETOUCH LUER SLIP SYRINGE	T4	
CORNWALL SYRINGE TIP CONNECTOR	T3	
DAVOL IRRIGATION SYRINGE	T3	
DOVER BULB SYRINGE	T4	
EASY GLIDE CATHETER TIP SYRING	T4	
EASY GLIDE LUER LOCK SYRINGE	T4	
EASY GLIDE LUER SLIP TB SYRING	T4	
EASY TOUCH FLIPLK 10ML 20GX1.5	T4	
EASY TOUCH FLIPLK 10ML 21GX1.5	T4	
EASY TOUCH FLIPLK 10ML 22GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T4	
EASY TOUCH FLIPLOCK	T4	
EASY TOUCH FLIPLOCK 1 ML 25GX1	T3	
EASY TOUCH FLIPLOCK 10ML 21GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 18GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 20GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 21GX1	T4	
EASY TOUCH FLIPLOCK 5 ML 18GX1	T4	
EASY TOUCH FLIPLOCK 5 ML 21GX1	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH FLIPLOCK SYRINGE	T4	
EASY TOUCH FLIPLOK 10 ML 20GX1	T4	
EASY TOUCH FLIPLOK 10 ML 25GX1	T4	
EASY TOUCH FLIPLOK 1ML 26GX3/8	T3	
EASY TOUCH FLIPLOK 1ML 27GX0.5	T3	
EASY TOUCH FLIPLOK 3ML 18GX1.5	T4	
EASY TOUCH FLIPLOK 3ML 20GX1.5	T4	
EASY TOUCH FLIPLOK 3ML 21GX1.5	T4	
EASY TOUCH FLURINGE	T3	
EASY TOUCH FLURINGE FLIPLOCK	T3	
EASY TOUCH FLURINGE FLU TRAY	T4	
EASY TOUCH FLURINGE SHEATHLOCK	T3	
EASY TOUCH LUER LOCK INSULIN	T4	
EASY TOUCH LUER LOCK SYRINGE	T4	
EASY TOUCH SHEATHLOCK SYRG-NDL	T4	
EASY TOUCH SHEATHLOCK SYRINGE	T4	
EASY TOUCH SYR 1 ML 25GX5/8"	T3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T3	
EASY TOUCH SYR 3 ML 25GX5/8"	T3	
EASY TOUCH SYR ALLERGY TRAY	T4	
EASY TOUCH SYRINGE 1 ML 25GX1"	T3	
EASY TOUCH SYRINGE 3 ML 20GX1"	T3	
EASY TOUCH SYRINGE 3 ML 21GX1"	T3	
EASY TOUCH SYRINGE 3 ML 22GX1"	T3	
EASY TOUCH SYRINGE 3 ML 23GX1"	T3	
EASY TOUCH SYRINGE 3 ML 25GX1"	T3	
EASY TOUCH TUBERCULIN FLIPLOCK	T3	
EASY TOUCH TUBERCULIN SHEATHLK	T3	
EASY TOUCH UNI-SLIP	T4	
ECLIPSE SYRINGE	T3	
ECLIPSE SYRINGE-NEEDLE	T3	
ENFIT SYRINGE	T4	
ENFIT SYRINGE STERILE	T4	
ENFIT THUMB CONTROL RING SYRIN	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
EXEL SYRINGE	T3	
EXEL TB WITH NEEDLE	T3	
EXEL TUBERCULIN SYRINGE	T3	
EXTENDED RESERVOIR	T4	
FILTER, MILLEX-OR SYRINGE	T4	
FINGER GRIP EXTENDER	T4	
INJECT-EASE	T3	
INSULIN CARTRIDGE	T3	
INSULIN SYR 0.5 ML 28G 12.7MM	T3	
INSULIN SYRINGE U-500	T3	
INSULIN SYRINGE 1 ML 27G 16MM	T3	
INSULIN SYRINGE 1ML 28G 12.7MM	T3	
INTEGRA SYRINGE	T3	
INTERLINK SYRINGE	T3	
INTERLINK SYRINGE W-CANNULA	T4	
KENDALL DISINFECTANT CAP	T4	
LEVER LOCK CANNULA	T4	
LIFESHIELD BLUNT CANNULA	T3	
LUER LOCK SYRINGE	T3	
LUER SLIP TIP SYRINGE TRAY	T4	
LUER TIP CAP TRAY	T4	
LUER-LOK SYRINGE	T3	
LUER-LOK SYRINGE-NEEDLE	T3	
LUER-LOK TIP SYRINGE	T3	
LUERSLIP SYRINGE	T3	
MAGELLAN SAFETY SYRINGE	T3	
MAGELLAN TB SAFETY SYRINGE	T3	
MAGELLAN TUBERCULIN SYRINGE	T3	
MINIMED RESERVOIR 1.8 ML	T4	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT 3 ML SYRINGE 25GX1"	T3	
MONOJECT 6CC SAFETY SYRINGE	T3	
MONOJECT ALLERGY TRAY-NEEDLE	T3	
MONOJECT CONTROL SYRINGE	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
MONOJECT ENFIT SYRINGE	T4	
MONOJECT ENFIT SYRINGE CAP	T4	
MONOJECT LUER LOCK TB SYRINGE	T3	
MONOJECT MAGELLAN	T3	
MONOJECT PHARMACY TRAY	T3	
MONOJECT SAFETY SYR TIP CAP	T4	
MONOJECT SAFETY SYRINGE	T3	
MONOJECT SMARTIP CANNULA	T4	
MONOJECT SYRINGE	T3	
MONOJECT SYRINGE 140 ML	T4	
MONOJECT SYRINGE 35 ML	T3	
MONOJECT SYRINGE PHARMACY TRAY	T3	
MONOJECT TB	T3	
MONOJECT TB SAFETY SYRINGE	T3	
MONOJECT TB SYRINGE	T3	
MONOJECT TUBERCULIN SYRINGE	T3	
NORM-JECT SYRINGE	T4	
NORM-JECT TUBERKULIN SYRINGE	T4	
PARADIGM	T3	
PISTON ENFIT SYRINGE	T4	
PRECISIONGLIDE	T3	
PRODIGY COUNT-A-DOSE	T3	
SAFESNAP ALLERGY SYRINGE	T4	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 10 ML	T4	
SAFESNAP SYRINGE 3 ML	T3	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP SYRINGE 5 ML	T4	
SAFESNAP TUBERCULIN SYRINGE	T4	
SAFETY SYRINGE WITH SHIELD	T3	
SAFETY SYRINGE-NEEDLE	T4	
SAFETYGLIDE ALLERGY	T3	
SAFETYGLIDE ALLERGY SYRINGE	T4	
SAFETYGLIDE INSULIN SYRINGE	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
SAFETY-LOK SAFETY SYRINGE	T3	
SAFETY-LOK SAFETY SYRINGES	T3	
SAFETY-LOK SYRINGES	T3	
SLIP-TIP SYRINGE	T4	
SUPOR	T4	
SYRINGE	T3	
SYRINGE BULK	T3	
SYRINGE CATHETER TIP	T3	
SYRINGE CATHETER TIP NON-STER	T3	
SYRINGE FILTER, MILLEX-GP	T4	
SYRINGE FILTER, MILLEX-GS	T4	
SYRINGE LUER-LOK	T3	
SYRINGE LUER-LOK NON-STERILE	T3	
SYRINGE LUER-LOK STERILE	T3	
SYRINGE SLIP TIP	T3	
SYRINGE SLIP TIP NON-STERILE	T3	
SYRINGE STORAGE BIN	T4	
SYRINGE TIP CAP	T3	
SYRINGE WITH NEEDLE	T3	
SYRINGE WITH NEEDLE DISP	T3	
SYRINGE WITHOUT NEEDLE	T3	
SYRINGE-LUER TIP CAP	T3	
SYRINGE-NEEDLE	T3	
SYRINGE-PRECISIONGLIDE NEEDLE	T3	
TB SYRINGE	T3	
TERUMO ALLERGY SYRINGE	T3	
TERUMO HYPODERMIC NEEDLE-SYRIN	T3	
TERUMO SURGUARD2	T3	
TERUMO SYRINGE	T3	
TOOMEY SYRINGE	T3	
TUBERCULIN SLIP-TIP SYRINGE	T4	
TUBERCULIN SYRINGE	T3	
TUBERCULIN SYRINGE-NEEDLE	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
TWINPAK DUAL CANNULA	T3	
ULTICARE LDS SYR 1 ML 22G 1.5"	T4	
ULTICARE LDS SYR 3 ML 22GX1.5"	T3	
ULTICARE SAFETY SYRINGE	T4	
ULTICARE SYRINGE	T4	
ULTICARE TB SAFETY 1 ML 25GX1"	T3	
ULTICARE TB SAFETY 1ML 25GX5/8	T3	
ULTICARE TB SAFETY SYRINGE	T3	
ULTIGUARD SAFE 1ML 30G 12.7MM	T4	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T4	
ULTRA-FINE INSULIN SYRINGE	T3	
UNIVERSAL SYRINGE TIP ADAPTOR	T4	
VANISHPOINT 1 ML TB SYR 25X5/8	T3	
VANISHPOINT 1 ML TB SYR 27X1/2	T3	
VANISHPOINT 20GX1" 3 ML SYRING	T3	
VANISHPOINT 21GX1" 5 ML SYRING	T3	
VANISHPOINT 21GX1.5" 3 ML SYR	T3	
VANISHPOINT 22GX1" 3 ML SYR	T3	
VANISHPOINT 22GX1-1/2" 5 ML SY	T3	
VANISHPOINT 23GX1" 3 ML SYRING	T3	
VANISHPOINT 23GX1-1/2 3 ML SYR	T3	
VANISHPOINT 25GX1" 3 ML SYRING	T3	
VANISHPOINT 25GX5/8" 3 ML SYR	T3	
VANISHPOINT 3 ML 21GX1" SYRING	T3	
VANISHPOINT 3 ML 22GX1.5" SYRG	T3	
VANISHPOINT SYRINGE	T4	
VANISHPOINT SYRINGE 1 ML 25X1"	T3	
VEO INSULIN SYRINGE	T3	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
BANDAGES AND RELATED SUPPLIES		
ARGLAES FILM	T4	
CONFORMANT 2	T4	
DERMAVIEW	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BANDAGES AND RELATED SUPPLIES (cont.)		
DERMAVIEW II	T3	
IV 3000	T3	
IV3000 FRAME DELIVERY	T4	
KENDALL	T3	
NEXCARE TEGADERM 2.375"X2.75"	T4	
NEXCARE TEGADERM DRESSING	T3	
OPSITE	T4	
OPSITE IV 3000	T3	
POLYSKIN II	T3	
SURESITE MATRIX	T3	
SURESITE WINDOW	T3	
TEGADERM 1.75X1.75" DRSSNG	T4	
TEGADERM 2"X2.75" DRESSING	T3	
TEGADERM 2.375"X2.75" DRESSING	T3	
TEGADERM 2.375"X4" DRESSING	T3	
TEGADERM 2.375X2.75" DRSSNG	T3	
TEGADERM 3.5" X 4" DRESSING	T3	
TEGADERM 3.5"X 10" DRESSING	T4	
TEGADERM 3.5"X 6" DRESSING	T4	
TEGADERM 3.5"X13.75" DRESS	T4	
TEGADERM 3.5"X4.125" DRESS	T3	
TEGADERM 3.5"X8" DRESSING	T4	
TEGADERM 4" X 10" DRESSING	T3	
TEGADERM 4" X 4-3/4" DRESSING	T3	
TEGADERM 4"X4.75" DRESSING	T3	
TEGADERM 6" X 8" DRESSING	T3	
TEGADERM 8" X 12" DRESSING	T3	
TEGADERM ABSORBENT	T4	
TEGADERM HP 4" X 4.5 " DRSSN	T3	
TEGADERM HP 4.5"X4.75" DRSS	T3	
TEGADERM HP DRESSING	T3	
TEGADERM HP DRESSING	T4	
TEGADERM I.V.	T4	
TEGADERM I.V. 2.5"X2.75" DRSSN	T4	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM I.V. 4"X4.75" DRSSN	T3	
TRANSPARENT DRESSING	T4	
TRANSPARENT FILM DRESSING	T4	
TRANSPARENT I.V. SITE DRESSING	T3	
TRANSPARENT MEPITEL FILM DRESS	T4	
TRANSPARENT THIN FILM DRESSING	T3	
WINDOW BANDAGES	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
acti-lance lite 28g lancets	T2	
acti-lance special 17g lancets	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
acti-lance univers 23g lancets	T2	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH SAFETY LANCETS	T3	
CARETOUCH TWIST LANCET	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
CHOSEN LANCET	T3	
CHOSEN SAFETY LANCET	T3	
CLEVER CHEK LANCETS	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH BUTTON 30G LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
lancets	T2	
LANCETS	T3	
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
MEDLANCE PLUS 21G LANCETS	T3	
medlance plus 21g lancets	T2	
MEDLANCE PLUS 30G LANCETS	T3	
medlance plus 30g lancets	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
MEDLANCE PLUS LITE 25G LANCETS	T3	
medlance plus lite 25g lancets	T2	
MEDLANCE PLUS SPECIAL BLADE	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MICROTAINER LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ON-THE-GO	T3	
PERFECT POINT SAFETY LANCETS	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCE SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTEST LANCET	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	
ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VIVAGUARD LANCET	T3	
VIVAGUARD SAFETY LANCET	T3	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T4	
ALCOH-WIPE	T4	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T3	
ACCU-CHEK	T4	
ACCU-CHEK RAPID D 10-100	T4	
ACCU-CHEK RAPID D 10-50	T4	
ACCU-CHEK RAPID D 10-70	T3	
ACCU-CHEK RAPID D 6-100	T4	
ACCU-CHEK RAPID D 6-50	T3	
ACCU-CHEK RAPID D 6-70	T4	
ACCU-CHEK RAPID D 8-100	T4	
ACCU-CHEK RAPID D 8-50	T3	
ACCU-CHEK RAPID D 8-70	T3	
ACCU-CHEK SPIRIT	T3	
ACCU-CHEK TENDER	T3	
ACCU-CHEK ULTRAFLEX	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL ADMINISTRATION SETS (cont.)		
DELTEC COZMO CLEO INFUSION SET	T3	
INSET 30 TUBING	T3	
IV ADMINISTRATION SET	T3	
NERIA	T4	
PARADIGM INFUSION	T3	
POLYFIN QR	T3	
PSV SET	T4	
Q-SYTE	T3	
SILHOUETTE	T3	
SURE-T	T3	
RESPIRATORY AIDS,DEVICES,EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T3	
AEROCHAMBER MECHANICAL VENT	T3	
AEROCHAMBER MINI	T3	
AEROCHAMBER MV	T3	
AEROCHAMBER PLUS FLOW-VU	T3	
AEROCHAMBER Z-STAT PLUS	T3	
AEROTRACH PLUS	T3	
AEROVENT PLUS	T3	
BREATHERITE	T3	
BREATHERITE SPACER-ADULT MASK	T3	
BREATHERITE SPACER-INFANT MASK	T3	
BREATHERITE SPACER-LG CHLD MSK	T3	
BREATHERITE SPACER-NEONATE MSK	T3	
BREATHERITE SPACER-SM CHLD MSK	T3	
BREATHRITE	T3	
CLEVER CHOICE HOLDING CHAMBER	T3	
COMFORTSEAL	T3	
COMPACT SPACE CHAMBER	T3	
EASIVENT	T3	
FLEXICHAMBER	T3	
FLEXICHAMBER MASK	T3	
INSPIRACHAMBER	T3	
LITEAIRE	T3	

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
LITETOUCH	T3	
MICROCHAMBER	T3	
MICROSPACER	T3	
MOUTHPIECE	T3	
ONE WAY MOUTHPIECE	T3	
OPTICHAMBER	T3	
OPTICHAMBER DIAMOND	T3	
PANDA MASK	T3	
PEDIATRIC MASK	T3	
PEDIATRIC PANDA MASK	T3	
POCKET CHAMBER	T3	
PRIMEAIRE	T3	
PRO COMFORT SPACER-ADULT MASK	T3	
PRO COMFORT SPACER-CHILD MASK	T4	
PRO COMFORT SPACER-INFANT MASK	T4	
PROCARE SPACER WITH ADULT MASK	T3	
PROCARE SPACER WITH CHILD MASK	T3	
PROCHAMBER	T3	
PURE COMFORT PEAK FLOW MOUTHPCE	T3	
PURE COMFORT SPACER WITH MASK	T4	
RITEFLO	T3	
SIDESTREAM PEDIATRIC	T3	
SILICONE MASK	T3	
SPACE CHAMBER	T3	
SPACE CHAMBER-LARGE MASK	T3	
SPACE CHAMBER-MEDIUM MASK	T3	
SPACE CHAMBER-SMALL MASK	T3	
VORTEX	T3	
VORTEX VHC FROG MASK	T3	
VORTEX VHC LADYBUG MASK	T3	
VORTEX VHC PEDIATRIC MASK	T3	

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

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T4	
COMFORT PAC-TIZANIDINE	T4	
SKELETAL MUSCLE RELAXANTS		
baclofen 5 mg tablet	T2	HD
baclofen 10 mg tablet	T2	HD
baclofen 15 mg tablet	T2	HD
baclofen 20 mg tablet	T2	HD
baclofen 5 mg/5 ml suspension	T2	HD
baclofen 25 mg/5 ml suspension	T2	ST
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T2	HD
carisoprodol (Soma)	T2	
carisoprodol/aspirin	T2	
chlorzoxazone	T2	
chlorzoxazone (Lorzone)	T2	
cyclobenzaprine hcl	T2	
cyclobenzaprine hcl (Amrix)	T2	PA
cyclobenzaprine hcl (Fexmid)	T2	
DANTRIUM *(dantrolene sodium)*	T4	
dantrolene sodium	T2	
dantrolene sodium (Dantrium)	T2	
FEXMID *(cyclobenzaprine hcl)*	T4	PA
LORZONE *(chlorzoxazone)*	T4	PA
metaxalone 400 mg tablet	T2	
metaxalone 800 mg tablet	T2	
methocarbamol	T2	
methocarbamol 500 mg tablet	T2	
methocarbamol 750 mg tablet	T2	
methocarbamol 1,000 mg tablet	T2	
NORGESIC (*orphenadrine/aspirin/caffeine)*	T4	
NORGESIC FORTE (*orphenadrine/aspirin/caffeine*)	T4	
orphenadrine citrate	T2	
orphenadrine/aspirin/caffeine (Norgesic Forte)	T2	
orphenadrine/aspirin/caffeine (Norgesic)	T2	
SOMA (*carisoprodol*)	T4	

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

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS (cont.)		
tizanidine hcl	T2	
tizanidine hcl (Zanaflex)	T2	
ZANAFLEX (*tizanidine hcl*)	T4	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T4	
BRAINSTRONG PRENATAL	T4	
CADEAU DHA	T4	
CITRANATAL 90 DHA	T4	
CITRANATAL ASSURE	T4	
CITRANATAL B-CALM	T4	
CITRANATAL DHA	T4	
CITRANATAL HARMONY	T4	
CITRANATAL RX	T4	
cvs prenatal multi-dha softgel	T2	PPACA
cvs prenatal vitamins tablet	T2	PPACA
DUET DHA 400	T4	
DUET DHA BALANCED	T4	
EXPECTA PRENATAL	T3	
ft prenatal tablet	T2	PPACA
gnp prenatal vitamins tablet	T2	PPACA
GS PRENATAL VITAMINS TABLET	T4	
HM ONE DAILY PRENATAL COMBO PK	T3	
hm prenatal tablet	T2	PPACA
KOSHER PRENATAL PLUS IRON	T4	
KPN PRENATAL TABLET	T3	
kpn tablet	T2	PPACA
MARNATAL-F	T4	
MINI PRENATAL	T4	
MTERYTI	T4	
MTERYTI FOLIC 5	T4	
NATACHEW	T4	
NEONATAL COMPLETE	T4	

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
NEONATAL PLUS	T4	
NEONATAL-DHA	T4	
NESTABS	T4	
NESTABS ABC	T4	
NESTABS DHA	T4	
OB COMPLETE ONE	T4	
OB COMPLETE PETITE	T4	
OB COMPLETE PREMIER	T4	
OB COMPLETE WITH DHA	T4	
OBSTETRIX EC	T4	
OBTREX DHA	T4	
ONE A DAY WOMEN'S PRENATAL DHA	T4	
ONE-A-DAY PRENATAL-1	T4	
pnv 11/iron fum/folic acid/om3	T2	
pnv 119/iron fum/folic acid	T2	
pnv no. 154/iron fum/folic acid	T2	
pnv 66/iron/folic/docusate/dha	T2	
pnv 69/iron/folic/docusate/dha	T2	
pnv 80/iron fum/folic/dss/dha	T2	
pnv cmb 52/iron/fa/omega-3/dha	T2	
pnv no.118/iron fumarate/fa	T2	
pnv,calcium 72/iron,carb/folic	T2	
pnv,calcium 72/iron/folic acid	T2	
pnv/iron,carb/docusat/folic ac	T2	
pnv19/iron bg,s.p/folic ac/om3	T2	
pnv81/iron edta,ps/folic/omeg3	T2	
PRENATA	T4	
prenatal 105/iron/folic ac/dha	T2	
prenatal 12/iron/folic/dss/om3	T2	
PRENATAL 19 CHEWABLE TABLET	T4	
prenatal 19 chewable tablet	T2	
PRENATAL 19 TABLET	T4	
prenatal 19 tablet	T2	
prenatal 21/iron fu/folic acid	T2	PPACA

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal 53/iron/folic ac/omg3	T2	
prenatal 54/iron/folic ac/omg3	T2	
prenatal 12/iron/folic/dss/om3	T2	
prenatal 93/iron/folate 9/dha	T2	
prenatal caplet	T2	PPACA
prenatal comb no.42/folic acid (Vitamedmd Redichew Rx)	T2	
PRENATAL FORMULA	T3	
PRENATAL FORMULA-DHA *(prenatal vit116/iron/folic/dha)*	T4	
PRENATAL GUMMIES	T4	
PRENATAL MULTI	T4	
prenatal multi-dha softgel	T2	PPACA
PRENATAL MULTI-DHA SOFTGEL	T3	
PRENATAL MULTI-DHA SOFTGEL	T4	
prenatal multivitamin tablet	T2	PPACA
PRENATAL MULTIVITAMIN TABLET	T4	
PRENATAL MULTIVITAMIN-DHA SFGL	T3	
PRENATAL PLUS VITAMIN-MINERAL	T4	
PRENATAL PLUS-DHA	T4	
prenatal tablet	T2	PPACA
PRENATAL TABLET	T4	
prenatal vit 14/iron fum/folic	T2	
prenatal vit 55/iron/folic/om3	T2	
prenatal vit 91/iron/folic/dha	T2	
prenatal vit no.126/iron/folic	T2	PPACA
prenatal vit no.129/iron/folic	T2	PPACA
prenatal vit,cal 73/iron/folic	T2	
prenatal vit,calc76/iron/folic	T2	
prenatal vit,calc78/iron/folic	T2	
prenatal vit/iron fum/folic ac	T2	
prenatal vit27,calcium/iron/fa	T2	
prenatal vit86/iron/folic acid	T2	
PRENATAL VITAMIN + DHA	T3	
prenatal vitamin tablet	T2	PPACA
PRENATAL VITAMIN TABLET *(prenatal vit no.124/iron/folic)*	T4	

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal vitamins tablet	T2	PPACA
prenatal vits calc.36/iron/fa	T2	PPACA
prenatal,calc.40/iron/folate 1	T2	
prenatal71/iron/folic acid/dha	T2	
PRENATE DHA	T4	
PRENATE ELITE	T4	
PRENATE ENHANCE	T4	
PRENATE MINI	T4	
PRENATE PIXIE	T4	
PRENATE RESTORE	T4	
PRENATE STAR	T4	
PRIMACARE	T4	
PROVIDA OB	T4	
qc prenatal tablet	T2	PPACA
ra one daily prenatal dha pack	T2	PPACA
ra prenatal tablet	T2	PPACA
R-NATAL OB	T4	
SELECT-OB	T4	
SELECT-OB *(prenatal vit128/iron/folic acd)*	T4	
SELECT-OB + DHA	T4	
SIMILAC PRENATAL	T4	
sm prenatal vitamins tablet	T2	PPACA
STUART ONE *(pnv no.63/iron,carb/folic/dha)*	T4	
sv prenatal tablet	T2	PPACA
SV PRENATAL VITAMINS TABLET	T4	
THERANATAL	T4	
THERANATAL COMPLETE	T4	
THERANATAL ONE	T4	
THERANATAL OVAVITE	T4	
THERANATAL PLUS	T4	
THRIVITE RX	T4	
TRICARE	T4	
TRICARE PRENATAL DHA ONE	T4	
TRISTART DHA	T4	

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
ULTRA PRENATAL PLUS DHA	T4	
VITAFOL FE PLUS	T4	
VITAFOL GUMMIES	T4	
VITAFOL NANO	T4	
VITAFOL ULTRA	T4	
VITAFOL-OB	T4	
VITAFOL-OB+DHA	T4	
VITAFOL-ONE	T4	
VITAMEDMD ONE RX	T4	
VITAMEDMD REDICHEW RX (*prenatal comb no.42/folic acid*)	T4	
VITAPEARL	T4	
VITATRUE	T4	
VP-PNV-DHA	T4	
WOMEN'S PRENATAL PLUS DHA	T3	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CVS PRENATAL GUMMIES	T4	
PRENATAL GUMMIES	T4	
TRINAZ	T4	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8]		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T2	HD
REMERON *(mirtazapine)*	T4	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T2	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
ATIVAN *(lorazepam)*	T4	
chlordiazepoxide hcl	T2	
clorazepate dipotassium	T2	
diazepam 10 mg tablet (Valium)	T2	
diazepam 2 mg tablet (Valium)	T2	
diazepam 25 mg/5 ml oral conc	T2	
diazepam 5 mg tablet (Valium)	T2	

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
diazepam 5 mg/5 ml oral soln	T2	
diazepam 5 mg/5 ml solution	T2	
diazepam 5 mg/ml oral conc	T2	
lorazepam	T2	
lorazepam (Ativan)	T1	
oxazepam	T2	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T2	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	QL (28 caps/365 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	QL (28 caps/365 days) SP HD
ZURZUVAE 30 MG CAPSULE	T4	QL (14 caps/365 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T4	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
LITHOBID *(lithium carbonate)*	T4	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T4	
NARDIL (*phenelzine sulfate*)	T4	
PARNATE (*tranylcypromine sulfate*)	T4	
phenelzine sulfate (Nardil)	T2	
tranylcypromine sulfate (Parnate)	T2	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T4	
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T4	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
bupropion hcl	T1	HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
citalopram hbr 10 mg/5 ml soln	T2	HD
escitalopram oxalate 5 mg/5 ml	T1	ST HD
fluoxetine 20 mg/5 ml solution cup	T2	HD
fluoxetine hcl	T2	ST QL(4 caps/fill) HD
fluoxetine hcl 10 mg tablet	T2	ST QL(30 tabs/fill) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	HD
fluoxetine hcl 20 mg tablet	T2	ST HD
fluoxetine hcl 60 mg tablet	T2	ST HD
fluvoxamine maleate	T2	ST QL(60 caps/fill) HD
fluvoxamine maleate 100 mg tab	T2	QL(90 tabs/fill) HD
fluvoxamine maleate 25 mg tab	T2	QL(30 tabs/fill) HD
fluvoxamine maleate 50 mg tab	T2	QL(60 tabs/fill) HD
paroxetine hcl (Paxil Cr)	T2	ST QL(60 tabs/fill) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL(30 tabs/fill) HD
paroxetine hcl 10 mg/5 ml susp (Paxil)	T2	ST HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL(60 tabs/fill) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL(60 tabs/fill) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL(30 tabs/fill) HD
PAXIL 10 MG TABLET *(paroxetine hcl)*	T4	ST QL(30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION *(paroxetine hcl)*	T4	ST HD
PAXIL 20 MG TABLET *(paroxetine hcl)*	T4	ST QL(60 tabs/fill) HD
PAXIL 30 MG TABLET *(paroxetine hcl)*	T4	ST QL(60 tabs/fill) HD
PAXIL 40 MG TABLET *(paroxetine hcl)*	T4	ST QL(30 tabs/fill) HD
PAXIL CR (*paroxetine hcl)*	T4	ST QL(60 tabs/fill) HD
sertraline 20 mg/ml oral conc (Zoloft)	T2	HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL(45 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T2	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T4	ST QL(30 tabs/fill) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL(60 caps/fill) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL(30 caps/fill) HD
duloxetine hcl dr 40 mg cap	T1	ST QL(30 caps/fill) HD

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL(60 caps/fill) HD
FETZIMA ER 20 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 40 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 80 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 120 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA 20-40 MG TITRATION PAK	T3	ST QL (28 caps/30 days)
venlafaxine hcl	T1	QL(90 tabs/fill) HD
venlafaxine hcl er 150 mg tab	T2	ST QL(30 tabs/fill) HD
venlafaxine hcl er 225 mg tab	T2	ST QL(30 tabs/fill) HD
venlafaxine hcl er 37.5 mg tab	T2	ST QL(30 tabs/fill) HD
venlafaxine hcl er 75 mg tab	T2	ST QL(30 tabs/fill) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX	T4	ST QL (30 tabs/30 days)
TRINTELLIX 10 MG TABLET	T4	ST QL(30 tabs/fill) HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T2	HD
perphenazine/amitriptyline hcl	T2	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T2	HD
ANAFRANIL *(clomipramine hcl)*	T4	HD
clomipramine hcl (Anafranil)	T2	HD
desipramine hcl	T2	HD
doxepin 10 mg capsule	T2	HD
doxepin 10 mg/ml oral conc	T2	HD
doxepin 25 mg, 50 mg capsule	T2	HD
doxepin 75 mg capsule	T2	HD
doxepin 100 mg capsule	T2	HD
doxepin 150 mg capsule	T2	HD
imipramine hcl (Tofranil)	T1	HD
imipramine pamoate	T2	HD
maprotiline hcl	T2	HD
nortriptyline hcl	T2	HD
nortriptyline hcl (Pamelor)	T1	HD

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
PAMELOR *(nortriptyline hcl)*	T4	HD
protriptyline hcl	T2	HD
SURMONTIL *(trimipramine maleate)*	T4	HD
TOFRANIL (*imipramine hcl*)	T4	HD
trimipramine maleate (Surmontil)	T2	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine 10 mg capsule (Vyvanse)	T2	
lisdexamfetamine 10 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 20 mg capsule (Vyvanse)	T2	
lisdexamfetamine 20 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 30 mg capsule (Vyvanse)	T2	
lisdexamfetamine 30 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 40 mg capsule (Vyvanse)	T2	
lisdexamfetamine 40 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 50 mg capsule (Vyvanse)	T2	
lisdexamfetamine 50 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 60 mg capsule (Vyvanse)	T2	
lisdexamfetamine 60 mg tb chew (Vyvanse)	T2	ST
lisdexamfetamine 70 mg capsule (Vyvanse)	T2	
VYVANSE *(lisdexamfetamine dimesylate)*	T4	ST
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl er 0.1 mg tablet (Kapvay)	T2	
guanfacine hcl (Intuniv)	T2	HD
KAPVAY (*clonidine hcl*)	T4	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (*methylphenidate hcl*)	T4	ST
atomoxetine hcl (Strattera)	T2	HD
AZSTARYS	T3	ST
COTEMPLA XR-ODT	T4	ST
DAYTRANA (*methylphenidate*)	T4	ST
dexmethylphenidate hcl (Focalin Xr)	T2	
dexmethylphenidate hcl (Focalin)	T1	

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
JORNAY PM	T4	ST
METADATE CD *(methylphenidate hcl)*	T4	ST
METHYLIN *(methylphenidate hcl)*	T4	
methylphenidate	T2	ST
methylphenidate hcl	T2	
methylphenidate hcl (Metadate Cd)	T2	
methylphenidate hcl (Methylin)	T2	
methylphenidate hcl (Ritalin La)	T2	
methylphenidate hcl (Ritalin)	T2	
methylphenidate er 10 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 15 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 20 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 30 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 40 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 50 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 60 mg cap (Aptensio Xr)	T2	ST
methylphenidate er 10 mg tab	T2	
methylphenidate er 18 mg tab (Concerta)	T2	
methylphenidate er 18 mg tab (Relexxii)	T2	
methylphenidate er 20 mg tab	T2	
methylphenidate er 27 mg tab (Relexxii)	T2	
methylphenidate er 27 mg tab (Concerta)	T2	
methylphenidate er 36 mg tab (Relexxii)	T2	
methylphenidate er 36 mg tab (Concerta)	T2	
methylphenidate er 54 mg tab (Relexxii)	T2	
methylphenidate er 54 mg tab (Concerta)	T2	
methylphenidate er 72 mg tab	T2	
METHYLPHENIDATE ER 72 MG TAB	T4	ST
QELBREE ER	T4	ST
RELEXXII ER 72 MG TABLET	T4	ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
QELBREE	T4	ST

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T4	PA
VYLEESI	T4	PA QL(8 auto-injs/fill) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8]		
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T2	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T2	QL(60 tabs/fill)
CAPLYTA	T4	QL(30 caps/fill)
clozapine	T2	
clozapine (Clozaril)	T2	
CLOZARIL (*clozapine*)	T4	
GEODON (*ziprasidone hcl*)	T4	QL(60 caps/fill)
INVEGA ER 3 MG TABLET (*paliperidone*)	T4	QL(30 tabs/fill)
INVEGA ER 6 MG TABLET (*paliperidone*)	T4	QL(60 tabs/fill)
INVEGA ER 9 MG TABLET (*paliperidone*)	T4	QL(30 tabs/fill)
LYBALVI	T4	QL (30 tabs/30 days)
olanzapine (Zyprexa Zydis)	T2	QL(30 tabs/fill)
quetiapine er 200 mg tablet (Seroquel Xr)	T2	QL(30 tabs/fill)
quetiapine er 300 mg tablet (Seroquel Xr)	T2	QL(60 tabs/fill)
quetiapine er 400 mg tablet (Seroquel Xr)	T2	QL(60 tabs/fill)
quetiapine er 50 mg tablet (Seroquel Xr)	T2	QL(60 tabs/fill)
quetiapine fumarate 200 mg tab (Seroquel)	T1	QL(90 tabs/fill)
quetiapine fumarate 300 mg tab (Seroquel)	T1	QL(60 tabs/fill)
RISPERDAL 0.5 MG TABLET (*risperidone*)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG TABLET (*risperidone*)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (risperidone)	T4	
RISPERDAL 2 MG TABLET (*risperidone*)	T4	QL(60 tabs/fill)
RISPERDAL 3 MG TABLET (*risperidone*)	T4	QL(60 tabs/fill)
RISPERDAL 4 MG TABLET (*risperidone*)	T4	QL(60 tabs/fill)
risperidone	T2	QL(60 tabs/fill)
risperidone 0.5 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 1 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 1 mg/ml solution (Risperdal)	T2	
risperidone 2 mg tablet (Risperdal)	T1	QL(60 tabs/fill)

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)		
risperidone 3 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 4 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
SECUADO	T4	QL(30 patches/fill)
VERSACLOZ	T4	
ziprasidone hcl (Geodon)	T2	QL(60 caps/fill)
ZYPREXA (*olanzapine*)	T4	QL(30 tabs/fill)
ZYPREXA ZYDIS (*olanzapine*)	T4	QL(30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR	T4	QL (30 caps/30 days)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T4	
ABILIFY MYCITE	T4	QL(30 tabs/fill)
aripiprazole	T2	QL(60 tabs/fill)
aripiprazole 1 mg/ml solution	T2	
aripiprazole 2 mg tablet (Abilify)	T1	QL(30 tabs/fill)
aripiprazole 10 mg tablet (Abilify)	T1	QL(30 tabs/fill)
aripiprazole 20 mg tablet (Abilify)	T1	QL(30 tabs/fill)
aripiprazole 30 mg tablet (Abilify)	T1	QL(30 tabs/fill)
REXULTI	T4	QL(30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T2	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T2	
fluphenazine hcl	T2	
perphenazine	T2	
thioridazine hcl	T2	
trifluoperazine hcl	T2	

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T2	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T4	PA SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T2	PA QL(30 tabs/fill)
modafinil 100 mg tablet (Provigil)	T2	PA QL(30 tabs/fill)
SUNOSI	T3	PA QL(30 tabs/fill)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ STARTER PACK	T4	PA SP HD
LUMRYZ ER	T4	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T4	PA SP HD QL (540ml/30 days)
XYREM	T4	PA QL(540 mls/fill) SP HD
XYWAV	T4	PA QL(540 mls/fill) SP HD
BARBITURATES		
phenobarbital	T2	
secobarbital sodium	T2	QL(30 caps/fill)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA QL(30 caps/fill) SP HD
HETLIOZ LQ	T4	PA QL(158 mls/fill) SP HD
ramelteon (Rozerem)	T2	QL(30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T2	QL (15 tabs/fill)
flurazepam hcl	T2	QL (15 caps/fill)
HALCION *(triazolam)*	T4	QL (15 tabs/fill)
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T4	
midazolam hcl 2 mg/ml syrup	T2	
RESTORIL *(temazepam)*	T4	QL (15 caps/fill)
temazepam (Restoril)	T2	QL (15 caps/fill)
triazolam	T2	
triazolam (Halcion)	T2	QL (15 tabs/fill)

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

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T4	ST QL(30 tabs/fill)
DAYVIGO	T4	ST QL (30 tabs/fill)
doxepin hcl 3 mg tablet (Silenor)	T2	ST QL(30 tabs/fill)
doxepin hcl 6 mg tablet (Silenor)	T2	ST QL(30 tabs/fill)
EDLUAR	T4	ST QL(30 tabs/fill)
eszopiclone (Lunesta)	T2	QL(30 tabs/fill)
IGALMI	T4	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T4	
QUVIVIQ	T4	ST QL (30 tabs/fill)
SILENOR (*doxepin hcl*)	T4	ST QL(30 tabs/fill)
zaleplon 10 mg capsule	T2	QL(60 caps/fill)
zaleplon 5 mg capsule	T2	QL(30 caps/fill)
zolpidem tartrate	T2	QL(30 tabs/fill)
zolpidem tartrate (Ambien Cr)	T2	QL(30 tabs/fill)
zolpidem tartrate (Ambien)	T2	QL(30 tabs/fill)
ZOLPIMIST	T4	ST QL (1 canister/30 days)
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
acetic acid	T2	
neomycin sulf/polymyxin b sulf	T2	
PHYSIOLYTE (*physiological irrig soln no.1*)	T4	
PHYSIOSOL (*physiological irrig soln no.1*)	T4	
ringer's solution	T2	
ringer's solution,lactated	T2	
sod,pot chlor/mag/sod,pot phos	T2	
sodium chloride 0.9% irrig	T2	
sodium chloride 0.9% prcss sol	T2	
SODIUM CHLORIDE 0.9% IRRIG.	T4	
sodium chloride irrig solution	T2	
SORBITOL	T4	
SORBITOL-MANNITOL	T4	
water for irrigation,sterile	T2	

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

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OXIDIZING AGENTS		
hydrogen peroxide	T2	
PRESERVATIVES		
formaldehyde	T2	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T2	
methoxsalen	T2	
SKYRIZI	T4	PA QL(150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T4	PA QL(150 mg/84 days) SP HD
SKYRIZI PEN	T4	PA QL(150 mg/84 days) SP HD
SOTYKTU	T4	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL(1 ml/28 days) SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T4	PA QL (1 ml/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac sodium 1% gel	T2	ST QL(500 gms/28 days) HD
FLECTOR	T3	ST QL(60 patches/fill) HD
LICART	T3	ST QL(30 patches/fill) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T4	ST
isotretinoin (Absorica)	T2	
ACNE AGENTS, TOPICAL		
ACZONE *(dapsone)*	T4	ST
adapalene/benzoyl peroxide	T2	
adapalene/benzoyl peroxide (Epiduo Forte)	T2	
AZELEX	T4	ST
clindamycin phos/benzoyl perox	T2	
clindamycin phos/benzoyl perox (Acanya)	T2	

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, TOPICAL (cont.)		
clindamycin/tretinoin (Veltin)	T2	
clindamycin/tretinoin (Ziana)	T2	PA
dapsone (Aczone)	T2	
EPIDUO FORTE	T4	ST
EPIDUO FORTE *(adapalene/benzoyl peroxide)*	T4	ST
KLARON *(sulfacetamide sodium)*	T4	ST
NEUAC 1.2-5% KIT	T4	ST
neuac gel	T2	
ONEXTON	T3	ST
ONEXTON (*clindamycin phos/benzoyl perox*)	T4	ST
sulfacetamide sodium (Klaron)	T2	
ANTIPRURITICS, TOPICAL		
doxepin 5% cream (Zonalon)	T2	ST QL(90 gms/30 days)
doxepin hcl (Zonalon)	T2	ST QL(90 gms/30 days)
ZONALON	T4	ST QL(90 gms/30 days)
ZONALON (*doxepin hcl*)	T4	ST QL(90 gms/30 days)
ANTIPSORIATICS AGENTS		
calcipotriene 0.005% cream (Dovonex)	T2	QL(120 gms/30 days)
calcipotriene 0.005% ointment	T2	QL(120 gms/30 days)
calcipotriene 0.005% solution	T2	QL(120 mls/30 days)
calcitriol 3 mcg/g ointment (Vectical)	T2	
DOVONEX (*calcipotriene*)	T4	ST QL(120 gms/30 days)
DUOBRII	T4	ST QL(200 gms/30 days)
tazarotene 0.05% cream (Tazorac)	T2	PA
tazarotene 0.1% cream (Tazorac)	T2	PA
tazarotene 0.05% gel (Tazorac)	T2	PA
tazarotene 0.1% gel (Tazorac)	T2	PA
TWYNEO	T4	PA ST
VECTICAL (*calcitriol*)	T4	
VTAMA	T3	PA QL (60 gms/28 days)
ZIANA *(clindamycin/tretinoin)*	T4	PA ST
ZORYVE 0.3% CREAM	T4	PA QL (60 gms/30 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T4	

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEBORRHEIC AGENTS (cont.)		
OVACE (*sulfacetamide sodium*)	T4	
OVACE PLUS	T4	
OVACE PLUS WASH	T4	
PLEXION NS	T4	
selenium sulfide	T2	
sod sulfacetam 10% clnsng gel	T2	
sod sulfacetamide 10% shampoo	T2	
sod sulfacetamide 9.8% shampoo	T2	
SODIUM SULFACETAMIDE 10% WASH	T4	
*sodium sulfacetamide 10% wash (*Ovace*)*	T2	
TERSI FOAM	T4	
ANTISEPTICS,GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% SWABS	T3	
alcohol 70% swabs	T2	
ALCOHOL 70% WIPES	T3	
alcohol antiseptic pads	T2	
alcohol prep pads	T2	
alcohol swabs	T2	
CARETOUCH ALCOHOL PREP PAD	T3	
CURITY ALCOHOL PREPS	T3	
CVS ALCOHOL 70% PREP PADS	T3	
cvs isopropyl alcohol 70% wipe	T2	
DROPSAFE PREP PADS	T3	
EASY COMFORT ALCOHOL PAD	T3	
EASY TOUCH ALCOHOL PREP PADS	T3	
fifty50 alcohol prep pads	T2	
GS ALCOHOL 70% SWABS	T3	
HM ALCOHOL 70% PREP PADS	T3	
INCONTROL ALCOHOL PADS	T3	
PHARM CHOICE ALCOHOL PREP PADS	T3	
pharm choice alcohol prep pads	T2	

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL (cont.)		
PRO COMFORT ALCOHOL PADS	T3	
PURE COMFORT ALCOHOL PAD	T3	
qc alcohol 70% swabs	T2	
ra alcohol swabs	T2	
RA ISOPROPYL ALCOHOL 70% WIPES	T3	
RELION ALCOHOL 70% SWABS	T3	
SAPS ALCOHOL 70% PREP PADS	T3	
SINGLE USE SWAB	T3	
SM ALCOHOL 70% PREP PADS	T3	
sm alcohol prep pads	T2	
SURE COMFORT ALCOHOL	T3	
SURE-PREP ALCOHOL PREP PADS	T3	
TRUE COMFORT ALCOHOL PADS	T3	
TRUE COMFORT PRO ALCOHOL PADS	T3	
ULTILET ALCOHOL SWAB	T3	
v-r alcohol prep pads	T2	
WEBCOL	T3	
ANTISEPTICS,MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	QL(15 gms/fill)
IMMUNOMODULATORS		
imiquimod	T2	
*imiquimod (*Zyclara*)*	T2	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T4	
methyl salicylate	T2	
YCANTH	T4	SP
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL(30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T4	ST

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS		
benzepro 6% foaming cloths	T2	
BENZEPRO 7% CREAMY WASH (*benzoyl peroxide microspheres*)	T4	ST
benzoyl peroxide	T2	
benzoyl peroxide (Pacnex)	T2	
ENZOCLEAR	T4	ST
INOVA	T4	ST
INOVA 4-1	T4	ST
INOVA 8-2	T4	ST
PACNEX (*benzoyl peroxide*)	T4	ST
podofilox 0.5% gel (Condylox)	T2	ST QL (7 gms/30 days)
podofilox 0.5% topical soln	T2	
PR BENZOYL PEROXIDE (*benzoyl peroxide microspheres*)	T4	ST
PROTECTIVES		
PHARMABASE BARRIER (*zinc oxide*)	T4	
zinc oxide 20% ointment	T2	
ZINC OXIDE PASTE	T3	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T2	
EPSOLAY	T4	ST
FINACEA 15% FOAM	T3	ST
FINACEA 15% GEL *(azelaic acid)*	T4	ST
ivermectin 1% cream (Soolantra)	T2	QL(45 gms/30 days)
METROCREAM *(metronidazole)*	T4	ST
METROGEL *(metronidazole)*	T4	ST
metronidazole 0.75% cream (Metrocream)	T2	
metronidazole 0.75% lotion	T2	
metronidazole top 1% gel pump	T2	
metronidazole topical 0.75% gl	T2	
metronidazole topical 1% gel (Metrogel)	T2	
MIRVASO	T3	PA
RHOFADE	T4	PA
rosadan 0.75% cream (Metrocream)	T2	
ROSADAN 0.75% CREAM KIT	T4	ST

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ROSACEA AGENTS, TOPICAL (cont.)		
rosadan 0.75% gel	T2	
ROSADAN 0.75% GEL KIT	T4	ST
SOOLANTRA (*ivermectin*)	T4	ST QL(60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T4	
SURGISEAL STYLUS	T4	
SURGISEAL TEARDROP	T4	
SURGISEAL TWIST	T4	
TISSEEL VHSD	T4	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T3	ST QL(120 gms/30 days)
ZORYVE 0.15% CREAM	T3	ST QL (60 gms/30 days)
ZORYVE 0.3% FOAM	T4	ST QL (60 gms/30 days)
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T4	PA ST
ARAZLO	T4	PA
TOPICAL AGENTS, MISCELLANEOUS		
L-MESITRAN SOFT	T4	
MEDIHONEY	T4	
trichloroacetic acid	T2	
TRICHLOROACETIC ACID 100% (*trichloroacetic acid*)	T4	
TRICHLOROACETIC ACID 20% (*trichloroacetic acid*)	T3	
TRICHLOROACETIC ACID 25%	T4	
TRICHLOROACETIC ACID 30%	T3	
TRICHLOROACETIC ACID 35%	T3	
TRICHLOROACETIC ACID 40%	T3	
TRICHLOROACETIC ACID 50%	T3	
TRICHLOROACETIC ACID 75%	T4	
TRICHLOROACETIC ACID 80%	T3	
TRICHLOROACETIC ACID 85%	T3	
TRICHLOROACETIC ACID 90%	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T4	ST QL(30 gms/fill)

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*hydrocortisone*)	T4	ST
alclometasone dipropionate	T2	
amcinonide	T2	ST
betamethasone dipropionate	T2	
betamethasone va 0.1% cream	T2	
betamethasone va 0.1% lotion	T2	
betamethasone valer 0.1% ointm	T2	
betamethasone valer 0.12% foam	T2	ST
betamethasone/propylene glyc	T2	
betamethasone/propylene glyc (Diprolene)	T2	
BRYHALI	T4	ST
CAPEX SHAMPOO	T4	ST
clobetasol 0.05% cream	T2	QL (120 gms/30 days)
clobetasol 0.05% gel	T2	QL(120 gms/30 days)
clobetasol 0.05% ointment (Temovate)	T2	QL(120 gms/30 days)
clobetasol 0.05% shampoo (Clobex)	T2	ST QL(236 mls/30 days)
clobetasol 0.05% solution	T2	QL(100 mls/30 days)
clobetasol 0.05% topical lotn	T2	ST QL(118 mls/30 days)
clobetasol emollient 0.05% crm	T2	QL(120 gms/30 days)
clobetasol emollnt 0.05% foam	T2	ST QL(100 gms/30 days)
clobetasol prop 0.05% foam (Olux)	T2	ST QL(100 gms/30 days)
clobetasol prop 0.05% spray (Clobex)	T2	ST QL(125 mls/30 days)
clobetasol propionate/emoll	T2	ST QL(100 gms/30 days)
CLOBEX 0.05% SHAMPOO *(clobetasol propionate)*	T4	ST QL(236 mls/30 days)
CLOBEX 0.05% SPRAY (*clobetasol propionate*)	T4	ST QL(125 mls/30 days)
clocortolone pivalate (Cloderm)	T2	ST
clocortolone pivalate 0.1% crm (Cloderm)	T2	
CLODAN 0.05% KIT	T4	ST QL(2 kits/28 days)
clodan 0.05% shampoo (Clobex)	T2	ST QL(236 mls/30 days)
CLODERM	T4	ST
CLODERM (*clocortolone pivalate*)	T4	ST
CORDRAN 0.025% CREAM	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% CREAM *(flurandrenolide)*	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% LOTION *(flurandrenolide)*	T4	ST QL(120 mls/30 days)

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
CORDRAN 0.05% OINTMENT (flurandrenolide)	T4	ST QL(120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T4	ST
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T4	ST
DERMA-SMOOTHE-FS *(fluocinolone/shower cap)*	T4	ST
DERMASORB HC	T4	ST
DERMASORB TA	T4	ST
DERMATOP *(prednicarbate)*	T4	ST
DESONATE *(desonide)*	T4	ST
desonide (Desonate)	T2	ST
desonide 0.05% cream (Desowen)	T2	
desonide 0.05% cream (Tridesilon)	T2	
desonide 0.05% gel (Desonate)	T2	ST
desonide 0.05% lotion	T2	ST
desonide 0.05% ointment	T2	
DESOWEN *(desonide)*	T4	ST
desoximetasone (Topicort)	T2	ST
diflorasone diacet/emollient	T2	ST
diflorasone diacetate	T2	ST QL(120 gms/30 days)
DIPROLENE *(betamethasone/propylene glyc)*	T4	ST
fluocinolone acetonide	T2	
fluocinolone acetonide (Derma-Smoothe-Fs)	T2	
fluocinolone acetonide (Synalar)	T2	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T2	
fluocinonide 0.05% cream	T2	QL(120 gms/30 days)
fluocinonide 0.05% gel	T2	QL(120 gms/30 days)
fluocinonide 0.05% ointment	T2	QL(120 gms/30 days)
fluocinonide 0.05% solution	T2	QL(120 gms/30 days)
fluocinonide 0.1% cream (Vanos)	T2	ST QL(120 gms/30 days)
fluocinonide/emollient base	T2	QL(120 gms/30 days)
flurandrenolide 0.05% cream (Cordran)	T2	ST QL(120 gms/30 days)
flurandrenolide 0.05% lotion (Cordran)	T2	ST QL(120 mls/30 days)
flurandrenolide 0.05% ointment (Cordran)	T2	ST QL(120 gms/30 days)
fluticasone prop 0.005% oint	T2	
fluticasone prop 0.05% cream	T2	

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
fluticasone prop 0.05% lotion	T2	ST
fluticasone propionate	T2	ST
halcinonide 0.1% cream (Halog)	T2	ST
halcinonide 0.1% solution	T2	
halobetasol propionate	T2	
halobetasol prop 0.05% cream	T2	
halobetasol prop 0.05% foam	T2	ST
halobetasol prop 0.05% ointmnt	T2	
halobetasol prop 0.05% cream (Ultravate)	T2	
halobetasol prop 0.05% ointmnt (Ultravate)	T2	
HALOG	T4	ST
HALOG (*halcinonide*)	T4	ST
hydrocort buty 0.1% lipid crm (Locoid Lipocream)	T2	QL(120 gms/30 days)
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T2	QL(120 gms/30 days)
hydrocort/min oil/petrolat,wht	T2	
hydrocortisone	T2	
hydrocortisone (Ala-Scalp)	T2	
hydrocortisone (Anusol-Hc)	T2	ST QL (10gm/28 days)
hydrocortisone buty 0.1% cream	T2	QL(120 gms/30 days)
hydrocortisone butyr 0.1% lotn (Locoid)	T2	ST QL(118 mls/30 days)
hydrocortisone butyr 0.1% oint	T2	ST
hydrocortisone butyr 0.1% soln	T2	ST QL(120 mls/30 days)
IMPEKLO	T4	ST QL(136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (*triamcinolone acetonide*)	T4	ST QL(100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (*triamcinolone acetonide*)	T4	ST QL(100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (*triamcinolone acetonide*)	T4	ST QL(126 gms/30 days)
mometasone furoate 0.1% cream	T2	
mometasone furoate 0.1% oint	T2	
mometasone furoate 0.1% soln	T2	
nolix 0.05% cream (Cordran)	T2	ST QL(120 gms/30 days)
nolix 0.05% lotion (Cordran)	T2	ST QL(120 mls/30 days)
NUCORT	T4	ST
OLUX (*clobetasol propionate*)	T4	ST QL(100 gms/30 days)
PANDEL	T4	ST

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
prednicarbate	T2	
prednicarbate (Dermatop)	T2	
SCALACORT DK	T4	ST
SYNALAR	T4	ST
SYNALAR (*fluocinolone acetonide*)	T4	ST
SYNALAR TS	T4	ST
TEMOVATE (*clobetasol propionate*)	T4	ST QL(120 gms/30 days)
TEXACORT	T4	ST
TOPICORT 0.05% CREAM (*desoximetasone*)	T4	ST
TOPICORT 0.05% GEL (*desoximetasone*)	T4	ST
TOPICORT 0.05% OINTMENT (*desoximetasone*)	T4	ST
TOPICORT 0.25% CREAM (*desoximetasone*)	T4	ST
TOPICORT 0.25% OINTMENT (*desoximetasone*)	T4	ST
triamcinolone 0.025% cream, lotion	T2	
triamcinolone 0.025% oint	T2	
triamcinolone 0.05% ointment	T2	ST
triamcinolone 0.1% cream, lotion	T2	
triamcinolone 0.1% ointment	T2	
triamcinolone 0.147 mg/g spray (Kenalog)	T2	ST QL(126 gms/30 days)
triamcinolone 0.147 mg/g spray (Kenalog)	T2	ST QL(100 gms/30 days)
triamcinolone 0.5% cream	T2	
triamcinolone 0.5% ointment	T2	
triamcinolone acetonide	T2	ST
triderm 0.1% cream	T2	
triderm 0.5% cream	T2	ST
TRIDESILON (*desonide*)	T4	ST
ULTRAVATE X	T4	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (*hydrocortisone/pramoxine*)	T4	ST
EPIFOAM	T4	ST
hydrocort-pramoxine 2.5-1% crm	T2	ST
lidocaine/hydrocortisone ac	T2	
lidocaine-hc 3-0.5% cream	T2	
PRAMOSONE	T4	ST

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIPARASITICS		
lindane	T2	
malathion (Ovide)	T2	
OVIDE (*malathion*)	T4	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T4	PA QL(240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T2	
iodine/sodium iodide	T2	
IODOFLEX	T4	
IODOSORB	T4	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T2	ST QL(60 gms/30 days)
calcipotriene/betamethasone (Taclonex)	T2	QL(60 gms/30 days)
ENSTILAR	T3	ST QL(60 gms/30 days)
TACLONEX 0.005%-0.064% SUSPENS *(calcipotriene/betamethasone)*	T4	QL(60 gms/30 days)
TACLONEX OINTMENT *(calcipotriene/betamethasone)*	T4	ST QL(60 gms/30 days)
WYNZORA	T4	ST QL(60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL(180 gms/fill)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T2	
ADAPALENE 0.1% LOTION	T4	ST
adapalene 0.1% solution	T2	
adapalene 0.1% swab	T2	ST
adapalene 0.3% gel	T2	
adapalene 0.3% gel pump (Differin)	T2	
ALTRENO	T4	PA
avita 0.025% cream (Retin-A)	T2	PA
AVITA 0.025% GEL	T4	PA
DIFFERIN	T4	ST
DIFFERIN *(adapalene)*	T4	ST
RETIN-A *(tretinoin)*	T4	PA
RETIN-A MICRO PUMP 0.06% GEL	T4	PA
RETIN-A MICRO PUMP 0.08% GEL	T4	PA

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES (cont.)		
tretinoin	T2	
tretinoin 0.01% gel (Retin-A)	T2	PA
tretinoin 0.025% cream (Retin-A)	T2	PA
tretinoin 0.025% gel (Retin-A)	T2	PA
tretinoin 0.05% cream (Retin-A)	T2	PA
tretinoin 0.05% gel (Atralin)	T2	PA
tretinoin 0.1% cream (Retin-A)	T2	PA
tretinoin microspheres (Retin-A Micro Pump)	T2	PA
tretinoin microspheres (Retin-A Micro)	T2	PA
SMOKING DETERRENTS (Smoking Cessation)[8]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T4	QL(180 ds/365 days) PPACA
NICOTROL NS	T4	QL(180 ds/365 days) PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	QL(180 ds/365 days) PPACA
APO-VARENICLINE 1 MG TABLET	T3	QL(180 ds/365 days) PPACA
CHANTIX	T4	QL(180 ds/365 days) PPACA
varenicline 0.5 mg tablet	T2	
varenicline 1 mg tablet	T2	
varenicline starting month box	T2	
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T2	QL(180 ds/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
methimazole	T1	HD
propylthiouracil	T2	HD
THYROID HORMONES		
adthyza 15 mg, 30 mg tablet	T2	HD
adthyza 60 mg tablet	T2	HD
adthyza 90 mg tablet	T2	HD
adthyza 120 mg tablet	T2	HD
ARMOUR THYROID	T3	HD

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

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES (cont.)		
ERMEZA SOLUTION	T4	ST HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T2	HD
thyroid,pork	T2	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T4	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL (84 tabs/fill) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL(112 tabs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL(112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
SYMDEKO	T4	PA QL(56 tabs/fill) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	SP PA HD QL (56 packets/28 days)
TRIKAFTA 100-50-75 MG/75MG PKT	T4	SP PA HD QL (56 packets/28 days)
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL(56 tabs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T4	PA SP QL (56 packets/28 days)
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL(56 packs/fill) SP HD
KALYDECO 25 MG, 50 MG, 75 MG GRANULES PACKET	T4	PA QL(56 packs/fill) SP HD
LUNG SURFACTANTS		
CUROSURF	T4	
INFASURF	T4	
SURVANTA	T4	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA QL(60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T4	PA SP QL (60 tabs/30 days)
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL(56 tabs/28 days) SP
VIJOICE 50 MG GRANULE PACKET	T4	PA QL (28 packs/28 days) SP
VIJOICE 50 MG, 125 MG TABLET	T4	PA QL(28 tabs/28 days) SP
ZOKINVY	T4	PA QL(120 caps/fill) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T4	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA QL(60 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate (Firazyr)	T2	PA SP HD
icatibant acetate (Firazyr)	T2	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T4	PA SP
ORLADEYO 110MG CAPSULE	T4	PA SP QL (28 caps/28 days)
ORLADEYO 150MG CAPSULE	T4	PA SP QL (28 caps/28 days)
TAKHZYRO 300MG/2ML	T4	PA SP HD QL (2 units/28 days)
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T2	CSL
mesna (Mesnex)	T2	SP CSL
MESNEX *(mesna)*	T4	SP CSL
VISTOGARD	T4	PA QL(20 packs/30 days) SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*chlorhexidine gluconate*)	T4	

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Dental Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DENTAL AIDS AND PREPARATIONS (cont.)		
triamcinolone 0.1% paste	T2	
triamcinolone acetonide	T2	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T2	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T2	PA QL (8 tabs/30 days)
CAVERJECT 20 MCG, 40 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL(12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL(12 syringes/fill)
CIALIS (*tadalafil*)	T4	PA QL (8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA *(vardenafil hcl)*	T3	PA QL(8 tabs/fill)
MUSE	T2	PA QL(12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T3	
sildenafil 25 mg tablet (Viagra)	T2	PA QL (8 tabs/30 days) HD
sildenafil 100 mg tablet (Viagra)	T2	PA QL (8 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T2	PA QL (8 tabs/30 days) HD
tadalafil 10 mg tablet (Cialis)	T2	PA QL (8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T2	PA QL (8 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T2	PA QL (8 tabs/30 days) HD
STENDRA *(avanafil)*	T4	PA QL (8 tabs/30 days)
tadalafil 2.5 mg tablet	T2	PA QL (30 tabs/30 days) HD
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
vardenafil hcl	T2	PA QL(8 tabs/fill)
vardenafil hcl (Levitra)	T2	PA QL(8 tabs/fill)
VIAGRA (*sildenafil citrate*)	T4	PA QL (8 tabs/30 days)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T4	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T4	
SILATRIX	T4	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T4	
GELX	T4	
ORAMAGICRX	T4	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T4	
PPAR AGONIST		
IQIRVO	T4	PA SP HD
LIVDELZI	T4	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T4	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T4	
BOCASAL	T4	
CAPHOSOL	T4	
MUCOSITISRX	T4	
NEUTRASAL	T4	
NUMOISYN	T4	
SALIVAMAX	T4	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T4	PA QL (30 tabs/30 days) SP HD

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T2	ST
paricalcitol	T2	ST SP HD
paricalcitol (Zemplar)	T2	ST SP HD
RAYALDEE	T4	ST
ZEMPLAR (*paricalcitol*)	T4	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T4	
mifepristone 200 mg tablet	T2	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T2	PA SP
AMMONIA INHIBITORS		
CARBAGLU *(carglumic acid)*	T4	PA SP HD
carglumic acid (Carbaglu)	T2	PA SP HD
PHEBURANE	T4	PA SP
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD QL (4 syr/28 days)
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T2	
disulfiram	T2	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267mg capsules	T2	PA SP HD QL (270 caps/30 days)
CI ESTERASE INHIBITORS		
HAEGARDA	T4	PA SP HD
HAEGARDA 2,000UNIT VIAL	T4	PA SP HD QL (24 vials/28 days)
HAEGARDA 3,000UNIT VIAL	T4	PA SP HD QL (16 vials/28 days)
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T2	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T2	

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T2	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (*nitisinone*)	T4	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA SP HD QL (56 caps/28 days)
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T4	
GENERAL INHALATION AGENTS		
HYPER-SAL	T4	
nebusal 3% vial	T2	
NEBUSAL 6% VIAL	T4	
sodium chloride 0.9% inhal vl	T2	
sodium chloride 10% vial	T2	
sodium chloride 3% vial	T2	
sodium chloride 7% vial	T2	
sodium chloride for inhalation	T2	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI 5 MG TABLET	T4	PA SP HD
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T4	PA QL (240 mls/30 days) SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T2	PA QL(90 caps/30 days) sp
OPFOLDA	T4	PA QL(8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T2	ST QL(30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	PA
deferasirox (Exjade)	T2	PA SP HD

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT (cont.)		
*deferasirox (*Jadenu Sprinkle*)*	T2	PA SP HD
*deferasirox (*Jadenu*)*	T2	PA SP HD
*deferiprone (*Ferriprox (3 Times A Day))	T2	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX (3 TIMES A DAY) (*deferiprone*)	T4	PA SP
FERRIPROX 100 MG/ML SOLUTION	T4	PA SP
FERRIPROX 500 MG TABLET (*deferiprone*)	T4	PA SP
GALZIN	T4	SP
RADIOGARDASE	T4	
SYPRINE (*trientine hcl*)	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA QL(15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
*sapropterin dihydrochloride (*Kuvan*)*	T2	PA SP
*sapropterin dihydrochloride (*Kuvan*)*	T2	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA SP
VYNDAMAX	T4	PA SP HD
VYNDAQEL	T4	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T4	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T4	PA QL(112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T4	PA QL(56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T4	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T4	PA QL(84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T4	
cvs isopropyl alcohol 91%	T2	
CVS ISOPROPYL RUB ALCOHOL 70%	T4	
cvs isopropyl rub alcohol 70%	T2	
eql isopropyl alcohol 91%	T2	

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SOLVENTS (cont.)		
eql isopropyl rub alcohol 70%	T2	
FT ISOPROPYL ALCOHOL 91%	T4	
FT ISOPROPYL RUB ALCOHOL 70%	T4	
gnp isopropyl alcohol 99%	T2	
hm isopropyl alcohol 70%	T2	
hm isopropyl alcohol 91%	T2	
INSTACLEAN	T3	
ISOPROPANOL	T3	
isopropyl 70% alcohol	T2	
isopropyl alcohol	T2	
isopropyl alcohol 70%	T2	
ISOPROPYL ALCOHOL 70%	T4	
isopropyl alcohol 91%	T2	
isopropyl alcohol 99%	T2	
isopropyl rubbing alcohol 70%	T2	
ISOPROPYL RUBBING ALCOHOL 70%, 91%	T4	
kro isopropyl alcohol 91%	T2	
MURI-LUBE MINERAL OIL	T3	
polyethylene glycol	T2	
qc isopropyl alcohol 91%	T2	
qc isopropyl rubbing alcohol	T2	
ra isopropyl alcohol 70%	T2	
ra isopropyl alcohol 91%	T2	
sm isopropyl alcohol 70%	T2	
swan isopropyl alcohol 70%	T2	
SUSPENDING AGENTS		
GELFILM	T4	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T2	PA SP
CARNITOR (*levocarnitine (with sugar)*)	T4	

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DEFICIENCY AGENTS (cont.)		
CARNITOR (*levocarnitine*)	T4	
CARNITOR SF (*levocarnitine*)	T4	
levocarnitine 4 gm/20 ml vial	T2	
levocarnitine (Carnitor Sf)	T2	
levocarnitine (Carnitor)	T2	
levocarnitine (with sugar) (Carnitor)	T2	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 560 mcg/2.24ml pen (Forteo)	T2	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL (1 pen/28 days) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T4	ST QL(4 tabs/28 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET (*risedronate sodium*)	T4	ST QL(1 tab/30 days) HD
ACTONEL 35 MG TABLET *(risedronate sodium)*	T4	ST QL(4 tabs/28 days) HD
alendronate sod 70 mg/75 ml	T2	QL(300 mls/28 days) HD
alendronate sodium 5 mg, 10 mg tablet	T1	QL(30 tabs/fill) HD
alendronate sodium 35 mg tab	T1	QL(4 tabs/28 days) HD
alendronate sodium 40 mg tab	T2	HD
alendronate sodium 70 mg tab (Fosamax)	T1	QL(4 tabs/28 days) HD
ATELVIA *(risedronate sodium)*	T4	ST QL(4 tabs/28 days) HD
BINOSTO	T4	ST QL(4 tabs/28 days) HD
EVISTA (*raloxifene hcl)*	T4	HD
FOSAMAX (*alendronate sodium*)	T4	ST QL(4 tabs/28 days) HD
ibandronate sodium	T2	QL(1 tab/30 days) HD
raloxifene hcl (Evista)	T2	HD PPACA
risedronate sodium (Atelvia)	T2	QL(4 tabs/28 days) HD
risedronate sodium 150 mg tab (Actonel)	T2	QL(1 tab/30 days) HD
risedronate sodium 30 mg tab	T2	QL(30 tabs/fill) HD
risedronate sodium 35 mg tab (Actonel)	T2	QL(4 tabs/28 days) HD
risedronate sodium 5 mg tablet	T2	QL(30 tabs/fill) HD

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

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T4	PA QL(4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA 100 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 12.5 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 25 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 50 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA TITRATION PACK	T3	ST QL (55 tabs/30 days)
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA QL(4 mls/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
pregabalin (Lyrica Cr)	T2	PA HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA QL(4 syringes/28 days) SP HD
ADBRY AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
EBGLYSS PEN	T4	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T4	PA SP
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T4	PA QL(28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T2	PA QL (224 tabs/30 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine hcl	T2	
buprenorphine hcl/naloxone hcl	T2	
buprenorphine hcl/naloxone hcl (Suboxone)	T2	
ZUBSOLV	T3	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA QL(30 tabs/fill) SP

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T2	HD
dutasteride (Avodart)	T2	ST HD
finasteride (Proscar)	T2	HD
FLOMAX *(tamsulosin hcl)*	T4	ST HD
PROSCAR (*finasteride*)	T4	ST HD
silodosin (Rapaflo)	T2	HD
tamsulosin hcl (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl	T2	ST HD
dutasteride/tamsulosin hcl (Jalyn)	T2	ST HD
JALYN *(dutasteride/tamsulosin hcl)*	T4	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
tiopronin 100 mg tablet (Thiola)	T2	PA SP
tiopronin dr 100 mg tablet (Thiola Ec)	T2	PA SP HD
tiopronin dr 300 mg tablet (Thiola Ec)	T2	PA SP
tiopronin dr 300 mg tablet (Thiola Ec)	T2	PA SP HD
tiopronin (Thiola Ec)	T2	PA SP
THIOLA EC *(tiopronin)*	T4	PA SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T4	HD
mirabegron (Myrbetriq)	T2	HD
MYRBETRIQ	T3	HD
MYRBETRIQ *(mirabegron)*	T3	HD
URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin hydrobromide	T2	HD
solifenacin succinate (Vesicare)	T2	HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
fesoterodine fumarate (Toviaz)	T2	HD
flavoxate hcl	T2	HD
oxybutynin chloride	T2	HD
OXYTROL	T4	ST QL (8 patches/28 days) HD

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT (cont.)		
tolterodine tartrate (Detrol La)	T2	HD
tolterodine tartrate (Detrol)	T2	HD
trospium chloride	T2	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol 625 mg/5 ml susp	T2	
megestrol acet 40 mg/ml susp	T2	
megestrol acet 400 mg/10 ml	T2	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T4	
a/c/e/zinc ox/cupric ox/lutein	T2	
ADULT 50 PLUS EYE HEALTH	T4	
ANTIOXIDANT FORMULA	T4	
EQ VISION FORMULA TABLET	T3	
eql eye health plus lutein tab	T2	
EYE HEALTH AND LUTEIN	T4	
EYE HEALTH WITH LUTEIN	T4	
EYE HEALTH PLUS LUTEIN TABLET	T4	
EYE MULTIVITAMIN	T3	
EYE MULTIVITAMIN WITH LUTEIN	T4	
EYEPROTECT	T4	
gnp healthy eyes tablet	T2	
HEALTHY EYES TABLET	T3	
healthy eyes tablet	T2	
I-CAPS	T3	
ICAPS AREDS FORMULA DR TABLET	T4	
ICAPS AREDS2	T4	
LIPOTRIAD	T4	
LIPOTRIAD VISIONARY	T4	
LUTEIN PLUS WITH ZEAXANTHIN	T4	
MACULAR BENEFITS	T4	
MACULAR HEALTH FORMULA	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
MACUVEX	T4	
MACUZIN	T4	
MULTI-BETIC	T3	
OCULAR VITAMINS	T4	
OCUVEL	T4	
OCUVITE ADULT 50 PLUS	T3	
OCUVITE WITH LUTEIN	T3	
PRESERVISION AREDS	T3	
PRESERVISION LUTEIN	T3	
VISION FORMULA TABLET	T4	
VISION FORMULA WITH LUTEIN	T4	
VISION OPTIMIZER	T4	
VISTA ADVANCED AREDS2	T4	
vit a/vit c/vit e/zinc/copper	T2	
vits a,c,e/lutein/minerals	T2	
BIOFLAVONOIDS		
bioflav,lemon/vit bcomp,c	T2	
bioflav,lemon/vit bcomp,c (Lipo-Flavonoid Plus)	T2	
CITRUS BIOFLAVONOIDS	T4	
EAR HEALTH PLUS CAPLET	T4	
ear health plus caplet (Lipo-Flavonoid Plus)	T2	
FLAVOVIT	T4	
FLOGEN	T4	
INNER EAR PLUS	T4	
LIPO FLAVONOID	T4	
LIPO-FLAVONOID PLUS (*bioflav,lemon/vit bcomp,c*)	T3	
QUERCETIN	T4	
rutin	T2	
VASCULERA	T4	
VASOFLEX D1	T4	
VENALIV	T4	
FOLIC ACID PREPARATIONS		
cvs folic acid 800 mcg tablet	T2	PPACA
DENOVO	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FOLIC ACID PREPARATIONS (cont.)		
DEPLIN-ALGAL OIL *(levomefolate/algal oil)*	T4	
DEPLIN FC	T4	
ENLYTE	T4	
FA-8	T4	
folic acid 0.4 mg tablet	T2	PPACA
folic acid 0.8 mg tablet	T2	PPACA
folic acid 1 mg tablet	T2	
folic acid 1,000 mcg tablet	T2	
FOLIC ACID 20 MG CAPSULE	T4	
folic acid 400 mcg tablet	T2	PPACA
FOLIC ACID 5 MG CAPSULE	T4	
folic acid 5 mg/ml vial	T2	
folic acid 50 mg/10 ml vial	T2	
FOLIC ACID 800 MCG CAPSULE	T4	
folic acid 800 mcg tablet	T2	PPACA
folic acid/b6/ca phos/ginger	T2	
ft folic acid 400 mcg tablet	T2	PPACA
ft folic acid 800 mcg tablet	T2	PPACA
FOLIKA-V	T4	
FOLITE	T4	
GENICIN VITA-Q	T4	
gnp folic acid 400 mcg tablet	T2	PPACA
hm folic acid 400 mcg tablet	T2	PPACA
HYLAZINC	T4	
levomefolate calcium	T2	
*levomefolate/algal oil (*Deplin-Algal Oil*)*	T2	
METHYLFOLATE	T4	
MI-VITE RX	T4	
PUREVITA FOLIC ACID	T4	
ra folic acid 0.4 mg tablet	T2	PPACA
ra folic acid 800 mcg tablet	T2	PPACA
sm folic acid 0.4 mg tablet	T2	PPACA
sm folic acid 400 mcg tablet	T2	PPACA
sv folic acid 800 mcg tablet	T2	PPACA

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FOLIC ACID PREPARATIONS (cont.)		
true folic acid 1600mcg dfe tb	T2	
true folic acid 667 mcg dfe tb	T2	PPACA
XAQUIL XR	T4	
GERIATRIC VITAMIN PREPARATIONS		
a thru z advanced formula tab (Vision Plus Lutein)	T2	
a thru z select tablet (Vision Plus Lutein)	T2	
CENTRUM SILVER CHEWABLE TABLET	T3	
eldertonic elixir	T2	
ELDERTONIC LIQUID	T4	
GERITOL COMPLETE	T3	
GERITOL TONIC	T3	
multivit with iron,minerals	T2	
multivit with minerals/lutein (Vision Plus Lutein)	T2	
REQ49+	T4	
SPECTRAVITE ADULT 50+	T4	
VISION PLUS LUTEIN (*multivit with minerals/lutein*)	T3	
MULTIVITAMIN PREPARATIONS		
a thru z advanced formula tab	T2	
A THRU Z MEN'S ULTIMATE TABLET	T3	
A THRU Z SELECT MEN 50+ TABLET	T4	
a thru z select multivit tab	T2	
a thru z select multivit tab (Centrum Silver)	T2	
a thru z select multivit tab (Certavite Senior)	T2	
a thru z select tablet (Centrum Silver)	T2	
a thru z select tablet (Certavite Senior)	T2	
a thru z select women's tablet	T2	
a/c/e/zinc/sod selenate/copper	T2	
ABC COMPLETE ADULT	T3	
ABC COMPLETE MEN'S	T3	
ABC COMPLETE SENIOR WOMEN'S	T4	
ACTIVNUTRIENTS	T4	
ACTIVNUTRIENTS PERFORMANCE	T4	
ADEK GUMMIES PLUS ZINC	T4	
ADULT MULTI	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ADULT MULTI GUMMIES	T4	
ADULT MULTIVITAMIN GUMMIES	T4	
ADULT ONE DAILY GUMMIES	T4	
ADULTS' DAILY FORMULA	T4	
ADULTS MULTIVITAMIN	T4	
ADVANCED MULTI EA	T4	
ALIVE ADULT ULTRA POTENCY	T4	
ALIVE DAILY ENERGY	T4	
ALIVE HAIR, SKIN AND NAILS	T4	
ALIVE DAILY SUPPORT PRENATAL	T4	
ALIVE MAX POTENCY	T4	
ALIVE MEN'S 50 PLUS GUMMY	T4	
ALIVE MEN'S 50 PLUS ULTRA	T4	
ALIVE MEN'S ULTRA POTENCY	T4	
ALIVE PREMIUM ADULT	T4	
ALIVE MEN'S ENERGY	T4	
ALIVE MEN'S GUMMY	T4	
ALIVE PREMIUM PRENATAL	T4	
ALIVE WOMEN'S 50 PLUS	T4	
ALIVE WOMEN'S 50 PLUS ULTRA	T4	
ALIVE WOMEN'S ENERGY	T4	
ALIVE ADULT ULTRA POTENCY	T4	
ALIVE WOMEN'S MULTIVITAMIN	T4	
ALIVE WOMEN'S ULTRA POTENCY	T4	
ALPHA BETIC MULTIVITAMIN	T4	
ALTRIXA	T4	
amino acids/mv,tx,iron,mineral	T2	
AMLADEX	T4	
ANIMI-3	T4	
AQUADEKS	T3	
BACMIN	T4	
BARIATRIC MULTIVITAMINS	T4	
b-complex with vitamin c	T2	
*b-complex with vitamin c (*Support-500*)*	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
b-complex w-vitamin c caplet	T2	
BEROCCA	T4	
beta-carotene(a)-vits c,e/mins	T2	
BIO-35	T4	
BLADDER 2.2	T3	
BODY, HAIR, SKIN AND NAILS	T4	
CENTRAL-VITE	T4	
CENTRAL-VITE WOMEN'S MATURE (*multivit-min/iron/folic/lutein*)	T4	
CENTRAVITES ADULTS	T4	
CENTRUM	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T4	
CENTRUM ADULT 50 PLUS	T4	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM CHEWABLES ADULTS TAB	T4	
CENTRUM COMPLETE	T3	
CENTRUM FLAVOR BURST ADULT	T4	
CENTRUM MEN	T3	
CENTRUM MULTIGUMMIES	T4	
CENTRUM SILVER MEN	T4	
CENTRUM SILVER TABLET (*multivit-min/fa/lycopen/lutein*)	T4	
CENTRUM SILVER ULTRA MEN'S (*multivit-min/fa/lycopen/lutein*)	T3	
CENTRUM SILVER WOMEN (*multivit-min/iron/folic/lutein*)	T4	
CENTRUM SPECIALIST ENERGY	T4	
CENTRUM SPECIALIST HEART	T3	
CENTRUM ULTRA MEN'S	T3	
cvs adult multivitamin gummy	T2	
certavite-antioxidant tablet (Certavite-Antioxidant)	T2	
CERTAVITE-ANTIOXIDANT TABLET (*multivitamin/iron/folic acid*)	T4	
certavite-antioxidant tablet (Tab-A-Vite Multivit With Iron)	T2	
COMPLETE MEN	T3	
COMPLETE MEN 50 PLUS	T4	
COMPLETE MULTIVITAMIN-MINERAL	T4	
CONCEPT DHA (*mvn-min75/iron/iron ps/om3/dha*)	T4	
CONCEPT OB (m*vn-min 74/iron fum/iron/fa*)	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
CORVITE	T4	
CULTURELLE PROBIOTIC-MULTIVIT	T4	
cvs b-complex-vit c caplet	T2	
cvs hair, skin and nails cplt	T2	
cvs one daily essential tablet (Daily-Vite)	T2	
DAILY GUMMIES	T4	
DAILY MULTIPLE	T3	
DAILY MULTIVITAMIN	T4	
daily-vite tablet (Daily-Vite)	T2	
DAILY-VITE TABLET (*multivitamin with folic acid*)	T4	
DAVIMET WITH IRON	T4	
DAYAVITE	T4	
DECUBI VITE	T4	
DEKAS BARIATRIC	T4	
DEKAS ESSENTIAL	T4	
DEKAS PLUS	T4	
DERMACINRX FOLIFLEX	T4	
DERMACINRX FOLITIN-Z	T4	
DERMACINRX MULTITAM	T4	
DERMACINRX RIBOTIN-E	T4	
DERMACINRX VENEXA	T4	
DERMACINRX VENEXA FE	T4	
DERMACINRX VENTRIXYL	T4	
DERMACINRX VENTRIXYL FE	T4	
DERMACINRX VITRAMYN	T4	
DERMACINRX VITRANOL	T4	
DERMACINRX VITRANOL FE	T4	
DERMACINRX VITREXATE	T4	
DERMACINRX VITREXATE FE	T4	
DERMACINRX ZINTREXYL-C	T4	
DIABETES HEALTH FORMULA	T4	
DIABETES HEALTH PACK	T4	
DIABETIC VITAMIN	T4	
DIALYVITE 800 WITH IRON	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
DIATROL	T4	
ELON MATRIX 5000 COMPLETE	T4	
ENBRACE HR	T4	
ENDUR-VM IRON-FREE	T4	
ENDUR-VM WITH IRON	T4	
EQ ONE DAILY MEN'S TABLET	T3	
EQ ONE DAILY WOMEN'S HEALTH TB	T4	
EQ ONE DAILY WOMEN'S TABLET	T3	
ESSENTIAL MAN	T4	
ESSENTIAL MAN 50+	T4	
ESSENTIAL WOMAN 50+	T4	
ESTROVEN MENOPAUSE	T4	
fa/mv,ca,iron,min/lycopene/lut	T2	
FATIGUE RELIEF COMPLEX (*bcomp,c/st.jhn wrt/s.ginsg/pgn*)	T4	
FINAZOL	T4	
FLORRAXYL	T4	
FOLAGENT DHA	T4	
FOLAMAX	T4	
FOLAMED DHA	T4	
FOLAPRIME	T4	
folic acid/multivit,iron,miner	T2	
folic acid/mv,iron,min/lutein	T2	
FOLIC ACID-VIT B-6-VIT B-12	T4	
folic/mvi ther-min/lycop/lut	T2	
FOLIKA-CI	T4	
FOLIKA-MG	T4	
FORTAVIT	T4	
FREEDAVITE	T4	
ft b complex plus vit c tablet	T2	
FT HAIR, SKIN AND NAILS TABLET	T4	
ft one daily men's tablet	T2	
ft one daily women's tablet	T2	
GENADEK STEP 1	T4	
GENADEK STEP 2	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
GERBER GS PRENATAL NOURISH PLS	T4	
GNP B-COMPLEX PLUS VIT C TAB	T4	
gnp one daily tablet	T2	
HAIR FORMULA	T4	
HAIR, SKIN AND NAILS CAPLET	T4	
HAIR, SKIN AND NAILS SOFTGEL	T4	
HAIR, SKIN AND NAILS TABLET (*multivitamin/folic acid/biotin*)	T4	
HEARTBURN ACID REFLUX	T4	
high potency multivitamin tab	T2	
HIGH POTENCY MULTIVITAMIN TAB	T4	
high potency multivitamin tab (Certavite-Antioxidant)	T2	
high potency multivitamin tab (Tab-A-Vite Multivit With Iron)	T2	
HM HAIR, SKIN AND NAILS TABLET	T4	
HM MEN'S ONE DAILY TABLET	T3	
ICAPS MV	T3	
ICAPS TABLET	T3	
IMMUNERX	T4	
INFUVITE ADULT	T4	
K-PAX IMMUNE SUPPORT	T3	
lecithin/pyridoxine/kelp	T2	
lmefolate/b3/copp/zn/sel/chrom	T2	
MAXIMIN	T4	
MEBOLIC	T4	
MEN 50 PLUS ADVANCED ONE DAILY	T4	
MEN 50 PLUS MULTIVITAMIN	T4	
MEN'S 50 PLUS DAILY FORMULA	T4	
MEN'S 50 PLUS MULTIVITAMIN	T4	
MEN'S DAILY FORMULA	T4	
MEN'S DAILY GUMMIES	T4	
MEN'S DAILY PACK	T4	
MEN'S MULTIVITAMIN	T4	
MEN'S ONE DAILY	T3	
MONOCAPS	T4	
MULTI FOR HER 50 PLUS	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
MULTI FOR HER SOFTGEL	T4	
multi for her tablet	T2	
MULTI PRO	T4	
MULTIA DAILY MULTIVITAMIN	T4	
MULTI-DAY PLUS MINERALS	T4	
MULTILEX TABLET	T4	
multilex tablet	T2	
MULTILEX T-M	T4	
multivit 47/iron/folate 1/dha	T2	
multivit infusn,adult 1,vit k	T2	
multivit no.51/iron/folic acid	T2	
multivit with calcium,iron,min	T2	
multivit,calc,mins/iron/folic	T2	
multivit,iron,minerals/lutein	T2	
multivit,stress formula/zinc (Stress Formula With Zinc)	T2	
multivit/iron/folic acid/hb179	T2	
multivitamin	T2	
MULTI-VITAMIN	T4	
multivitamin combination no.55	T2	
multivitamin combination no.56	T2	
MULTIVITAMIN GUMMIES	T4	
MULTIVITAMIN LIQUID	T4	
MULTIVITAMIN-MULTIMINERAL	T4	
multivitamin tablet	T2	
multivitamin with folic acid (Daily-Vite)	T2	
multivitamin with iron	T2	
MULTIVITAMIN WITH MINERALS	T4	
multivitamin with minerals	T2	
multivitamin,stress formula	T2	
multivitamin,ther and minerals	T2	
multivitamin,therapeutic	T2	
multivitamin,therapeutic (Oncovite)	T2	
multivitamin/ferrous gluconate	T2	
multivitamin/iron/folic acid (Certavite-Antioxidant)	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)	T2	
MULTI-VITE	T4	
multivit-min/fa/lycopen/lutein	T2	
multivit-min/fa/lycopen/lutein (Centrum Silver)	T2	
multivit-min/ferrous gluconate	T2	
multivit-min/folic acid/biotin	T2	
multivit-min/iron fum/folic ac	T2	
multivit-min/iron/folic/lutein (Central-Vite Women'S Mature)	T2	
multivit-min/iron/folic/lutein (Centrum Silver Women)	T2	
multivit-min69/iron/folic acid	T2	
multivit-minerals/fa/lycopene	T2	
multivit-minerals/folic acid	T2	
multivit-minerals/folic acid (One-A-Day)	T2	
multivit-minerals/folic/ginkgo	T2	
multivit-mins no.7/folic acid	T2	
multivit-mins/iron/folic/lycop	T2	
mv, min 59/iron/folic/docusate	T2	
mv,cal,min/iron/folic acid/lut	T2	
mv,iron,min/ginkgo/pan.ginseng	T2	
mv-min/iron/folic ac/vit k/lut	T2	
mv-mins 71/iron/folic no.1/dha	T2	
mv-mins/folic/lycopene/ginkgo	T2	
mv-mn/folic ac/calcium/vit k1	T2	
mv-mn/folic acid/lutein/hrb178	T2	
mvn no.53/iron/folic/dss/dha	T2	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T2	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T2	
MVW MODULATR FORM MINI MULTIVT	T4	
NEEVODHA	T4	
NEOVITE	T4	
NESTABS ONE	T4	
NICOMIDE	T4	
NIVA-PLUS (*multivit-mins60/iron fum/folic*)	T4	
NUTRIVIT	T3	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
OB COMPLETE	T4	
OBSTETRIX ONE	T4	
OCUVITE EYE PLUS MULTI	T4	
om-3/dha/epa/b12/fa/b6/phytost	T2	
OMNIVEX	T4	
ONCOVITE (*multivitamin,therapeutic*)	T3	
ONE-A-DAY TRIPLE IMMUNE SUPPRT	T4	
ONE-A-DAY WOMEN'S 50 PLUS TAB	T4	
one-a-day women's 50 plus tab (One-A-Day)	T2	
ONE DAILY ESSENTIALS	T4	
ONE DAILY ESSENTIAL TABLET	T4	
one daily essential tablet	T2	
one daily essential tablet (Daily-Vite)	T2	
ONE DAILY HEALTHY WEIGHT	T4	
ONE DAILY MEN'S 50 PLUS	T4	
ONE DAILY MEN'S 50 PLUS D3	T4	
ONE DAILY MEN'S HEALTH	T4	
ONE DAILY MEN'S MULTIVITAMIN	T4	
one daily multivit-mineral tab	T2	
ONE DAILY MULTIVITAMIN TABLET	T4	
one daily multivitamin tab	T2	
ONE DAILY MULTIVIT-MINERAL TAB	T4	
one daily multivitamin tablet (Daily-Vite)	T2	
one daily tablet	T2	
ONE DAILY WOMEN 50 PLUS TAB	T4	
ONE DAILY WOMEN'S 50 PLUS ADV	T4	
ONE DAILY WOMEN'S 50+	T3	
ONE DAILY WOMEN'S FORMULA	T4	
one daily women's health tab	T2	
ONE DAILY WOMEN'S MULTIVITAMIN	T4	
ONE-A-DAY (*multivit-minerals/folic acid*)	T4	
ONE-A-DAY ENERGY	T4	
ONE-A-DAY MEN VITACRAVES	T4	
ONE-A-DAY MENOPAUSE FORMULA	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ONE-A-DAY MEN'S	T3	
ONE-A-DAY MEN'S 50 PLUS	T3	
ONE-A-DAY MEN'S 50 PLUS (*mv-mins/folic/lycopene/ginkgo*)	T3	
ONE-A-DAY MEN'S COMPLETE	T4	
ONE-A-DAY PROACTIVE 65 PLUS	T4	
ONE-A-DAY VITACRAVES	T4	
ONE-A-DAY VITACRAVES IMMUNITY	T4	
ONE-A-DAY VITACRAVES OMEGA-3	T4	
ONE-A-DAY VITACRAVES SOUR	T4	
ONE-A-DAY WEIGHTSMART	T3	
ONE-A-DAY WOMEN VITACRAVES	T4	
ONE-A-DAY WOMEN'S COMPLETE	T3	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T4	
ONE-A-DAY WOMEN'S PETITES	T4	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-A-DAY WOMEN'S TABLET	T4	
ONE-DAILY MULTI	T4	
ONE-DAILY MULTI-VITAMIN-IRON	T4	
ONE-DAILY MULTIVITAMIN-MINERAL	T4	
ONEVITE	T4	
OPTIFAST	T4	
OPTISOURCE	T4	
OPURITY MULTIVITAMIN	T4	
POLY VITAMIN-IRON	T4	
PRENATAL GUMMIES	T4	
PRENATE AM	T4	
PRENATE CHEWABLE	T4	
PRENATE ESSENTIAL	T4	
PROCERV HP	T4	
PROFOLA	T4	
PRORENAL QD	T3	
PROTECT CARDIO AF	T4	
PROTECT IRON	T4	
PROTECT PLUS SO	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
PUREFE OB PLUS	T4	
PUREFE PLUS	T4	
QUINTABS	T4	
QUINTABS-M	T4	
ra one daily essential tablet (One-A-Day)	T2	
ra one daily women's tablet	T2	
REMEDIENT	T4	
sm b complex with vit c tablet	T2	
sm super b complex-c caplet	T2	
SOLO	T4	
SPECTRAVITE MEN 50 PLUS	T4	
SPECTRAVITE ULTRA MEN 50+	T4	
SPECTRAVITE ULTRA MEN'S	T4	
STRESS B-COMPLEX	T4	
stress formula tablet	T2	
STRESS FORMULA WITH ZINC TAB (*multivit,stress formula/zinc*)	T4	
stress formula with zinc tab (Stress Formula With Zinc)	T2	
stress-c with zinc tablet (Stress Formula With Zinc)	T2	
STROVITE FORTE (*multivit,iron,min 5/folic acid*)	T4	
STROVITE ONE	T4	
SUPER GINSENG MULTIVITAMIN	T4	
SUPER MULTIPLE-LOW IRON	T4	
SUPERIOR MEN'S MULTI	T4	
SUPPORT-500 (*b-complex with vitamin c*)	T4	
SV HAIR, SKIN AND NAILS CAPLET	T4	
TAB-A-VITE MULTIVIT WITH IRON	T4	
tab-a-vite multivit with iron	T2	
TAB-A-VITE MULTIVIT WITH IRON (*multivitamin/iron/folic acid)*	T4	
THERAGRAN-M PREMIER 50 PLUS	T4	
thera-m caplet	T2	
THERA-M CAPLET	T4	
thera-m tablet	T2	
THERAMILL FORTE	T4	
THERANATAL LACTATION SUPPORT	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
THEREMS-H	T3	
TOBAKIENT	T4	
TRUE MULTIVITAMIN	T4	
TRUEPLUS MULTIVITAMIN (*multivit-min/folic acid/vit k1*)	T4	
UDAMIN SP	T4	
ULTRA FREEDA	T4	
VITABEX PLUS	T4	
VITACORE	T4	
VITAFUSION PRENATAL	T4	
VITAJOY ADULT MULTI	T4	
vitamin b complex-vit c cap (Support-500)	T2	
vitamin b complex-vit c caplet	T2	
vitamin b complex-vitamin c tb	T2	
VITAMIN D3-ALOE	T4	
VITAMINS A-D-E	T4	
VITREXYL	T4	
VITREXYL PLUS IRON	T4	
VITRUM 50 PLUS SENIOR	T3	
WELLESSE MULTI VITAMIN PLUS	T4	
WOMEN'S 50 PLUS ADVANCED	T4	
WOMEN'S 50 PLUS DAILY FORMULA	T4	
women's daily formula caplet	T2	
WOMEN'S DAILY FORMULA CAPLET	T3	
WOMEN'S DAILY FORMULA TABLET	T4	
WOMENS DAILY GUMMIES	T4	
WOMEN'S DAILY PACK	T4	
WOMEN'S MULTIVITAMIN	T4	
WOMEN'S MULTIVITAMIN W-BIOTIN	T4	
XYZBAC	T4	
ZYVANA	T4	
ZYVIT	T4	
NIACIN PREPARATIONS		
cvs niacin 400 mg capsule	T2	
ENDUR-AMIDE	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NIACIN PREPARATIONS (cont.)		
ENDUR-THINE	T4	
ft niacin 400 mg capsule	T2	
gnp niacin 250 mg tablet	T2	
gnp niacin 400 mg capsule	T2	
hm niacin tr 250 mg tablet (Slo-Niacin)	T2	
niacin	T2	
niacin (inositol niacinate)	T2	
niacin (Slo-Niacin)	T2	
niacin 50 mg, 100 mg , 250mg tablet	T2	
niacin 500 mg capsule	T2	
niacin 500 mg capsule sa	T2	
NIACIN 500 MG SOFTGEL	T3	
niacin 500 mg tablet	T2	
niacin 750 mg tablet sa (Slo-Niacin)	T2	
NIACIN ER 1,000 MG TABLET	T3	
niacin er 250 mg tablet (Slo-Niacin)	T2	
niacin er 500 mg caplet	T2	
niacin er 500 mg capsule	T2	
niacin er 500 mg tablet	T2	
niacin flush free 500 mg cap	T2	
NIACIN FLUSH FREE 750 MG CAP	T3	
niacin sa 250 mg capsule	T2	
niacin tr 250 mg capsule	T2	
niacin tr 250 mg tablet (Slo-Niacin)	T2	
niacin tr 500 mg caplet	T2	
niacin tr 500 mg tablet	T2	
niacinamide 500 mg tablet	T2	
NIACINAMIDE ER 500 MG TABLET	T4	
NO FLUSH NIACIN	T4	
PUREVITA VITAMIN B3	T4	
ra niacin 100 mg tablet	T2	
RA NIACIN 500 MG TABLET	T4	
ra niacin 500 mg tablet	T2	
SLO-NIACIN 250 MG TABLET (*niacin*)	T3	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NIACIN PREPARATIONS (cont.)		
slo-niacin 500 mg tablet	T2	
SLO-NIACIN 750 MG TABLET (*niacin*)	T3	
sv niacin flush free 500 mg	T2	
true vitamin b3 50 mg tablet	T2	
true vitamin b3 500 mg tablet	T2	
TRUE VITAMIN B3 250 MG TABLET	T4	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T4	
PANTETHINE	T4	
PUREVITA VITAMIN B5	T4	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T4	
ALIVE KIDS MULTIVITAMIN	T4	
ANIMAL SHAPES COMPLETE	T4	
ANIMAL SHAPES COMPLETE	T4	
CENTRUM KIDS	T4	
CHILD CHEWABLE VITAMN COMPLETE	T4	
CHILD COMPLETE CHEWABLE VITAMN	T4	
CHILD COMPLETE MULTIVITAMIN	T4	
CHILD MULTIVITAMIN PLUS IRON	T4	
CHILDREN MULTIVITAMIN	T4	
children multivitamin chew tab	T2	
CHILDREN MULTIVITAMIN GUMMIES	T4	
CHILDREN MULTIVITAMIN GUMMIES (*pediatric multivitamin no.120*)	T4	
CHILDREN'S CHEW MULTIVIT-IRON (*pedi multivit no.91/iron fum*)	T4	
childrens chew vitamin tab (Flintstones With Extra C)	T2	
childrens chew vitamin tab (Flintstones)	T2	
CHILDREN'S CHEWABLE	T4	
CHILDREN'S MULTI-VIT GUMMIES	T4	
CHILDREN'S MULTIVITAMIN GUMMY	T4	
CHILD'S CHEWABLE VITAMIN TAB	T4	
CHILD'S OMEGA-3 DHA MULTIVITAM	T4	
CULTURELLE KIDS PROBIOTIC-MV	T4	
CULTURELLE KIDS PRO-MV-LUTEIN	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
DAVIMET WITH FLUORIDE	T4	
DEKAS PLUS	T2	
EMERGEN-C KIDZ	T4	
EQ CHILD MULTIVITAMIN GUMMIES	T4	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (*multivit with iron,minerals*)	T4	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (*multivitamin*)	T4	
FLINTSTONES GUMMIES	T3	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T4	
FLINTSTONES MULTIVIT CHEW TAB (*pedi multivit no.25/folic acid*)	T4	
FLINTSTONES MULTI-VIT GUMMIES	T4	
FLINTSTONES PLUS CALCIUM	T3	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T4	
FLINTSTONES TABLET CHEWABLE (multivitamin)	T3	
FLINTSTONES WITH IRON	T4	
FLORAFOL PEDIATRIC	T4	
FLORAFOL FE PEDIATRIC	T4	
FLORIVA	T3	
FLORIVA PLUS	T4	
GENADEK	T4	
GERBER GROW MIGHTY	T4	
GERBER LIL BRAINIES	T4	
GUMMIES CHILDREN MULTIVITAMIN	T4	
GUMMY	T4	
GUMMY DINOS	T4	
INFANT-TODDLER MULTIVITAMIN	T4	
INFANT-TODDLER MULTIVIT-IRON	T4	
infant-toddler multivit-iron	T2	
INFANT-TODDLER TRI-VITAMIN	T4	
INFUVITE PEDIATRIC	T3	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
KIDS COD LIVER OIL +D	T4	
KIDS MULTIVITAMIN-MINERALS	T3	
LIVITA FOR CHILDREN	T4	
multivit with iron,minerals	T2	
multivit with iron,minerals (Flintstones Complete)	T2	
multivit with iron,minerals (Scooby-Doo)	T2	
multivitamin (Flintstones With Extra C)	T2	
multivitamin (Flintstones)	T2	
multivitamin with iron	T2	
MULTI-VIT-FLOR	T4	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T4	
multivit-fluor 0.25 mg tab chw	T2	PPACA
multivit-fluor 0.25 mg/ml drop	T2	PPACA
multivit-fluor 0.5 mg tab chew	T2	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T4	
multivit-fluor 0.5 mg/ml drop	T2	PPACA
multivit-fluoride 1 mg tab chw	T2	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T4	
MVW COMPLETE FORMLTN PEDIATRIC	T4	
MVW COMPLETE FORMULATION D3000	T4	
MVW COMPLETE FORMULATION D5000	T4	
MVW COMPLETE FORMULTN MULTIVIT	T4	
MVW MODULATR FORMLTN PEDIATRIC	T4	
NANO VM 1-3	T3	
NANO VM 4-8	T3	
NANOVM 9-18	T4	
NANOVM T-F	T4	
NOVAFERRUM PEDIATRIC MV-IRON	T4	
NOVAMV	T4	
ONE-A-DAY KID'S	T4	
ONE-A-DAY TEEN HER VITACRAVES	T4	
ONE-A-DAY TEEN HIM VITACRAVES	T4	
ped mvit a,c,d3 no.21/fluoride	T2	PPACA
pedi multivit 158/iron/vit k1	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
pedi multivit 45/fluoride/iron	T2	
pedi multivit no.12 w-fluoride	T2	PPACA
pedi multivit no.17 w-fluoride	T2	PPACA
pedi multivit no.159/iron sulf	T2	
pedi multivit no.23/folic acid	T2	
pedi multivit no.25/folic acid (Flintstones)	T2	
pedia poly-vite iron 5mg/0.5ml	T2	
PEDIA POLY-VITE WITH IRON DROP	T4	
PEDIA TRI-VITE	T4	
pediatric multivit no.36/iron	T2	
pediatric multivitamin no.17	T2	
pediatric multivitamin no.111	T2	
pediatric multivitamin no.212	T2	
PEDIATRIC POLY-VITAMIN	T4	
PEDIATRIC POLY-VITAMIN-IRON	T4	
PEDIATRIC POLY-VITE	T4	
PEDIATRIC POLY-VITE WITH IRON	T4	
PEDIATRIC TRI-VITAMIN	T4	
PEDIATRIC TRI-VITE	T4	
POLY-VI-FLOR	T4	
POLY-VI-FLOR WITH IRON	T4	
poly-vi-sol 0.5 ml oral syring	T2	
POLY-VI-SOL 1 ML ENFIT SYRINGE	T4	
POLY-VI-SOL 250MCG-50MG/ML DRP	T4	
POLY-VI-SOL WITH IRON	T4	
POLY-VITA	T4	
POLY-VITA WITH IRON	T4	
QUFLORA	T4	
QUFLORA FE	T4	
SCOOBY-DOO ONE A DAY GUMMIES	T4	
SCOOBY-DOO ONE A DAY TABLET (*multivit with iron,minerals*)	T3	
SOLUVITA MULTIVITAMIN FLUORIDE	T4	
SOLUVITA MULTIVITAMIN FLUORIDE (pedi multivit no.82 w-fluoride)	T4	
TRI-VI-FLOR	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
TRI-VI-SOL	T4	
TROPICAL LIQUID NUTRITION (*pediatric multivitamin no.118*)	T4	
vit a palmitate/vit c/vit d3	T2	
ZOO FRIENDS	T4	
ZOO FRIENDS COMPLETE	T4	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T2	
gnp norwegian cod liver oil	T2	
SV COD LIVER OIL SOFTGEL	T4	
VITAMIN A PREPARATIONS		
A-25	T4	
AQUASOL A	T3	
beta-carotene	T2	
cvs vitamin a 2,400 mcg sftgl	T2	
FT VITAMIN A 3,000 MCG SOFTGEL	T4	
gnp vitamin a 10,000 unit sfgl	T2	
NORWEGIAN COD LIVER OIL SFGL	T4	
PREVENT	T3	
ra vitamin a 10,000 unit sftgl	T2	
VITAMIN A BETA CAROTENE	T4	
vitamin a 10,000 unit capsule, softgel	T2	
VITAMIN A 10,000 UNIT SOFTGEL	T4	
vitamin a 3,000 mcg softgel	T2	
vitamin a 8,000 unit capsule	T2	
VITAMIN A PALMITATE	T4	
vitamin a/vit c/zinc/propolis	T2	
VITAMINS A D	T4	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T4	HD
acetylcyst/methylb12/levomefol (Cerefolin Brain Wellness)	T2	HD
ALBA-LYBE	T3	HD
APETEX (*vitamin b complex/lysine*)	T3	HD
APETIGEN (*vitamin b complex/lysine*)	T3	HD
ARKALIOX	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
B ACTIV	T4	HD
b comp no3/folic/c/biotin/zinc	T2	HD
b comp/ferrous gluc/lysin/znox	T2	HD
b complex 11/folic/c/biot/zinc	T2	HD
b complex c no.10/folic acid	T2	HD
b complex capsule	T2	HD
b complex tablet	T2	HD
b complex w-c no.20/folic acid (Virt-Caps)	T2	HD
B-COMPLEX 100	T4	HD
B-COMPLEX FAST DISSOLVE TABLET	T4	HD
B COMPLEX WITH B-12	T4	HD
B COMPLEX WITH VITAMIN C	T4	HD
B COMPLEX-FOLIC ACID *(cyanocobalamin/folic ac/vit b6)*	T4	HD
b12/levomefolate calcium/b-6	T2	HD
B-50 COMPLEX	T4	HD
balanced b-100 complex tab sa	T2	HD
b-complex 100 injection	T2	HD
b-complex injection vial	T2	HD
b-complex plus vitamin c cplt (Vita-Bee With C)	T2	HD PPACA
b-complex tablet	T2	HD PPACA
B-COMPLEX WITH B-12	T4	HD
b-complex with b12 tablet	T2	HD
b-complex with vit c caplet (Vita-Bee With C)	T2	HD PPACA
b-complex with vit c tablet (Vita-Bee With C)	T2	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T3	HD
BIOTIN 1,000 MCG GUMMIES	T4	HD
biotin 1,000 mcg tablet	T2	HD
BIOTIN 10 MG TABLET	T3	HD
BIOTIN 10,000 MCG SOFTGEL	T4	HD
BIOTIN 10,000 MCG TABLET	T3	HD
biotin 2,500 mcg softgel (Hard Nails)	T2	HD
biotin 300 mcg tablet	T2	HD
BIOTIN 5 MG TABLET	T4	HD
biotin 5,000 mcg capsule (Meribin)	T2	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
BIOTIN 5,000 MCG FAST DISSOLVE	T4	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T4	HD
biotin 5,000 mcg softgel (Meribin)	T2	HD
BIOTIN 5,000 MCG TABLET	T4	HD
biotin 800 mcg tablet	T2	HD
BIOTIN FORTE 3 MG TABLET	T4	HD
BIOTIN FORTE 5 MG TABLET	T3	HD
BREWER'S YEAST	T4	HD
B-STRESS	T4	HD
CARDIOTEK-RX	T4	HD
CEREFOLIN *(vit b12/levomefolate/vit b6/b2)*	T4	HD
CEREFOLIN BRAIN WELLNESS *(acetylcyst/methylb12/levomefol)*	T4	HD
CEREFOLIN NAC	T4	HD
COMPLEX B-100 ER CAPLET	T4	HD
complex b-100 tablet sa	T2	HD
COMPLEX B-50	T4	HD
COMPLETE LIVER CLEANSE	T4	HD
CVS BALANCED B-100 TR CAPLET	T4	HD
cvs biotin 1,000 mcg tablet	T2	HD
CVS BIOTIN 5,000 MCG TABLET	T4	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T4	HD
cvs super b-complex-vit c cplt (Vita-Bee With C)	T2	HD PPACA
cyanocobalamin/folic ac/vit b6	T2	HD
cyanocobalamin/folic ac/vit b6	T2	HD PPACA
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	T2	HD
CYTO B7	T4	HD
DIALYVITE 3000	T4	HD
DIALYVITE 5000	T4	HD
DIALYVITE 800 CHEWABLE WAFER	T4	HD
DIALYVITE 800 PLUS D	T4	HD
dialyvite 800 tablet	T2	HD PPACA
DIALYVITE 800 WITH ZINC	T4	HD
DIALYVITE 800-ULTRA D	T3	HD
DIALYVITE SUPREME D	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
ELFOLATE PLUS	T4	HD
ENDUR-B COMPLEX	T4	HD
eql b complex 50 tablet	T2	HD
folic acid/b complex c no.17	T2	HD
folic acid/vit b complex and c	T2	HD PPACA
folic acid/vit b complex and c	T2	HD
folic acid/vit b complex and c (Vita-Bee With C)	T2	HD PPACA
folic acid/vit bcomp,c/cu/zinc	T2	HD
FOLIKA-BC	T4	HD
FOLIKA-NC	T4	HD
FOLIKA-T	T4	HD
FOLINIC-PLUS	T4	HD
FOLTX	T4	HD
ft biotin 5,000 mcg capsule (Meribin)	T2	HD
FT BIOTIN 10,000 MCG TABLET	T3	HD
FT BIOTIN 2,500 MCG GUMMY	T4	HD
GENICIN VITA-S	T4	HD
gnp biotin 5,000 mcg capsule (Meribin)	T2	HD
HAIR-SKIN-NAILS	T4	HD
HARD NAILS (*biotin*)	T4	HD
HM BIOTIN 10,000 MCG TABLET	T4	HD
hm biotin 5,000 mcg capsule (Meribin)	T2	HD
HOMOCYSTEINE FORMULA	T4	HD
HYLAVITE (*folic acid/vit b complex and c*)	T4	HD
levomefolate/b6/b12/algal oil	T2	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T4	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T4	HD
l-mefol/a-cyst/meb12/algal oil	T2	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T4	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T4	HD
LORID	T4	HD
LORMATE	T4	HD
mecobal/levomefolat ca/b6 phos	T2	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
MEGA BIOTIN	T4	HD
MERIBIN (*biotin*)	T3	HD
METANX	T4	HD
METANX FC	T4	HD
METANX RR	T4	HD
METHAVER	T4	HD
METHYL PROTECT	T4	HD
MINCORA	T4	HD
MULTIVITAMIN-ZINC-STRESS	T4	HD
NEPHRON FA	T4	HD
NEPHRO-VITE	T3	HD
NIVA-FOL (*cyanocobalamin/folic ac/vit b6*)	T4	HD
NUFOLA	T4	HD
PODIAPN	T4	HD
POTABA	T4	HD
PRORENAL	T3	HD
PUREVITA SUPER B-COMPLEX	T4	HD
QUIN B STRONG	T4	HD
ra balanced b-100 tablet	T2	HD PPACA
ra b-complex-vitamin b-12 tab	T2	HD
ra biotin 2,500 mcg capsule (Hard Nails)	T2	HD
RENAL VITAMIN	T4	HD
RENAL-VITE	T4	HD
RENAPLEX	T4	HD
RENAPLEX-D	T4	HD
RIBOZEL	T4	HD
sm biotin 5,000 mcg capsule (Meribin)	T2	HD
sm stress formula+zinc tablet	T2	HD
super b complex-vit c caplet (Vita-Bee With C)	T2	HD PPACA
super quints b-50 tablet	T2	HD PPACA
super quints b-50 tablets	T2	HD
SV BIOTIN 1,000 MCG SOFTGEL	T4	HD
sv biotin 5,000 mcg softgel (Meribin)	T2	HD
TRONVITE	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
ULTRA B-100 COMPLEX TABLET	T4	HD
ultra b-100 complex tablet	T2	HD
VIRT-CAPS (*b complex w-c no.20/folic acid*)	T4	HD
vit b comp c 19/folic acid/d3	T2	HD PPACA
vit b comp no.3/folic/c/biotin	T2	HD
vit b comp/c/fa/iron sulf/vite	T2	HD PPACA
vit b comp/c/folic/choline/inosi	T2	HD PPACA
vit b comp/c/folic/iron/vit e	T2	HD PPACA
vit b complex 100 combo no.2	T2	HD
vit b12/levomefolate/vit b6/b2 (Cerefolin)	T2	HD
VITA-BEE WITH C (*folic acid/vit b complex and c*)	T4	HD
VITAL-D RX	T4	HD
VITAJOY BIOTIN	T4	HD
vitamin b complex	T2	HD
vitamin b complex capsule	T2	HD
vitamin b complex softgel	T2	HD
vitamin b complex tablet	T2	HD PPACA
vitamin b complex tablet	T2	HD
vitamin b complex/folic acid	T2	HD PPACA
vitamin b complex/lysine (Apetex)	T2	HD
vitamin b complex/lysine (Apetigen)	T2	HD
vitamin b complex-vitamin c tb (Vita-Bee With C)	T2	HD PPACA
vitamin b-complex c caplet	T2	HD PPACA
VITA-RESPA	T4	HD
VITASURE	T4	HD
XVITE	T4	HD
ZELDANA	T4	HD
VITAMIN BI PREPARATIONS		
CYTO B-1	T4	
cvs vitamin b-1 100 mg tablet	T2	
ft vitamin b-1 100 mg tablet	T2	
gnp vitamin b-1 100 mg tablet	T2	
PUREVITA VITAMIN B1	T4	
ra vitamin b-1 100 mg tablet	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B1 PREPARATIONS (cont.)		
thiamine 100 mg tablet	T2	
thiamine 200 mg/2 ml vial	T2	
thiamine 250 mg tablet	T2	
THIAMINE 500 MG TABLET	T4	
thiamine hcl	T2	
true vitamin b-1 100 mg tablet	T2	
vitamin b-1 100 mg tablet	T2	
vitamin b-1 250 mg tablet	T2	
vitamin b-1 50 mg tablet	T2	
THIAMINE HCL-0.9% NACL	T4	
TRUE VITAMIN B-1 250 MG TABLET	T4	
TRUE VITAMIN B-1 50 MG TABLET	T4	
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T4	
APATATE	T3	
B-12 1,000 MCG FAST DISSOLVE	T4	
B-12 1,000 MCG LOZENGE	T4	
B-12 1,000 MCG QUICK DISSOLVE	T4	
b-12 1,000 mcg tablet	T2	
B-12 1,000 MCG/15 ML LIQUID	T3	
b-12 1,000 mcg/15 ml liquid	T2	
b-12 2,500 mcg microlozenge	T2	
b12 2,500 mcg tablet sl	T2	
b-12 2,500 mcg tablet sl	T2	
B-12 3,000 MCG TABLET SL	T4	
b-12 3,000 mcg/ml subling liq	T2	
B-12 5,000 MCG FAST DISSOLVE	T4	
B12 5,000 MCG MICROLOZENGE	T4	
B-12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG ODT	T4	
B-12 5,000 MCG QUICK DISSOLVE	T4	
B-12 5,000 MCG SUBLINGUAL TAB	T4	
B-12 5,000 MCG/ML SUBLING LIQ	T4	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
B-12 500 MCG QUICK DISSOLVE TB	T4	
b-12 500 mcg tablet	T2	
B12 ACTIVE	T4	
B-12 DUAL SPECTRUM	T4	
b-12 er 1,000 mcg tab	T2	
B-12 WITH FOLIC ACID	T4	
cvs b-12 1,000 mcg tablet	T2	
CVS B-12 5,000 MCG MICROLOZENG	T4	
CVS B-12 5,000 MCG MICROLOZENG	T3	
cvs vitamin b12 5,000 mcg chew	T2	
CVS VIT B12 2,500 MCG SOFT CHW	T4	
CVS VITAMIN B12 5,000 MCG TAB	T4	
CVS VIT B-12 500 MCG LOZENGE	T3	
cvs vit b-12 500 mcg lozenge	T2	
cvs vit b-12 tr 1,000 mcg tab	T2	
cvs vit b-12 tr 2,000 mcg tab	T2	
CVS VITAMIN B-12 500 MCG GUMMY	T4	
cvs vitamin b-12 500 mcg tab	T2	
cyanocobalamin (vitamin b-12)	T2	QL(4 units/30 days)
cyanocobalamin (vitamin b-12) (Nascobal)	T2	ST QL(4 units/30 days)
eql vitamin b-12 500 mcg tab	T2	
fn vitamin b-12 1,000 mcg tab	T2	
FOLTRATE	T4	
ft vit b-12 2,500 mcg tab sl	T2	
ft vitamin b-12 500 mcg tablet	T2	
ft vitamin b12 er 1,000 mcg tb	T2	
FT VITAMIN B-12 1500 MCG GUMMY	T4	
FT VITAMIN B-12 5,000 MCG TAB	T3	
gnp b12 2,500 mcg tablet sl	T2	
gnp vit b-12 er 1,000 mcg tab	T2	
gnp vitamin b-12 500 mcg tab	T2	
GNP VITAMIN B-12 1500MCG GUMMY	T4	
hm vit b-12 tr 1,000 mcg tab	T2	
hm vitamin b-12 500 mcg tablet	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
hydroxocobalamin	T2	
INTRINSI B12-FOLATE	T4	
METHYL B-12	T4	
METHYLCOBALAMIN	T4	
METHYLCOBALAMIN 5,000 MCG TAB	T4	
MTX SUPPORT	T4	
NASCOBAL *(cyanocobalamin (vitamin b-12))*	T3	ST QL(4 units/30 days)
NEURIN-SL	T4	
OPURITY	T4	
PAXLYTE	T4	
PUREVITA VITAMIN B12	T4	
ra vit b12 1,000 mcg tab sa	T2	
RA VIT B-12 1,000 MCG/ML LIQ	T4	
ra vitamin b-12 100 mcg tablet	T2	
ra vitamin b12 er 2,000 mcg tb	T2	
RAPID B-12 ENERGY	T4	
sm vitamin b12 1,000 mcg tab	T2	
sm vitamin b-12 100 mcg tablet	T2	
sm vitamin b-12 500 mcg tablet	T2	
sv b-12 2,500 mcg microlozenge	T2	
SV B-12 5,000 MCG MICROLOZENGE	T3	
SV VIT B-12 500 MCG LOZENGE	T3	
sv vitamin b-12 500 mcg tablet	T2	
sv vitamin b12 tr 1,000 mcg tb	T2	
true vitamin b-12 500 mcg, 1000 mcg tab	T2	
VIT B-12 500 MCG SUBLING TAB	T4	
VITAMIN B12	T4	
VITAMIN B-12 1,000 MCG SOFTGEL	T4	
vitamin b-12 1,000 mcg tab sl	T2	
vitamin b-12 1,000 mcg tablet	T2	
vitamin b-12 100 mcg tablet	T2	
vitamin b-12 2,000 mcg tab sa	T2	
VITAMIN B-12 2,000 MCG TABLET	T4	
vitamin b-12 2,500 mcg tab sl	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
VITAMIN B-12 250 MCG LOZENGE	T4	
vitamin b-12 250 mcg tablet	T2	
VITAMIN B-12 3,000 MCG SL LOZ	T4	
VITAMIN B-12 3,000 MCG SOFTGEL	T4	
VITAMIN B-12 3,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG ODT	T4	
VITAMIN B-12 5,000 MCG SOFTGEL	T4	
VITAMIN B-12 5,000 MCG TAB SL	T3	
vitamin b-12 5,000 mcg tab sl	T2	
VITAMIN B-12 5,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG TABLET	T4	
VITAMIN B-12 50 MCG LOZENGE	T4	
VITAMIN B-12 500 MCG LOZENGE	T3	
vitamin b12 50 mcg, 500 mcg tablet	T2	
vitamin b-12 500 mcg tablet	T2	
vitamin b-12 tr 1,000 mcg tab	T2	
vitamin b-12 tr 2,000 mcg tab	T2	
VITAMIN B12	T4	
VITAMIN B12-FOLIC ACID	T4	
VITAMIN B12 2,500 MCG TABLET	T4	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T4	
PUREVITA VITAMIN B2	T4	
riboflavin (vitamin b2)	T2	
riboflavin 100 mg tablet	T2	
RIBOFLAVIN 400 MG TABLET	T4	
riboflavin 50 mg tablet	T2	
VITAMIN B6 PREPARATIONS		
cvs vitamin b-6 100 mg tablet	T2	
eql vitamin b-6 100 mg tablet	T2	
ft vitamin b-6 100 mg tablet	T2	
gnp vitamin b-6 100 mg tablet	T2	
PUREVITA VITAMIN B6	T4	
pyridoxine 100 mg/ml vial	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B6 PREPARATIONS (cont.)		
pyridoxine 25 mg tablet	T2	
pyridoxine 250 mg tablet	T2	
PYRIDOXINE 50 MG TABLET (*pyridoxine hcl (vitamin b6)*)	T3	
pyridoxine 50 mg tablet (Pyridoxine Hcl)	T2	
PYRIDOXINE 500 MG TABLET *(pyridoxine hcl (vitamin b6))*	T4	
pyridoxine hcl (vitamin b6)	T2	
pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)	T2	
ra vitamin b-6 100 mg tablet	T2	
ra vitamin b-6 50 mg tablet	T2	
sm vitamin b-6 100 mg tablet	T2	
sv vitamin b-6 100 mg tablet	T2	
TRUE VITAMIN B-6 10 MG TABLET	T2	
true vitamin b-6 100 mg tablet	T2	
true vitamin b-6 25 mg tablet	T2	
true vitamin b-6 50 mg tablet	T2	
VB6 P5P	T4	
vitamin b-6 100 mg tablet	T2	
vitamin b-6 25 mg tablet	T2	
vitamin b-6 250 mg tablet	T2	
vitamin b-6 50 mg tablet	T2	
VITAMIN C PREPARATIONS		
ASCOR	T4	
ascorbate calcium	T2	
ascorbic acid	T2	
ascorbic acid 500 mg tablet	T2	
ascorbic acid 500 mg/5 ml cup	T2	
ascorbic acid 500 mg/ml vial	T2	
ASCORBIC ACID GRANULES	T3	
ascorbic acid/ascorbate sodium	T2	
BIO C 1:1	T4	
c-1,000 mg tablet sa	T2	
cod liver oil tab chewable	T2	
cvs vit c-rose hip 1,000 mg tb	T2	
cvs vit c-rose hip 500 mg chew	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
cvs vit c-rose hip 500 mg cplt	T2	
cvs vit c-rose hips 500 mg tab	T2	
cvs vitamin c 1,000 mg caplet	T2	
CVS VITAMIN C 1,000 MG POWDER	T4	
cvs vitamin c 250 mg tablet	T2	
cvs vitamin c 500 mg caplet	T2	
cvs vitamin c 500 mg tablet	T2	
CYTO C	T4	
EASY-C IMMUNE HEALTH	T4	
EMERGEN-C	T4	
EMERGEN-C ELDERBERRY	T4	
EMERGEN-C IMMUNE PLUS	T4	
EMERGEN-C MSM LITE	T4	
eql vitamin c 1,000 mg tablet	T2	
ESSENCE C	T4	
ESTER-C 1,000 MG TABLET	T4	
ESTER-C 500 MG TABLET	T3	
FLEVOXIN	T4	
FRUIT C-100 TABLET CHEWABLE	T4	
fruit c-100 tablet chewable	T2	
FRUIT C-200	T4	
ft vit c-rose hip 1,000 mg tab	T2	
ft vit c-rose hips 500 mg tab	T2	
FT VITAMIN C 500 MG CHEW TAB	T3	
ft vitamin c 1,000 mg tablet	T2	
gnp vit c-rose hips 500 mg tab	T2	
gnp vitamin c 1,000 mg tablet	T2	
gnp vitamin c 250 mg tablet	T2	
gnp vitamin c 500 mg tab chew	T2	
gnp vitamin c 500 mg tablet	T2	
gnp vitamin c er 500 mg tablet	T2	
hm vit c-rose hip 1,000 mg tab	T2	
hm vit c-rose hips 500 mg cplt	T2	
hm vitamin c 500 mg tab chew	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
LIQUID C	T4	
PAN-C 500	T4	
PERIDIN-C	T3	
PUREVITA VITAMIN C	T4	
ra vit c-rose hips 500 mg tab	T2	
ra vitamin c 1,000 mg tab sa	T2	
ra vitamin c 250 mg, 500 mg, 1,000 mg tablet	T2	
ra vitamin c 500 mg chew tab	T2	
ra vitamin c 500 mg tab chew	T2	
RA VITAMIN C 53 MG DROP	T4	
ra vitamin c tr 500 mg caplet	T2	
SAMBUCUS ELDERBERRY-VITAMIN C	T4	
sm vit c-rose hips 500 mg tab	T2	
sm vitamin c 1,000 mg tablet	T2	
sm vitamin c 250 mg tablet	T2	
sm vitamin c 500 mg chew tab	T2	
sm vitamin c 500 mg tab chew	T2	
sm vitamin c 500 mg tablet	T2	
sm vitamin c with rose hips	T2	
SPAN C	T4	
sv vit c-rose hip 1,000 mg tab	T2	
sv vit c-rose hips 1,000 mg tb	T2	
sv vit c-rose hips 500 mg tab	T2	
sv vitamin c 500 mg tab chew	T2	
sv vitamin c tr 1,000 mg tab	T2	
true vitamin c 1,000 mg tablet	T2	
true vitamin c 250 mg tablet	T2	
true vitamin c 500 mg tablet	T2	
vit c-rose hip 1,000 mg caplet	T2	
vit c-rose hips 1,000 mg cplt	T2	
vit c-rose hips 1,000 mg tab	T2	
VIT C-ROSE HIPS 500 MG CAPSULE, CHEW TB	T4	
vit c-rose hips 500 mg capsule, tablet	T2	
vit c-rose hips tr 1,000 mg	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
vit c-rose hips tr 500 mg cplt	T2	
vit c-rose hips tr 500 mg tab	T2	
VITAJOY DAILY C	T4	
vitamin c 1,000 mg caplet	T2	
vitamin c 1,000 mg tablet	T2	
vitamin c 1,500 mg tablet sa	T2	
vitamin c 100 mg tablet	T2	
VITAMIN C 125 MG GUMMIES	T4	
vitamin c 250 mg tablet	T2	
VITAMIN C 250 MG TABLET CHEW	T4	
vitamin c 250 mg tablet chew	T2	
vitamin c 500 mg capsule sa	T2	
vitamin c 500 mg chew tablet	T2	
VITAMIN C 500 MG POWDER PACKET	T4	
VITAMIN C 500 MG SOFTGEL	T4	
vitamin c 500 mg tablet	T2	
vitamin c 500 mg tablet chew	T2	
VITAMIN C 500 MG WAFER	T4	
VITAMIN C 500 MG/15 ML LIQUID	T4	
vitamin c 500 mg/5 ml liquid	T2	
vitamin c drops	T2	
VITAMIN C FIZZY DRINK	T4	
VITAMIN C POWDER	T4	
vitamin c powder	T2	
vitamin c tr 1,000 mg tablet	T2	
vitamin c tr 500 mg caplet	T2	
vitamin c tr 500 mg tablet	T2	
vitamin c-500 mg tablet	T2	
vitamin c-500 mg tr capsule	T2	
VITAMIN C-BIOFLAVINOIDS-RH	T4	
vitamin c-rose hip 1,000 mg tb	T2	
v-r vitamin c 1,000 mg tablet	T2	
v-r vitamin c 250 mg tab chew	T2	
v-r vitamin c 500 mg tab chew	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
well vitamin c 1,000 mg tablet	T2	
well vitamin c 500 mg tablet	T2	
XCELLENT C	T4	
ZINC PLUS	T4	
ZINC-VITAMIN C	T4	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T4	HD
BABY DDROPS	T4	HD
BABY VITAMIN D3	T4	HD
BABY'S SUPER DAILY D3	T4	HD
BIO-D-MULSION	T4	HD
BIO-D-MULSION FORTE	T4	HD
calcitriol 0.25 mcg capsule	T2	
calcitriol 0.5 mcg capsule	T2	
calcitriol 1 mcg/ml ampul	T2	
calcitriol 1 mcg/ml solution (Rocaltrol)	T2	
CHOLECAL DF	T4	HD
cholecalciferol (vitamin d3)	T2	HD
cod liver oil	T2	HD
cod liver oil capsule	T2	HD
cod liver oil softgel	T2	HD
cvs vit d3 1,000 unit gummies	T2	HD
cvs vit d3 250 mcg softgel	T2	HD
cvs vitamin d3 25 mcg gummies	T2	HD
cvs vitamin d3 400 unit sftgl	T2	HD
cvs vitamin d3 1,000 unit sfgl	T2	HD
cvs vitamin d3 2,000 unit sfgl	T2	HD
cvs vitamin d3 5,000 unit sfgl	T2	HD
cvs vitamin d3 10 mcg softgel	T2	HD
cvs vitamin d3 25 mcg, 50 mcg softgel	T2	HD
cvs vitamin d3 125 mcg softgel	T2	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T4	HD
cvs vitamin d3 50 mcg tablet	T2	HD
CYFOLEX	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
D3 LIQUID	T4	HD
D3 PLUS K2 DOTS	T4	HD
D3-50	T3	HD
DDROPS	T4	HD
decara 10,000 unit softgel	T2	HD
DECARA 25,000 UNIT VEGICAP	T3	HD
decara 50,000 unit softgel	T2	HD
DECARA K	T4	HD
DERMACINRX DOTREMIN	T4	HD
DERMACINRX FOLDITAM	T4	HD
DERMACINRX FOLIXAPURE	T4	HD
DERMACINRX FOLIXATE	T4	HD
DERMACINRX FOLTAMIN	T4	HD
DERMACINRX FOLTREXYL	T4	HD
DERMACINRX PUREFOLIX	T4	HD
DIALYVITE VITAMIN D3 MAX	T4	HD
DOSOKAP	T4	HD
DOSOQUIN	T4	HD
eql vitamin d3 2,000 unit sfgl	T2	HD
eql vitamin d3 400 unit sftgl	T2	HD
ERGOCAL	T4	HD
ergocalciferol (vitamin d2)	T2	HD
FOLIC D3	T4	HD
FOLIKA-D	T4	HD
FOLVITE-D	T4	HD
ft vitamin d3 25 mcg, 50 mcg softgel	T2	HD
ft vitamin d3 125 mcg softgel	T2	HD
ft vitamin d3 125 mcg tablet	T2	HD
ft vitamin d3 25 mcg tablet	T2	HD
FT VITAMIN D3 250 MCG SOFTGEL	T4	HD
FT VITAMIN D3 250 MCG TABLET	T4	HD
gnp vitamin d3 50 mcg softgel	T2	HD
GNP VITAMIN D3 250 MCG SOFTGEL	T4	HD
GENICIN VITA-D	T4	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
gnp vit d3 10mcg(400 unit) chw	T2	HD
gnp vitamin d3 1,000 unit tab	T2	HD
gnp vitamin d3 10 mcg tablet	T2	HD
gnp vitamin d3 2,000 unit tab	T2	HD
gnp vitamin d3 25 mcg tablet	T2	HD
gnp vitamin d3 25mcg(1000 unt)	T2	HD
gnp vitamin d3 50 mcg tablet	T2	HD
gnp vitamin d3 5,000 unit tab	T2	HD
hm vitamin d3 1,000 unit tab	T2	HD
hm vitamin d3 2,000 unit sftgl	T2	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T4	HD
IS-D-10,000	T4	HD
K2 PLUS D3	T4	HD
K2-D3 10,000	T4	HD
K2-D3 5000	T4	HD
K2-D3 MAX	T4	HD
MAXIMUM D3	T3	HD
NOXIFOL-D3	T4	HD
OPTIMAL D3 M	T4	HD
ORTHO DF	T4	HD
OSTACHOL	T4	HD
PUREVITA VITAMIN D3	T4	HD
qc cod liver oil	T2	HD
ra cod liver oil	T2	HD
ra cod liver oil softgel	T2	HD
ra vitamin d3 1,000 unit tab	T2	HD
ra vitamin d3 2,000 unit sfgl	T2	HD
ra vitamin d3 2,000 unit sftgl	T2	HD
ra vitamin d3 5,000 unit sftgl	T2	HD
REPLESTA NX	T3	HD
REVESTA	T4	HD
ROCALTROL (*calcitriol*)	T4	ST
ROXIFOL-D	T4	HD
sm vitamin d3 1,000 unit tab	T2	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
sm vitamin d3 2,000 unit sftgl	T2	HD
sm vitamin d3 50 mcg softgel	T2	HD
SUPER DAILY D3	T4	HD
sv vitamin d3 1,000 unit gummy	T2	HD
sv vitamin d3 1,000 unit sftgl	T2	HD
sv vitamin d3 2,000 unit sftgl	T2	HD
sv vitamin d3 25mcg(1000 unit)	T2	HD
sv vitamin d3 400 unit softgel	T2	HD
sv vitamin d3 5,000 unit sftgl	T2	HD
thera-d 2000 tablet	T2	HD
THERA-D 4000 TABLET	T4	HD
thera-d rapid repletion tablet	T2	HD
thera-d sport 2,000 unit tab	T2	HD
true vitamin d3 1,250 mcg tab	T2	HD
true vitamin d3 10 mcg capsule	T2	HD
true vitamin d3 10 mcg tablet	T2	HD
true vitamin d3 125 mcg cap	T2	HD
true vitamin d3 125 mcg tablet	T2	HD
true vitamin d3 25 mcg capsule	T2	HD
true vitamin d3 50 mcg capsule	T2	HD
true vitamin d3 25 mcg, 50 mcg tablet	T2	HD
TRUE VITAMIN D3 1,250 MCG CAP	T4	HD
TRUE VITAMIN D3 250 MCG CAP	T4	HD
TRUE VITAMIN D3 250 MCG TABLET	T4	HD
vit d3 125 mcg (5000 unit) tab	T2	HD
VIT D3 5,000 UNIT FAST DISSOLV	T4	HD
VITAMIN D2 2,000 UNIT TABLET	T3	HD
vitamin d2 1.25mg(50,000 unit)	T2	HD
vitamin d2 400 unit tablet	T2	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T4	HD
VITAMIN D2-VITAMIN K1	T4	HD
VITAMIN D3-VITAMIN K2	T4	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T4	HD
vitamin d3 1,000 unit gummies	T2	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
vitamin d3 1,000 unit gummy	T2	HD
vitamin d3 1,000 unit softgel	T2	HD
VITAMIN D3 1,000 UNIT SPRAY	T4	HD
vitamin d3 1,000 unit tab chew	T2	HD
vitamin d3 1,000 unit tablet	T2	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T4	HD
vitamin d3 1,250 mcg capsule	T2	HD
vitamin d3 1.25 mg softgel	T2	HD
vitamin d3 10 mcg tablet	T2	HD
vitamin d3 10 mcg(400 unit)/ml	T2	HD
vitamin d3 10 mcg/ml drop	T2	HD
VITAMIN D3 10 MCG/ML ENFIT SYR	T4	HD
vitamin d3 10 mcg/ml liquid	T2	HD
VITAMIN D3 10,000 UNIT CAPSULE	T4	HD
vitamin d3 10,000 unit softgel	T2	HD
VITAMIN D3 10,000 UNIT TABLET	T4	HD
vitamin d3 125 mcg (5000 unit)	T2	HD
vitamin d3 125 mcg capsule, softgel, tablet	T2	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T4	HD
vitamin d3 2,000 unit softgel	T2	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T4	HD
vitamin d3 2,000 unit tablet	T2	HD
vitamin d3 25 mcg (1,000 unit)	T2	HD
vitamin d3 25 mcg gummy	T2	HD
vitamin d3 25 mcg softgel	T2	HD
vitamin d3 25 mcg tablet	T2	HD
VITAMIN D3 250 MCG TABLET	T4	HD
VITAMIN D3 3,000 UNIT TABLET	T4	HD
vitamin d3 400 unit softgel	T2	HD
vitamin d3 400 unit tab chew	T2	HD
vitamin d3 400 unit tablet	T2	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T4	HD
vitamin d3 400 unit/ml liquid	T2	HD
vitamin d3 5,000 unit capsule	T2	HD

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
vitamin d3 5,000 unit softgel	T2	HD
vitamin d3 5,000 unit tablet	T2	HD
vitamin d3 5,000 unit/ml drops	T2	HD
vitamin d3 50 mcg (2,000 unit)	T2	HD
vitamin d3 50 mcg capsule	T2	HD
vitamin d3 50 mcg softgel	T2	HD
VITAMIN D3 62.5 MCG SOFTGEL	T4	HD
vitamin d3 50 mcg tablet	T2	HD
vitamin d3 50,000 unit capsule	T2	HD
vitamin d3/folic acid	T2	HD
v-r cod liver oil capsule	T2	HD
well vitamin d3 125 mcg softgl	T2	HD
well vitamin d3 25 mcg softgel	T2	HD
well vitamin d3 50 mcg softgel	T2	HD
VITAMIN E PREPARATIONS		
AQUA-E	T3	
AQUA-E CONCENTRATE	T4	
cvs vitamin e 180 mg softgel	T2	
cvs vitamin e 200 unit softgel	T2	
CVS VITAMIN E 450 MG SOFTGEL	T4	
cvs vitamin e 90 mg softgel	T2	
eql vitamin e 1,000 unit sftgl	T2	
eql vitamin e 180 mg softgel	T2	
ft vitamin e 180 mg softgel	T2	
gnp vitamin e 180 mg softgel	T2	
gnp vitamin e 400 unit softgel	T2	
GNP VITAMIN E 450 MG SOFTGEL	T4	
gnp vitamin e 90 mg softgel	T2	
hm vitamin e 180 mg softgel	T2	
hm vitamin e 200 unit softgel	T2	
hm vitamin e 400 unit softgel	T2	
MIXED TOCOTRIENOLS	T4	
ra vitamin e 268 mg softgel	T2	
sv vitamin e 180 mg softgel	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN E PREPARATIONS (cont.)		
sv vitamin e 400 unit softgel	T2	
sv vitamin e 450 mg softgel	T2	
sv vitamin e 670 mg softgel	T2	
true vitamin e 180 mg capsule	T2	
true vitamin e 90 mg capsule	T2	
TRUE VITAMIN E 450 MG CAPSULE	T4	
vitamin e (dl,tocopheryl acet)	T2	
vitamin e 1,000 unit softgel	T2	
VITAMIN E 1,000 UNIT SOFTGEL	T4	
vitamin e 100 unit softgel	T2	
VITAMIN E 100 UNIT TABLET	T4	
vitamin e 15 unit/0.3 ml drop	T2	
vitamin e 180 mg softgel	T2	
vitamin e 180mg(400 unit) sfgl	T2	
vitamin e 200 unit capsule, softgel	T2	
vitamin e 268 mg softgel	T2	
vitamin e 400 unit capsule	T2	
vitamin e 400 unit softgel	T2	
vitamin e 45 mg softgel	T2	
VITAMIN E 450 MG SOFTGEL	T4	
vitamin e 450 mg softgel	T2	
vitamin e 600 unit capsule	T2	
vitamin e 90 mg softgel	T2	
VITAMIN E NATURAL OIL DROPS	T3	
VITAMIN E OIL	T4	
VITAMIN E OIL DROPS	T3	
VITAMIN E OIL DROPS	T4	
VITAMIN E-OIL	T3	
WHEAT GERM OIL	T3	
XCELLENT E	T4	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T4	
FNP VITAMIN K2 40 MCG TABLET	T4	
ft vitamin k2 100 mcg capsule	T2	

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN K PREPARATIONS (cont.)		
gnp vitamin k2 100 mcg capsule	T2	
K1-1000	T4	
K2 LIQUID	T4	
K2-45	T4	
MEPHYTON (*phytonadione (vit k1)*)	T4	QL(10 tabs/fill)
phytonadione (vit k1)	T2	
PHYTONADIONE 1 MG/0.5 ML SYR	T3	
phytonadione 1 mg/0.5 ml syr	T2	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
phytonadione 10 mg/ml ampul	T2	
phytonadione 10 mg/ml vial	T2	
VITAMIN K	T3	
VITAMIN K-1	T3	
VITAMIN K2	T4	
VITAMIN K2 100 MCG SOFTGEL	T4	
VITAMIN K2 (MENAQUINONE-4)	T4	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
ALIVE MEN'S MAX3 POTENCY	T4	
BOOSTNOW IMMUNE SUPPORT	T4	
CENTRUM ADULTS 50 PLUS MINIS	T4	
CENTRUM MEN 50 PLUS MINIS	T4	
DAVIMET-M	T4	
LIVITA FOR ADULT	T4	
MULTITOL-M	T4	
NANOVM ADULT	T4	
SUPERIOR WOMEN'S MULTI	T4	
PEDIATRIC VITAMIN PREPARATIONS		
ft children's multi gummy	T2	
GNP CHILDREN'S MULTI GUMMY	T4	

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

Exclusions and limitations for coverage

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

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

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

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

Index of Medications

Symbols

A

Index of Medications

Index of Medications

Index of Medications

B

Index of Medications

C

Index of Medications

Index of Medications

Index of Medications

D

Index of Medications

Index of Medications

Index of Medications

Index of Medications

F

Index of Medications

Index of Medications

G

Index of Medications

H

Index of Medications

Index of Medications

J

K

Index of Medications

L

Index of Medications

M

Index of Medications

Index of Medications

Index of Medications

N

Index of Medications

O

Index of Medications

P

Index of Medications

Index of Medications

Index of Medications

Q

R

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

U

Index of Medications

Index of Medications

W

Index of Medications

Index of Medications

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

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

cigna healthcare

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. 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 penalized regardless of where you fill your prescriptions.
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 3 (preferred brand). This is true even if the medication is listed as Tier 4 (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 Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- 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 Healthcare 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 Healthcare
Nondiscrimination Complaint Coordinator
P.O. 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

cigna healthcare

896375d 04/23

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 شمارەگیری کنید).