# 2026 California Small Group 4-Tier PPO Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of October 1, 2026 and is subject to change after this date. All previous versions of this PDL are no longer in effect. Your estimated coverage and copay/coinsurance may vary based on the benefit plan you choose and the effective date of the plan.

The current PDL can also be accessed online at **uhc.com/CA-SmallGroup-4TADV-CDI-Current**. An example of a plan coverage document may be accessed online at **uhc.com/content/dam/uhcdotcom/en/statepdls/lg/2024-CA-LrgGrp-SBC.pdf**.

If you are a UnitedHealthcare member, please register or log on to **myuhc.com**, or call the toll-free number on your member ID card to find coverage documents and pharmacy information specific to your benefit plan.

This PDL is applicable to the following health insurance products offered by UnitedHealthcare:

- Navigate

**Updated 8/1/2026**

8/26 © 2026 United HealthCare Services, Inc. All Rights Reserved. WF21077959-L

United Healthcare®

# Contents


Understand your medication options . . . . . 3

How do I use my PDL? . . . . . 5

What are tiers? . . . . . 6

When does the PDL change? . . . . . 6

Utilization Management programs . . . . . 7

Your right to request access to a non-formulary drug . . . . . 8

Requesting a prior authorization or step therapy exception . . . . . 9

How do I locate and fill a prescription through a retail network pharmacy? . . . . . 9

Prescription delivery options . . . . . 9

How do I locate and fill a prescription through the mail order pharmacy? . . . . . 10

How do I locate and fill a prescription at a specialty pharmacy? . . . . . 10

How do I get updated information about my pharmacy benefit? . . . . 11

Nondiscrimination notice and access to communication services . . . 12

Prescription drug list . . . . . 16

# Understand your medication options

Your pharmacy benefit offers flexibility and choice in determining the right medication for you. To help you get the most out of your pharmacy benefit, we've included some of the most commonly used terms and their definitions as well as frequently asked questions:

**Brand-name drug** means a Prescription Drug Product (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand-name" by the manufacturer, pharmacy, or your physician will be classified as brand-name by us. A brand-name drug is listed in this PDL in all CAPITAL letters.

**Coinsurance** means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

**Copayment** means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

**Deductible** means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either 1 deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

**Drug Tier** means a group of Prescription Drug Products that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a Prescription Drug Product is placed determines your portion of the cost for the drug.

**Exception request** means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

**Exigent circumstances** means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

**Formulary or Prescription Drug List (PDL)** means a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification.

**Generic drug** means a Prescription Drug Product: (1) that is therapeutically equivalent to a brand-name drug; or (2) that we identify as a generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your physician will be classified as a generic by us. A generic drug is listed in this PDL in *italicized lowercase* letters.

**Medically necessary** means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

**Non-formulary drug** means a Prescription Drug Product that is not listed on this PDL.

**Out-of-pocket costs** means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

**Prescribing provider** means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

**Prescription** means an oral, written, or electronic order from a prescribing provider authorizing a Prescription Drug Product to be provided to a specific individual.

**Prescription Drug Product** means a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill.

We will provide coverage under the pharmacy benefit for all medically necessary Prescription Drug Product which includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. This definition includes: Inhalers (with spacers); Insulin; the following diabetic supplies: standard insulin syringes with needles; blood-testing strips - glucose; urine-testing strips - glucose; ketone-testing strips and tablets; lancets and lancet devices; and glucose meters (including continuous glucose monitors); disposable devices which are medically necessary for the administration of a covered outpatient Prescription Drug Product.

Benefits will be provided for point-of-sale over-the-counter contraceptives without cost sharing or medical management restrictions when obtained from a network pharmacy. A prescription will not be required to trigger coverage of these products. Benefits will also be provided without cost-sharing for over-the-counter aids and/or drugs used for smoking cessation, or medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a network provider when medically necessary, as applicable.

Medications which, due to their traits, are administered or directly supervised by a qualified provider or licensed/certified health professional will be covered under the medical benefit when medically necessary.

**Prior authorization** means a process by your health insurer to determine that a health care benefit is medically necessary for you. If a Prescription Drug Product is subject to prior authorization in this PDL, your prescribing provider must request approval from your health insurer to cover the drug. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

**Step therapy** means a specific sequence in which Prescription Drug Products for a particular medical condition must be tried. If a drug is subject to step therapy in this PDL, you may have to try 1 or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

# How do I use my PDL?

When choosing a medication, you and your healthcare provider should consult the Prescription Drug List (PDL). It will help you and your healthcare provider choose the most cost-effective prescription drugs. This guide tells you if special programs apply. Bring this list with you when you see your healthcare provider. It is organized by therapeutic category and class. The therapeutic category and class are based on the AHFS Pharmacologic-Therapeutic Classification.

You may also find a drug by its brand or generic name in the alphabetical index. If a generic equivalent for a brand-name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

This is the way Prescription Drug Products appear in the PDL:

1. A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs;
2. The generic name for a brand-name drug is included after the brand-name in parentheses and all lowercase italicized letters;
3. If a generic equivalent for a brand-name drug is both available and covered, the generic drug will be listed separately from the brand-name drug in all lowercase italicized letters; and
4. If a generic drug is marketed under a proprietary, trademark-protected brand-name, the brand-name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized.

**Example:**

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG *(irbesartan)* | 3 | |
| *irbesartan oral tablet 150 mg, 300 mg, 75 mg* | 1 | |

If your medication is not listed in this document, please visit **myuhc.com** or call the toll-free member phone number on your member ID card.

Below is a list of drug tier numbers, abbreviations and designations used in the PDL as well as an explanation for each.

| | |
|---|---|
| **Drug Tier 1** | Your lowest cost medications |
| **Drug Tier 2** | Your mid-range cost medications |
| **Drug Tier 3** | Your mid-range cost medications |
| **Drug Tier 4** | Your highest cost medications |
| **PA** | Prior authorization required |
| **QL** | Quantity limit |
| **ST** | Step therapy |
| **H** | Health Care Reform Preventive |
| **H-N** | Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use |

| | |
|---|---|
| **SP** | Specialty medication |
| **CM** | Orally administered anti-cancer medication |
| **E** | Excluded from coverage unless covered as part of health care reform preventive |
| **SM** | $0 cost-share by state mandate when condition appropriate |
| **IF** | Two one-month fills are required before a three-month fill is available if allowed |

# What are tiers?

Tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is determined by your employer or health plan. This is how much you will pay when you fill a prescription. Tier 1 medications are your lowest-cost options. If your medication is placed in Tier 2, 3 or 4, look to see if there is a Tier 1 option available. Discuss these options with your healthcare provider.

For orally administered anti-cancer medications on any tier, the total amount of copayments and/or coinsurance shall not exceed $250 for an individual prescription of up to a 30-day supply. For high deductible health plans, the $250 maximum only applies once the deductible has been met.

For insulin medications on any tier, the total amount of copayments and/or coinsurance shall not exceed $35 for an individual prescription of up to a 30-day supply.

Check your benefit plan documents to find out your specific pharmacy plan costs, including any maximum dollar amount of cost sharing that may apply to a drug. Preferred medications are found in Tier 1, Tier 2 or Tier 3 and may vary depending on the medication and the condition it treats.

| $ | Drug tier | Includes | Helpful tips |
|---|---|---|---|
| $ | **Tier 1**<br>**Your lowest cost** | Medications that provide the highest overall value. Mostly generic drugs. Some preferred brand-name drugs may also be included. | Use tier 1 drugs for the lowest out-of-pocket costs. |
| $$ | **Tier 2 and 3**<br>**Your mid-range cost** | Medications that provide good overall value. A mix of nonpreferred generic drugs and preferred brand-name drugs. | Use tier 2 or tier 3 drugs instead of Tier 4 to help reduce your out-of-pocket costs. |
| $$$ | **Tier 4**<br>**Your highest cost** | Medications that provide the lowest overall value. May include drugs that must be distributed through a specialty pharmacy, drugs that require special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than $600 (net of rebates) for a 1-month supply. | Many tier 4 drugs have lower-cost options in tier 1, 2 or 3. Ask your healthcare provider if they could work for you. |

**Please note:** If you have a high deductible plan, the tier cost levels may apply once you reach your deductible. Refer to your enrollment and plan materials on **myuhc.com**, or call the toll-free number on your member ID card for more information about your benefit plan.

# When does the PDL change?

This PDL is required to be updated on a monthly basis.

- Medications may move to a lower tier or coverage may be added at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier, become non-formulary, or the dosage form covered may change, most often on Jan. 1, May 1, or Sept. 1.
- Medications may become subject to new or revised utilization management procedures, such as prior authorization, step therapy or quantity limits, at any time but most often upon FDA approval of the medication or its generic, Jan. 1, May 1, or Sept. 1.

When a medication changes tiers, you may have to pay a different amount for that medication.

The presence of a Prescription Drug Product on the PDL does not guarantee that you will be prescribed that Prescription Drug Product by your provider for a particular medical condition.

# Utilization Management programs

**Prior authorization required** – Your healthcare provider is required to provide additional information to us to determine coverage.

**Quantity limit** – Amount of medication covered per copayment or in a specific time period. Medications with quantity limits may be dispensed in greater quantities if medically necessary and prior authorized by UnitedHealthcare.

**Step therapy** – Requires you to try 1 or more other medications before the medication you are requesting may be covered.

**Patient Protection and Affordable Care Act (PPACA) zero cost-share preventive care medication when age and/or condition appropriate** – This medication is part of a health care reform preventive benefit and may be available at no cost to you when used for appropriate preventive purposes. For more information, please refer to the California Advantage and Essential HMO and PPO Prescription Drug List (PDL) PPACA Zero Cost-Share Preventive Medications list, which is available at **myuhc.com**. PPACA zero cost-share preventive care medications can be obtained, free of charge, at network pharmacies with a prescription from a prescribing provider. A prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products. PPACA zero cost-share preventive care medications are obtained at a network pharmacy with a prescription order or refill from a physician and are payable at 100% of the prescription drug charge (without application of any copayment, coinsurance, deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

A complete list of PPACA zero cost-share preventive care medications covered under the outpatient prescription drug benefit can be found at **myuhc.com**.

**Designated specialty program** – For certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products, which are identified in the Coverage Requirements and Limits column of the Prescription Drug List (PDL). If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at **myuhc.com** or the telephone number on your member ID card.

**State mandated $0 cost-share when condition appropriate** – This medication is mandated to be covered at $0 cost-share when used for any of the following conditions:

- Abortion*
- COVID-19

***Please note:** If you have a high deductible plan, $0 cost-share will not apply until your deductible has been met.

To learn more about a pharmacy program or to find out if it applies to you, please visit **myuhc.com** or call the toll-free member phone number on your member ID card. If you are a pre-enrollee and you would like to learn more about your specific pharmacy benefit, please contact your employer.

Drugs administered by a health care professional are generally covered under the medical benefit while drugs that are self-administered are covered under the pharmacy benefit. In order to obtain medical benefits for drugs that are administered by a health care professional, your provider may also be required to obtain a prior authorization. The provider may contact UnitedHealthcare for more information or **uhcprovider.com**.

# Your right to request access to a non-formulary drug

This plan must cover all medically necessary Prescription Drug Products.

When a Prescription Drug Product is not on our PDL, you or your representative may request an exception to gain access to that Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your member ID card. We will notify you of our determination within 72 hours. If approved, we will cover the Prescription Drug Product for the duration of the prescription, including refills.

**Urgent requests**
If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours. If approved, we will cover the Prescription Drug Product for the duration of the exigency.

**External review**
If you are not satisfied with our determination of your exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your member ID card. The Independent Review Organization (IRO) will notify you of its determination within 72 hours.

**Expedited external review**
If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your member ID card or by sending a written request to the address set out in the determination letter. The IRO will notify you of our determination within 24 hours.

If we deny your exception request, you may appeal. Please refer to your Evidence of Coverage for details. The complaint and appeals process, including independent review, is described under Section 6: Questions, Complaints and Appeals. You may also call the telephone number listed on your member ID card.

## Requesting a prior authorization or step therapy exception

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization or step therapy exception from us. Your prescribing provider can submit a request by phone to Optum Rx® or electronically by contacting us at **ProviderPA.com**. The prior authorization staff of qualified pharmacists and technicians is available **from 5 a.m. to 10 p.m., PT Monday through Friday and from 6 a.m. to 3 p.m. PT on Saturday** to assist licensed physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your licensed physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested Prescription Drug Product meets plan criteria. You may determine whether a particular Prescription Drug Product is subject to prior authorization or step therapy requirements by going online at **myuhc.com** or by calling at the toll-free phone number on the back of your member ID card.

An exception to a step therapy requirement will be granted if your prescribing provider submits necessary justification and supporting clinical documentation supporting their determination that the required Prescription Drug Product is inconsistent with good professional practice for provision of medically necessary covered services, taking into consideration your needs and medical history, along with the professional judgment of your prescribing provider.

If you are currently taking a Prescription Drug Product which was approved by UnitedHealthcare for a specific medical condition and that drug is removed from the Prescription Drug List (PDL) and the prescribing provider continues to prescribe the Prescription Drug Product for your medical condition, we will continue to cover the Prescription Drug Product provided that the drug is appropriately prescribed and is considered safe and effective for treating your medical condition.

In the case of a standard prior authorization or step therapy exception request, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. In the case of an expedited prior authorization or step therapy exception request based on exigent circumstances, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. If we fail to respond to you, your designee, or your prescribing provider within the prescribed time limits, the request is deemed approved and we may not deny the request thereafter.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described in the Evidence of Coverage under Section 6: Questions, Complaints and Appeals. You may also call at the telephone number on your member ID card.

## How do I locate and fill a prescription through a retail network pharmacy?

UnitedHealthcare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. For a listing of network pharmacies, call the toll-free phone number on your member ID card to help locate a network pharmacy near you or visit our website at **myuhc.com > Pharmacies & Prescriptions > Find a pharmacy** for an up-to-date list.

## Prescription delivery options

You have choices on where to fill prescriptions you take regularly. You have the option to fill at a retail pharmacy or have them mailed to your home. It's up to you. Optum® Home Delivery Pharmacy is one of your network options. There may be other options in your network. Sign in at **myuhc.com > Pharmacies & Prescriptions > Find a pharmacy**.

# How do I locate and fill a prescription through the mail order pharmacy?

UnitedHealthcare offers a Mail Order Pharmacy Program. Here's how to fill prescriptions through Optum Home Delivery.

### E-prescribe

Ask your prescribing provider to electronically send new prescriptions to Optum Home Delivery for up to a 90-day supply. Or Optum Home Delivery can call your healthcare provider for you.

### Ordering prescriptions for home delivery

- **Online:** Visit **myuhc.com > Pharmacies Prescriptions > Rx profile** to set up an account. You will need to provide your payment method (credit card, debit card or bank account). Next go to **My prescriptions** tab and select the medication you want ordered through Optum Home Delivery.
- **Phone:** Call Optum Home Delivery at the number on your member ID card, any day, time.
- **Mail:** Download an order form at **optumrx.com > Information center**. Mail the completed form along with your prescription and applicable mail order pharmacy copayment. Make check or money order to Optum. No cash please.

New and refill prescription orders should typically arrive within 5 days from the date Optum Home Delivery receives the completed order.

# How do I locate and fill a prescription at a specialty pharmacy?

You have two options:

- **Sign in** to **myuhc.com > Pharmacies & Prescriptions > Drug pricing**. The Designated Specialty Pharmacy will be listed below the drug price quoted.
- **Call** the number on your member ID card.

### Designated pharmacies

If you require certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. There are both retail and mail pharmacies in the Designated Pharmacy network. Note that not all contracted retail pharmacies are in the Designated Pharmacy network. Only retail pharmacies that are in the Designated Pharmacy network will provide coverage to these Specialty Prescription Drug Products. If you choose not to obtain your Specialty Prescription Drug Product from the Designated Pharmacy, you will be responsible for the entire cost of the Specialty Prescription Drug Product and no benefits will be paid.

In urgent or emergent circumstances, you may contact customer service by calling the telephone number on the back of your member ID card. This will allow you access to the retail network override process and allow the urgent or emergent prescription claim to pay at your local pharmacy for same day access if they have the Prescription Drug Product available.

# How do I get updated information about my pharmacy benefit?

Since the PDL may change during your plan year, we encourage you to visit **myuhc.com** or call the toll-free member phone number on your member ID card for more current information.

**Sign in to myuhc.com > Pharmacies & Prescriptions for the following pharmacy information and tools:**

- Pharmacy benefit and coverage information
- Possible lower-cost medication options
- Medication interactions and side effects
- Participating retail pharmacies by zip code
- Your prescription history

**And, if mail order services are included in your pharmacy benefit, you can also:**

- Refill prescriptions
- Check the status of your order
- Set up reminders for refills
- Manage your account

## Learn more

Call the toll-free member phone number on your member ID card, or visit **myuhc.com**.

## Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

The Company complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2))). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

**Mail:** Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

**Email:** UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT **711**). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

**Online:** ocrportal.hhs.gov/ocr/smartscreen/main.jsf

**Phone:** 1-800-368-1019, 1-800-537-7697 (TDD)

**Mail:** U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://hhs.gov/ocr/complaints/index.html

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

4/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

**ATTENTION**: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. (TTY 711).

**ማሳሰቢያ**፡- **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትል
እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥ

**ملاحظة**: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

**দেখুন**: আপফ্রিফ্রি **বাংলায় (Bengali-Bangala)** কথা বফ্রে, তাহলে বিফ্রামূর্তে ভাষা সহায়তা পফ্রিষেবা এবং বড় মুদ্রফ্রে মতো অফ্রার্ফ্র ফফ্রর্মার্টে যোগাযোগগুলি আপফ্রাফ্রজফ্র বিফ্রামূর্তে উপলব্ধ। আপফ্রাফ্র সফ্রর্সে ফ্রপফ্রিচয়পর্ফ্রে ফ্রকার্ডেফ্রর্ফ্রে -ফ্রি ফ্রম্বফ্রের্ক করুফ্র

**ចំណាំ**: ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃនិងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

**請注意**：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

**ATTENTION** : Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

**ATANSYON**: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

**ACHTUNG**: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

**ΠΡΟΣΟΧΗ**: Εάν μιλάτε **ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον αριθμό χωρίς χρέωση στην κάρτα μέλους σας.

**ધ્યાનહ્યાપો**: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો પ્રિના મૂર્લ્યે ભાષાકીય મદદરૂપ સેપ્રાઓ અને અ
ફોર્મેટમાં પ્રિના મૂર્લ્યે સંસ્થાન કોટી પ્રિન્ટ તમારા માર્ટે ઉપલબ્ધ. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

**ध्यान दें**: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

**LUS TSEEM CEEB**: Yog tias koj hais **lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

**ATENSION**: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

**ATTENZIONE**: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

**注意事項**：**日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

**알림 사항**: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오

**ຫມາຍເຫດ**: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ , ເຊັ່ນ : ການພິມຕັວອັກສອນຂະຫນາດໃຫຍ່.
ໂທຫາເບີໂທຟຣີຢູ້ທີ່ບັດປະຈຳຕັວສະມາຊິກຂອງທ່ານ .

**ध्यान दिनुहोस्**: यदि तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, नि:शुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा नि:शुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्।. आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

**توجه**:گربه زبا ن **فارسی (Persian-Farsi)** صحب ت می‌کنید، خدما ت رایگا ن کمک زبانی و ارتباطا ت رایگا ن در قالب ه‌ای دیگر، مانند چاپ بزرگ، در دسترس شما هستند با شماره رایگا ن مندرج روی کار ت شناسایی عضویت تا ن تماس بگیرید.

**UWAGA**: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

**ATENÇÃO**: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

**ਦਿਆਨ ਦਿਓ**: ਿ ਤੁਸ਼ਾਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸ਼ਹਾਇਤਾ ਸ਼ੇਵਾਵਾਂ ਅਤੇ ਹ੍ਰੋ ਫ੍ਰਾ ਮੈਟਾਂ, ਿਿ ਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸ਼ੰਚਾ੍ਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬ੍ਰ ਪਛਾਣ ਕਾ੍ਰ ਡ ਤੇ ਟੋਲ-ਫ੍ਰਾ ਨੰਬ੍ਰ 'ਤੇ ਕਾਲ ਕ੍ਰ ੋ।

**ВНИМАНИЕ**! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

**ATENCIÓN**: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. (TTY 711).

**PAUNAWA**: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

**โปรดทราบ** หากคุณ**พูดภาษาไทย (Thai)** ได้
คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

**ЗВЕРНІТЬ УВАГУ**! Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на безкоштовний номер телефону, зазначений на вашій ідентифікаційній картці учасника.

**توجہ دیں**: اگر آپ **اردو (Urdu)** بولتے ہیں تو زبان کی معاونت خدمات اور دیگر فارمیٹ میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

**LƯU Ý**: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

**State of California**

**Table of Contents of Prescription Drug List**


INFORMATIONAL SECTION ..... 1
ANTIDOTE THERAPEUTICS ..... 16
ANTIHISTAMINE DRUGS - Drugs for Allergy ..... 18
ANTI-INFECTIVE AGENTS - Drugs for Infections ..... 21
ANTINEOPLASTIC AGENTS - Drugs for Cancer ..... 46
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM ..... 60
AUTONOMIC DRUGS ..... 64
AUTONOMIC DRUGS - Drugs for the Nervous System ..... 66
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood ..... 77
CARDIOVASCULAR DRUGS ..... 90
CARDIOVASCULAR DRUGS - Drugs for the Heart ..... 92
CENTRAL NERVOUS SYSTEM AGENTS ..... 119
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System ..... 119
DENTAL AGENTS ..... 164
DENTAL AGENTS - Oral Care ..... 165
DEVICES - Medical Supplies and Durable Medical Equipment ..... 167
DIAGNOSTIC AGENTS ..... 179
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants ..... 181
ELECTROLYTIC, CALORIC, AND WATER BALANCE ..... 182
ENZYMES ..... 191
EYE, EAR, NOSE AND THROAT (EENT) PREPS. ..... 193
GASTROINTESTINAL DRUGS ..... 207
GASTROINTESTINAL DRUGS - Drugs for the Stomach ..... 208
GOLD COMPOUNDS ..... 218
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron ..... 218
HORMONES AND SYNTHETIC SUBSTITUTES ..... 218
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones ..... 219
IMMUNOMODULATORY AGENTS (90:00) ..... 261
LOCAL ANESTHETICS - Drugs for Numbing ..... 271
MISCELLANEOUS THERAPEUTIC AGENTS ..... 271
NONHORMONAL CONTRACEPTIVES - Drugs for Women ..... 295
OXYTOCICS - Drugs for Women ..... 297
PHARMACEUTICAL AIDS ..... 297
RESPIRATORY TRACT AGENTS ..... 297
RESPIRATORY TRACT AGENTS - Drugs for the Lungs ..... 297
SKIN AND MUCOUS MEMBRANE AGENTS ..... 312
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin ..... 313
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles ..... 339
VITAMINS ..... 340

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ANTIDOTE THERAPEUTICS** | | |
| **ACETAMINOPHEN ANTIDOTE** | | |
| *acetylcysteine inhalation solution 10 %, 20 %* | 1 | |
| **ALCOHOL DETERRENTS (91:02)** | | |
| *acamprosate calcium oral tablet delayed release 333 mg* | 1 | |
| *disulfiram oral tablet 250 mg, 500 mg* | 1 | |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| **ANTIDOTE THERAPEUTICS** | | |
| *atropine sulfate ophthalmic solution 1 %* | 1 | |
| BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |
| BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |
| CHEMET ORAL CAPSULE 100 MG (*succimer*) | 2 | |
| DEPEN TITRATABS ORAL TABLET 250 MG (*penicillamine*) | 2 | SP |
| *ft naloxone hcl nasal liquid 4 mg/0.1ml* | 1 | QL (2 auto-injectors per prescription.) |
| *glucagon emergency kit injection solution reconstituted 1 mg* | 2 | |
| GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML | 2 | |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*) | 2 | QL (2 vials per copay.) |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*) | 2 | QL (2 prefilled syringes per copay.) |
| *hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *hyoscyamine sulfate oral elixir 0.125 mg/5ml* | 1 | |
| *hyoscyamine sulfate oral solution 0.125 mg/ml* | 1 | |
| *hyoscyamine sulfate oral tablet 0.125 mg* | 1 | |
| *hyoscyamine sulfate oral tablet dispersible 0.125 mg* | 1 | |
| *hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyoscyamine sulfate sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyosyne oral elixir 0.125 mg/5ml* | 1 | |
| *hyosyne oral solution 0.125 mg/ml* | 1 | |
| *iodine strong oral solution 5 %* | 1 | |
| KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*) | 1 | QL (2 devices per prescription.) |
| LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (*hyoscyamine sulfate*) | 3 | |
| LEVSIN ORAL TABLET 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| *naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml* | 1 | |
| *naloxone hcl injection solution cartridge 0.4 mg/ml* | 1 | |
| *naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml* | 1 | |
| *naloxone hcl nasal liquid 4 mg/0.1ml* | 1 | QL (2 auto-injectors per prescription.) |
| NARCAN NASAL LIQUID 4 MG/0.1ML (*naloxone hcl*) | 1 | QL (2 auto-injectors per prescription.) |
| NULEV ORAL TABLET DISPERSIBLE 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| OSCIMIN ORAL TABLET 0.125 MG | 3 | |
| OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG | 3 | |
| *penicillamine oral tablet 250 mg* | 2 | SP |
| *phytonadione oral tablet 5 mg* | 3 | QL (5 tablets per prescription.) |
| REXTOVY NASAL LIQUID 4 MG/0.25ML (*naloxone hcl*) | 1 | QL (one package (2 devices) per prescription.) |
| REZENOPY NASAL LIQUID 10 MG/0.11ML (*naloxone hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RIVIVE NASAL LIQUID 3 MG/0.1ML (*naloxone hcl*) | 2 | QL (1 package (2 devices) per prescription.) |
| **ANTIDOTES (91:04)** | | |
| *naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml* | 1 | |
| *naloxone hcl injection solution cartridge 0.4 mg/ml* | 1 | |
| *naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml* | 1 | |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| RADIOGARDASE ORAL CAPSULE 0.5 GM (*prussian blue insoluble*) | 3 | |
| *sevelamer carbonate oral packet 0.8 gm, 2.4 gm* | 2 | PA |
| *sevelamer carbonate oral tablet 800 mg* | 2 | |
| *sodium polystyrene sulfonate combination suspension 15 gm/60ml* | 1 | |
| *sodium polystyrene sulfonate oral powder* | 1 | |
| SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (*sodium polystyrene sulfonate*) | 3 | |
| SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (*sodium polystyrene sulfonate*) | 3 | |
| **CHEMOTHERAPY ANTIDOTES/PROTECTANTS** | | |
| *lederle leucovorin oral tablet 5 mg* | 1 | |
| *leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg* | 1 | |
| **CYANIDE ANTIDOTES** | | |
| EXODERM EXTERNAL LOTION 25-1 % (*sod thiosulfate-salicylic acd*) | 3 | |
| **FLUOROPYRIMIDINE ANTIDOTE** | | |
| VISTOGARD ORAL PACKET 10 GM (*uridine triacetate*) | 2 | QL (20 packets per prescription.) |
| **ANTIHISTAMINE DRUGS - Drugs for Allergy** | | |
| **ANTIHISTAMINE DRUGS - Drugs for Allergy** | | |
| *promethazine hcl oral tablet 25 mg* | 1 | |
| **ETHANOLAMINE DERIVATIVES - Drugs for Allergy** | | |
| *carbinoxamine maleate oral solution 4 mg/5ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *carbinoxamine maleate oral tablet 4 mg* | 1 | |
| CARBZAH ORAL SOLUTION 4 MG/5ML | 2 | |
| *clemastine fumarate oral tablet 2.68 mg* | 1 | |
| CLEMSZA ORAL TABLET 2.68 MG (*clemastine fumarate*) | 3 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| **FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy** | | |
| *cyproheptadine hcl oral syrup 2 mg/5ml* | 1 | |
| *cyproheptadine hcl oral tablet 4 mg* | 1 | |
| **FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy** | | |
| *carbinoxamine maleate oral solution 4 mg/5ml* | 1 | |
| *carbinoxamine maleate oral tablet 4 mg* | 1 | |
| CARBZAH ORAL SOLUTION 4 MG/5ML | 2 | |
| *clemastine fumarate oral tablet 2.68 mg* | 1 | |
| CLEMSZA ORAL TABLET 2.68 MG (*clemastine fumarate*) | 3 | |
| *cyproheptadine hcl oral syrup 2 mg/5ml* | 1 | |
| *cyproheptadine hcl oral tablet 4 mg* | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| *hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml* | 3 | PA; QL (360 ml per month.) |
| *hydroxyzine hcl oral syrup 10 mg/5ml* | 1 | |
| *hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg* | 1 | |
| *hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (*phenylephrine-chlorphen-dm*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml* | 1 | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| *promethazine-codeine oral solution 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-codeine oral syrup 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-dm oral syrup 6.25-15 mg/5ml* | 1 | |
| *promethazine-phenylephrine oral syrup 6.25-5 mg/5ml* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |
| *pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml* | 1 | |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*) | 3 | PA; QL (10 tablets per prescription and 30 tablets per month.) |
| **OTHER ANTIHISTAMINES - Drugs for Allergy** | | |
| *cimetidine hcl oral solution 300 mg/5ml* | 1 | |
| *cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg* | 1 | |
| *famotidine oral suspension reconstituted 40 mg/5ml* | 1 | |
| *hydroxyzine hcl oral syrup 10 mg/5ml* | 1 | |
| *hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg* | 1 | |
| *hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *olopatadine hcl nasal solution 0.6 %* | 3 | |
| **PHENOTHIAZINE DERIVATIVES - Drugs for Allergy** | | |
| *promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml* | 1 | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| *promethazine-codeine oral solution 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-codeine oral syrup 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-dm oral syrup 6.25-15 mg/5ml* | 1 | |
| *promethazine-phenylephrine oral syrup 6.25-5 mg/5ml* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **PROPYLAMINE DERIVATIVES - Drugs for Allergy** | | |
| *hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml* | 3 | PA; QL (360 ml per month.) |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (*phenylephrine-chlorphen-dm*) | 3 | |
| *pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml* | 1 | |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*) | 3 | PA; QL (10 tablets per prescription and 30 tablets per month.) |
| **SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy** | | |
| *epinastine hcl ophthalmic solution 0.05 %* | 3 | QL (5 ml per prescription) |
| *levocetirizine dihydrochloride oral solution 2.5 mg/5ml* | 3 | |
| *levocetirizine dihydrochloride oral tablet 5 mg* | 1 | |
| **ANTI-INFECTIVE AGENTS - Drugs for Infections** | | |
| **1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| *cefadroxil oral capsule 500 mg* | 1 | |
| *cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml* | 1 | |
| *cefadroxil oral tablet 1 gm* | 1 | |
| *cephalexin oral capsule 250 mg, 500 mg, 750 mg* | 1 | |
| *cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 1 | |
| *cephalexin oral tablet 250 mg, 500 mg* | 1 | |
| **2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| *cefaclor er oral tablet extended release 12 hour 500 mg* | 1 | |
| *cefaclor oral capsule 250 mg, 500 mg* | 1 | |
| *cefaclor oral suspension reconstituted 250 mg/5ml* | 1 | |
| *cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 1 | |
| *cefprozil oral tablet 250 mg, 500 mg* | 1 | |
| *cefuroxime axetil oral tablet 250 mg, 500 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics** | | |
| *cefdinir oral capsule 300 mg* | 1 | |
| *cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 1 | |
| *cefixime oral capsule 400 mg* | 3 | |
| *cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml* | 3 | |
| CEFIXIME ORAL TABLET 400 MG | 3 | |
| *cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml* | 1 | |
| *cefpodoxime proxetil oral tablet 100 mg, 200 mg* | 1 | |
| **ADAMANTANE ANTIVIRALS - Drugs for Viral Infections** | | |
| *amantadine hcl oral capsule 100 mg* | 1 | |
| *amantadine hcl oral solution 50 mg/5ml* | 1 | |
| *amantadine hcl oral tablet 100 mg* | 1 | |
| *rimantadine hcl oral tablet 100 mg* | 1 | |
| **ALLYLAMINE ANTIFUNGALS - Drugs for Fungus** | | |
| *terbinafine hcl oral tablet 250 mg* | 1 | |
| **AMEBICIDES - Drugs for the Mouth and Throat** | | |
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | 1 | |
| HUMATIN ORAL CAPSULE 250 MG (*paromomycin sulfate*) | 2 | |
| *hydrocortisone-iodoquinol external cream 1-1 %* | 1 | |
| LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*) | 3 | |
| *metronidazole external cream 0.75 %* | 1 | |
| *metronidazole external gel 0.75 %* | 1 | |
| *metronidazole external lotion 0.75 %* | 1 | |
| *metronidazole oral capsule 375 mg* | 1 | |
| *metronidazole oral tablet 250 mg, 500 mg* | 1 | |
| *metronidazole vaginal gel 0.75 %* | 2 | |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (*chlorhexidine gluconate*) | 3 | |
| *periogard mouth/throat solution 0.12 %* | 1 | |
| VANDAZOLE VAGINAL GEL 0.75 % (*metronidazole*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics** | | |
| ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (*amikacin sulfate liposome*) | 3 | PA; QL (8.4 ml per day.); SP |
| *gentamicin sulfate external cream 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate external ointment 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate ophthalmic solution 0.3 %* | 1 | QL (15 ml per prescription.) |
| HUMATIN ORAL CAPSULE 250 MG (*paromomycin sulfate*) | 2 | |
| *neomycin sulfate oral tablet 500 mg* | 1 | |
| TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*) | 3 | PA; QL (280 ml (1 carton) per 56 days.); SP |
| TOBI PODHALER INHALATION CAPSULE 28 MG (*tobramycin*) | 3 | PA; QL (224 capsules per 56 days.); SP |
| TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*) | 3 | |
| *tobramycin inhalation nebulization solution 300 mg/4ml* | 2 | PA; QL (224 ml per 56 days.); SP |
| TOBRAMYCIN NEBULIZATION SOLUTION 300 MG/5ML INHALATION | 3 | PA; QL (280 ml (1 carton) per 56 days.); SP |
| *tobramycin ophthalmic solution 0.3 %* | 1 | QL (5 ml  per prescription.) |
| *tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %* | 2 | |
| TOBREX OPHTHALMIC OINTMENT 0.3 % (*tobramycin*) | 3 | QL (3.5 grams per prescription.) |
| **AMINOMETHYLCYCLINES - Antibiotics** | | |
| NUZYRA ORAL TABLET 150 MG (*omadacycline tosylate*) | 3 | QL (30 tablets per prescription.) |
| **AMINOPENICILLIN ANTIBIOTICS - Antibiotics** | | |
| *amoxicillin oral capsule 250 mg, 500 mg* | 1 | |
| *amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml* | 1 | |
| *amoxicillin oral tablet 500 mg, 875 mg* | 1 | |
| *amoxicillin oral tablet chewable 125 mg, 250 mg* | 1 | |
| *amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *amoxicillin-potassium clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml* | 1 | |
| *amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg* | 1 | |
| *amoxicillin-potassium clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg* | 1 | |
| *ampicillin oral capsule 500 mg* | 1 | |
| PIVYA ORAL TABLET 185 MG (*pivmecillinam hcl*) | 4 | QL (9 tablets per course of therapy.) |
| VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (*amoxicillin-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (*amoxicill-clarithro-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| **ANTHELMINTICS - Drugs for Parasites** | | |
| *albendazole oral tablet 200 mg* | 3 | QL (124 tablets per month.) |
| BILTRICIDE ORAL TABLET 600 MG (*praziquantel*) | 3 | |
| EGATEN ORAL TABLET 250 MG (*triclabendazole*) | 3 | |
| EMVERM ORAL TABLET CHEWABLE 100 MG (*mebendazole*) | 4 | QL (6 tablets per 3 days.) |
| *ivermectin oral tablet 3 mg* | 1 | PA; QL (20 tablets per 3 months.) |
| *ivermectin oral tablet 6 mg* | 1 | PA |
| *praziquantel oral tablet 600 mg* | 2 | |
| STROMECTOL ORAL TABLET 3 MG (*ivermectin*) | 3 | PA; QL (20 tablets per 3 months.) |
| **ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus** | | |
| *griseofulvin microsize oral suspension 125 mg/5ml* | 1 | |
| *griseofulvin microsize oral tablet 500 mg* | 1 | |
| *griseofulvin ultramicrosize oral tablet 125 mg, 250 mg* | 1 | |
| *iodine strong oral solution 5 %* | 1 | |
| **ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections** | | |
| *bis subcit-metronid-tetracyc oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*) | 3 | QL (120 capsules per 180 days.) |
| **ANTILEPROSY AGENTS - Antibiotics** | | |
| *dapsone external gel 5 %, 7.5 %* | 3 | QL (60 grams per prescription.) |
| *dapsone oral tablet 100 mg, 25 mg* | 2 | |
| **ANTIMALARIALS - Drugs for the Mouth and Throat** | | |
| AMZEEQ EXTERNAL FOAM 4 % (*minocycline hcl micronized*) | 3 | QL (30 grams per prescription.) |
| ARAKODA ORAL TABLET 100 MG (*tafenoquine succinate*) | 3 | QL (16 tablets per month.) |
| *atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg* | 2 | |
| AVIDOXY ORAL TABLET 100 MG | 3 | |
| *chloroquine phosphate oral tablet 250 mg, 500 mg* | 1 | |
| COARTEM ORAL TABLET 20-120 MG (*artemether-lumefantrine*) | 2 | |
| DARAPRIM ORAL TABLET 25 MG (*pyrimethamine*) | 3 | PA; SP |
| *doxycycline hyclate oral capsule 100 mg, 50 mg* | 2 | |
| *doxycycline hyclate oral tablet 100 mg* | 2 | |
| *doxycycline hyclate oral tablet 20 mg* | 1 | |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | 1 | |
| *doxycycline monohydrate oral suspension reconstituted 25 mg/5ml* | 3 | |
| *doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg* | 1 | |
| *hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| KRINTAFEL ORAL TABLET 150 MG (*tafenoquine succinate*) | 1 | QL (2 tablets per prescription.) |
| MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (*atovaquone-proguanil hcl*) | 3 | |
| *mefloquine hcl oral tablet 250 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg* | 2 | |
| *minocycline hcl oral capsule 100 mg, 50 mg, 75 mg* | 1 | |
| *primaquine phosphate oral tablet 26.3 (15 base) mg* | 1 | |
| *pyrimethamine oral tablet 25 mg* | 2 | PA; SP |
| *quinidine gluconate er oral tablet extended release 324 mg* | 1 | |
| *quinidine sulfate oral tablet 200 mg, 300 mg* | 1 | |
| *quinine sulfate oral capsule 324 mg* | 1 | |
| *tetracycline hcl oral capsule 250 mg, 500 mg* | 3 | |
| ZILXI EXTERNAL FOAM 1.5 % (*minocycline hcl micronized*) | 3 | PA; ST; QL (30 grams per prescription.) |
| **ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics** | | |
| *dapsone oral tablet 100 mg, 25 mg* | 2 | |
| **ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat** | | |
| *nitazoxanide oral tablet 500 mg* | 2 | QL (6 tablets per prescription.) |
| **ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat** | | |
| *atovaquone oral suspension 750 mg/5ml* | 2 | |
| BACTRIM DS ORAL TABLET 800-160 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| BACTRIM ORAL TABLET 400-80 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| BENZNIDAZOLE ORAL TABLET 100 MG | 2 | QL (240 tablets per 720 days.) |
| BENZNIDAZOLE ORAL TABLET 12.5 MG | 2 | QL (720 tablets per 720 days.) |
| *bis subcit-metronid-tetracyc oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *dapsone external gel 5 %, 7.5 %* | 3 | QL (60 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dapsone oral tablet 100 mg, 25 mg* | 2 | |
| IMPAVIDO ORAL CAPSULE 50 MG (*miltefosine*) | 2 | QL (84 capsules per course of therapy.) |
| LAMPIT ORAL TABLET 120 MG (*nifurtimox*) | 3 | QL (7.5 tablets per day.) |
| LAMPIT ORAL TABLET 30 MG (*nifurtimox*) | 3 | QL (9 tablets per day.) |
| LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*) | 3 | |
| *metronidazole oral capsule 375 mg* | 1 | |
| *metronidazole oral tablet 250 mg, 500 mg* | 1 | |
| NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (*pentamidine isethionate*) | 3 | |
| *nitazoxanide oral tablet 500 mg* | 2 | QL (6 tablets per prescription.) |
| *pentamidine isethionate inhalation solution reconstituted 300 mg* | 2 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*) | 3 | QL (120 capsules per 180 days.) |
| SOLOSEC ORAL PACKET 2 GM (*secnidazole*) | 3 | ST; QL (1 packet per prescription.) |
| *sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml* | 1 | |
| *sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg* | 1 | |
| *sulfatrim pediatric oral suspension 200-40 mg/5ml* | 1 | |
| *tinidazole oral tablet 250 mg, 500 mg* | 3 | |
| **ANTIPROTOZOALS,NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat** | | |
| *tinidazole oral tablet 250 mg, 500 mg* | 3 | |
| **ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections** | | |
| SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (*lenacapavir sodium*) | 4 | QL (5 tablets per 365 days.) |
| **ANTITUBERCULOSIS AGENTS - Antibiotics** | | |
| CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (*ciprofloxacin*) | 3 | |
| CIPRO ORAL TABLET 250 MG, 500 MG (*ciprofloxacin hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg* | 1 | |
| *clarithromycin er oral tablet extended release 24 hour 500 mg* | 2 | |
| *clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 2 | |
| *clarithromycin oral tablet 250 mg, 500 mg* | 1 | |
| *cycloserine oral capsule 250 mg* | 1 | |
| *ethambutol hcl oral tablet 100 mg, 400 mg* | 1 | |
| *isoniazid oral syrup 50 mg/5ml* | 1 | |
| *isoniazid oral tablet 100 mg, 300 mg* | 1 | |
| *levofloxacin oral solution 25 mg/ml* | 1 | |
| *levofloxacin oral tablet 250 mg, 500 mg, 750 mg* | 1 | |
| *moxifloxacin hcl oral tablet 400 mg* | 3 | |
| PRETOMANID ORAL TABLET 200 MG | 3 | |
| PRIFTIN ORAL TABLET 150 MG (*rifapentine*) | 2 | |
| *pyrazinamide oral tablet 500 mg* | 1 | |
| *rifabutin oral capsule 150 mg* | 1 | |
| *rifampin oral capsule 150 mg, 300 mg* | 1 | |
| RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (*rifampin*) | 3 | PA |
| SIRTURO ORAL TABLET 100 MG, 20 MG (*bedaquiline fumarate*) | 2 | |
| **ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections** | | |
| LIVTENCITY ORAL TABLET 200 MG (*maribavir*) | 3 | PA; QL (4 tablets per day.); SP |
| PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*) | 2 | SM |
| PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (*nirmatrelvir-ritonavir*) | 2 | |
| PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*) | 2 | SM |
| PREVYMIS ORAL PACKET 120 MG, 20 MG (*letermovir*) | 2 | PA |
| PREVYMIS ORAL TABLET 240 MG, 480 MG (*letermovir*) | 2 | PA |
| TPOXX ORAL CAPSULE 200 MG (*tecovirimat*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (*baloxavir marboxil*) | 3 | QL (1 tablet per month.) |
| XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (*baloxavir marboxil*) | 3 | QL (1 tablet per month.) |
| **AZOLE ANTIFUNGALS - Drugs for Fungus** | | |
| CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (*isavuconazonium sulfate*) | 3 | |
| *fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml* | 1 | |
| *fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg* | 1 | |
| *itraconazole oral capsule 100 mg* | 1 | QL (180 capsules per 365 days) |
| *itraconazole oral solution 10 mg/ml* | 2 | QL (1800 ml per 365 days) |
| *ketoconazole external cream 2 %* | 1 | QL (30 grams per prescription.) |
| *ketoconazole external foam 2 %* | 3 | ST |
| *ketoconazole external shampoo 2 %* | 1 | |
| *ketoconazole oral tablet 200 mg* | 1 | |
| *ketodan external foam 2 %* | 3 | ST |
| NOXAFIL ORAL PACKET 300 MG (*posaconazole*) | 2 | |
| *posaconazole oral suspension 40 mg/ml* | 2 | |
| *posaconazole oral tablet delayed release 100 mg* | 2 | |
| SPORANOX ORAL CAPSULE 100 MG (*itraconazole*) | 3 | QL (180 capsules per 365 days) |
| VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*voriconazole*) | 3 | |
| VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (*oteseconazole*) | 3 | PA; QL (18 capsules per 84 days.) |
| *voriconazole oral suspension reconstituted 40 mg/ml* | 1 | |
| *voriconazole oral tablet 200 mg* | 1 | QL (62 tablets per prescription.) |
| *voriconazole oral tablet 50 mg* | 1 | QL (124 tablets per prescription) |
| **BACITRACIN ANTIBIOTICS - Antibiotics** | | |
| *bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %* | 1 | |
| **CORONAVIRUS (COVID-19) - Drugs for Viral Infections** | | |
| PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*) | 2 | SM |
| PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (*nirmatrelvir-ritonavir*) | 2 | |
| PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*) | 2 | SM |
| **ENDONUCLEASE INHIBITORS - Drugs for Viral Infections** | | |
| XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (*baloxavir marboxil*) | 3 | QL (1 tablet per month.) |
| XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (*baloxavir marboxil*) | 3 | QL (1 tablet per month.) |
| **ENTRY INHIBITORS - Drugs for Viral Infections** | | |
| HEPCLUDEX SUBCUTANEOUS SOLUTION RECONSTITUTED 8.5 MG (*bulevirtide acetate-gmod*) | 4 | PA; QL (30 vials per month.); SP; CM |
| **ERYTHROMYCIN ANTIBIOTICS - Antibiotics** | | |
| E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*) | 3 | |
| ERY EXTERNAL PAD 2 % | 3 | |
| ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (*erythromycin ethylsuccinate*) | 3 | |
| *erythromycin base oral capsule delayed release particles 250 mg* | 1 | |
| *erythromycin base oral tablet 250 mg, 500 mg* | 1 | |
| *erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg* | 3 | |
| *erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml* | 1 | |
| *erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml* | 3 | |
| *erythromycin external gel 2 %* | 1 | |
| *erythromycin external solution 2 %* | 1 | |
| *erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **GLYCOPEPTIDE ANTIBIOTICS - Antibiotics** | | |
| FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (*vancomycin hcl*) | 3 | |
| VANCOCIN ORAL CAPSULE 125 MG, 250 MG (*vancomycin hcl*) | 3 | |
| *vancomycin hcl oral capsule 125 mg, 250 mg* | 1 | |
| *vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml* | 1 | |
| VANCOMYCIN+SYRSPEND SF ORAL SUSPENSION 50 MG/ML (*vancomycin hcl*) | 3 | PA |
| **HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| EPCLUSA ORAL PACKET 150-37.5 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (2 packets per day and 84 packets per 720 days.); SP |
| EPCLUSA ORAL PACKET 200-50 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (1 packet per day and 84 packets per 720 days.); SP |
| EPCLUSA ORAL TABLET 200-50 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (1 tablet per day.); SP |
| EPCLUSA ORAL TABLET 400-100 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (84 tablets per 720 days.); SP |
| HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.) |
| HARVONI ORAL TABLET 45-200 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (84 tablets per 720 days.) |
| HARVONI ORAL TABLET 90-400 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (1 tablet per day and 28 tablets per month.) |
| LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG | 2 | PA; ST; QL (1 tablet per day and 28 tablets per month.) |
| SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG | 2 | PA; QL (84 tablets per 720 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SOVALDI ORAL PACKET 150 MG, 200 MG (*sofosbuvir*) | 4 | PA; ST; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.); SP |
| SOVALDI ORAL TABLET 200 MG (*sofosbuvir*) | 4 | PA; ST; QL (84 tablets per 720 days.) |
| SOVALDI ORAL TABLET 400 MG (*sofosbuvir*) | 4 | PA; ST; QL (84 tablets per 720 days.); SP |
| VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*) | 2 | PA; QL (84 tablets per 720 days.); SP |
| **HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| MAVYRET ORAL PACKET 50-20 MG (*glecaprevir-pibrentasvir*) | 2 | PA; QL (5 packets per day and 280 packets per 720 days.); SP |
| MAVYRET ORAL TABLET 100-40 MG (*glecaprevir-pibrentasvir*) | 2 | PA; QL (168 tablets per 720 days.); SP |
| VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*) | 2 | PA; QL (84 tablets per 720 days.); SP |
| **HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections** | | |
| EPCLUSA ORAL PACKET 150-37.5 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (2 packets per day and 84 packets per 720 days.); SP |
| EPCLUSA ORAL PACKET 200-50 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (1 packet per day and 84 packets per 720 days.); SP |
| EPCLUSA ORAL TABLET 200-50 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (1 tablet per day.); SP |
| EPCLUSA ORAL TABLET 400-100 MG (*sofosbuvir-velpatasvir*) | 2 | PA; QL (84 tablets per 720 days.); SP |
| HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.) |
| HARVONI ORAL TABLET 45-200 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (84 tablets per 720 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| HARVONI ORAL TABLET 90-400 MG (*ledipasvir-sofosbuvir*) | 2 | PA; ST; QL (1 tablet per day and 28 tablets per month.) |
| LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG | 2 | PA; ST; QL (1 tablet per day and 28 tablets per month.) |
| MAVYRET ORAL PACKET 50-20 MG (*glecaprevir-pibrentasvir*) | 2 | PA; QL (5 packets per day and 280 packets per 720 days.); SP |
| MAVYRET ORAL TABLET 100-40 MG (*glecaprevir-pibrentasvir*) | 2 | PA; QL (168 tablets per 720 days.); SP |
| SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG | 2 | PA; QL (84 tablets per 720 days.); SP |
| VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*) | 2 | PA; QL (84 tablets per 720 days.); SP |
| **HIV CAPSID INHIBITORS - Drugs for Viral Infections** | | |
| SUNLENCA ORAL TABLET 300 MG (*lenacapavir sodium*) | 4 | QL (24 tablets per year.); H |
| SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (*lenacapavir sodium*) | 4 | QL (5 tablets per 365 days.) |
| YEZTUGO ORAL TABLET 300 MG (*lenacapavir sodium*) | 3 | QL (4 tablets per year.); H |
| **HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections** | | |
| *maraviroc oral tablet 150 mg, 300 mg* | 2 | |
| RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (*fostemsavir tromethamine*) | 3 | |
| SELZENTRY ORAL TABLET 150 MG, 300 MG (*maraviroc*) | 3 | |
| **HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections** | | |
| BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (*bictegravir-emtricitab-tenofov*) | 3 | QL (1 tablet per day.) |
| DOVATO ORAL TABLET 50-300 MG (*dolutegravir-lamivudine*) | 2 | QL (1 tablet per day.) |
| GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*) | 2 | QL (1 tablet per day.) |
| ISENTRESS HD ORAL TABLET 600 MG (*raltegravir potassium*) | 2 | |
| ISENTRESS ORAL PACKET 100 MG (*raltegravir potassium*) | 2 | |
| ISENTRESS ORAL TABLET 400 MG (*raltegravir potassium*) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (*raltegravir potassium*) | 2 | |
| JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*) | 2 | QL (1 tablet per day.) |
| STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*) | 2 | QL (1 tablet per day.) |
| TIVICAY ORAL TABLET 50 MG (*dolutegravir sodium*) | 3 | |
| TIVICAY PD ORAL TABLET SOLUBLE 5 MG (*dolutegravir sodium*) | 3 | |
| TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*) | 2 | QL (1 tablet per day.) |
| TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG | 2 | QL (6 tablets per day.) |
| VOCABRIA ORAL TABLET 30 MG (*cabotegravir sodium*) | 3 | |
| **HIV NONNUCLEOSIDE REV.TRANSCRIP. INHIB. - Drugs for Viral Infections** | | |
| BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (*bictegravir-emtricitab-tenofov*) | 3 | QL (1 tablet per day.) |
| COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*) | 3 | QL (1 tablet per day.) |
| DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*) | 2 | QL (1 tablet per day.) |
| EDURANT ORAL TABLET 25 MG (*rilpivirine hcl*) | 2 | |
| EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (*rilpivirine hcl*) | 2 | |
| *efavirenz oral tablet 600 mg* | 1 | |
| *efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg* | 2 | QL (1 tablet per day.) |
| *efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg* | 2 | QL (1 tablet per day.) |
| *emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg* | 3 | QL (1 tablet per day.) |
| *etravirine oral tablet 100 mg, 200 mg* | 2 | |
| IDVYNSO ORAL TABLET 100-0.25 MG (*doravirine-islatravir*) | 3 | QL (30 tablets per month.) |
| INTELENCE ORAL TABLET 100 MG, 200 MG (*etravirine*) | 3 | |
| INTELENCE ORAL TABLET 25 MG (*etravirine*) | 2 | |
| JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*) | 2 | QL (1 tablet per day.) |
| *methocarbamol oral tablet 500 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *nevirapine er oral tablet extended release 24 hour 400 mg* | 2 | |
| *nevirapine oral suspension 50 mg/5ml* | 1 | |
| *nevirapine oral tablet 200 mg* | 1 | |
| ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*) | 3 | QL (1 tablet per day.) |
| PIFELTRO ORAL TABLET 100 MG (*doravirine*) | 3 | |
| *rilpivirine hcl oral tablet 25 mg* | 2 | |
| SYMFI ORAL TABLET 600-300-300 MG (*efavirenz-lamivudine-tenofovir*) | 2 | QL (1 tablet per day.) |
| **HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections** | | |
| *abacavir sulfate oral solution 20 mg/ml* | 1 | |
| *abacavir sulfate oral tablet 300 mg* | 1 | |
| *abacavir sulfate-lamivudine oral tablet 600-300 mg* | 1 | |
| BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (*bictegravir-emtricitab-tenofov*) | 3 | QL (1 tablet per day.) |
| CIMDUO ORAL TABLET 300-300 MG (*lamivudine-tenofovir*) | 2 | QL (1 tablet per day.) |
| COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*) | 3 | QL (1 tablet per day.) |
| DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*) | 2 | QL (1 tablet per day.) |
| DESCOVY ORAL TABLET 120-15 MG (*emtricitabine-tenofovir af*) | 3 | QL (1 tablet per day.) |
| DESCOVY ORAL TABLET 200-25 MG (*emtricitabine-tenofovir af*) | 3 | QL (1 tablet per day.); H |
| DOVATO ORAL TABLET 50-300 MG (*dolutegravir-lamivudine*) | 2 | QL (1 tablet per day.) |
| *efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg* | 2 | QL (1 tablet per day.) |
| *efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg* | 2 | QL (1 tablet per day.) |
| *emtricitabine oral capsule 200 mg* | 2 | |
| *emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg* | 1 | QL (1 tablet per day.) |
| *emtricitabine-tenofovir df oral tablet 200-300 mg* | 1 | QL (1 tablet per day.); H |
| *emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg* | 3 | QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| EMTRIVA ORAL CAPSULE 200 MG (*emtricitabine*) | 3 | |
| EMTRIVA ORAL SOLUTION 10 MG/ML (*emtricitabine*) | 2 | |
| EPIVIR ORAL SOLUTION 10 MG/ML (*lamivudine*) | 3 | |
| EPIVIR ORAL TABLET 150 MG, 300 MG (*lamivudine*) | 3 | |
| GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*) | 2 | QL (1 tablet per day.) |
| IDVYNSO ORAL TABLET 100-0.25 MG (*doravirine-islatravir*) | 3 | QL (30 tablets per month.) |
| *lamivudine oral solution 10 mg/ml* | 1 | |
| *lamivudine oral tablet 100 mg, 150 mg, 300 mg* | 1 | |
| *lamivudine-zidovudine oral tablet 150-300 mg* | 1 | |
| ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*) | 3 | QL (1 tablet per day.) |
| RETROVIR ORAL CAPSULE 100 MG (*zidovudine*) | 3 | |
| RETROVIR ORAL SYRUP 50 MG/5ML (*zidovudine*) | 3 | |
| STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*) | 2 | QL (1 tablet per day.) |
| SYMFI ORAL TABLET 600-300-300 MG (*efavirenz-lamivudine-tenofovir*) | 2 | QL (1 tablet per day.) |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*) | 3 | QL (1 tablet per day.) |
| *tenofovir disoproxil fumarate oral tablet 300 mg* | 1 | H |
| TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*) | 2 | QL (1 tablet per day.) |
| TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG | 2 | QL (6 tablets per day.) |
| TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (*emtricitabine-tenofovir df*) | 4 | QL (1 tablet per day.) |
| VIREAD ORAL POWDER 40 MG/GM (*tenofovir disoproxil fumarate*) | 3 | |
| VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (*tenofovir disoproxil fumarate*) | 2 | |
| ZIAGEN ORAL SOLUTION 20 MG/ML (*abacavir sulfate*) | 3 | |
| *zidovudine oral capsule 100 mg* | 1 | |
| *zidovudine oral syrup 50 mg/5ml* | 1 | |
| *zidovudine oral tablet 300 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections** | | |
| APTIVUS ORAL CAPSULE 250 MG (*tipranavir*) | 2 | |
| *atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg* | 2 | |
| *darunavir oral tablet 600 mg, 800 mg* | 1 | |
| EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*) | 2 | |
| *fosamprenavir calcium oral tablet 700 mg* | 2 | |
| KALETRA ORAL SOLUTION 400-100 MG/5ML (*lopinavir-ritonavir*) | 3 | |
| KALETRA ORAL TABLET 100-25 MG, 200-50 MG (*lopinavir-ritonavir*) | 3 | |
| *lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg* | 2 | |
| NORVIR ORAL PACKET 100 MG (*ritonavir*) | 2 | |
| PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (*darunavir-cobicistat*) | 2 | |
| PREZISTA ORAL SUSPENSION 100 MG/ML (*darunavir*) | 2 | |
| PREZISTA ORAL TABLET 150 MG, 75 MG (*darunavir*) | 2 | |
| REYATAZ ORAL PACKET 50 MG (*atazanavir sulfate*) | 2 | |
| *ritonavir oral tablet 100 mg* | 1 | |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*) | 3 | QL (1 tablet per day.) |
| VIRACEPT ORAL TABLET 250 MG, 625 MG (*nelfinavir mesylate*) | 2 | |
| **INTERFERON ANTIVIRALS - Drugs for Viral Infections** | | |
| BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; SP; CM |
| BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; QL (0.08 ml per day.); SP; CM |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*) | 2 | SP |
| PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*) | 2 | SP |
| **LINCOMYCIN ANTIBIOTICS - Antibiotics** | | |
| CLEOCIN ORAL CAPSULE 150 MG, 300 MG (*clindamycin hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CLEOCIN ORAL CAPSULE 75 MG (*clindamycin hcl*) | 2 | |
| CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (*clindamycin palmitate hcl*) | 3 | |
| CLEOCIN VAGINAL CREAM 2 % (*clindamycin phosphate*) | 3 | |
| CLEOCIN VAGINAL SUPPOSITORY 100 MG (*clindamycin phosphate*) | 2 | |
| CLEOCIN-T EXTERNAL LOTION 1 % (*clindamycin phosphate*) | 3 | |
| *clindacin etz external swab 1 %* | 1 | |
| *clindacin external foam 1 %* | 3 | |
| *clindacin-p external swab 1 %* | 1 | |
| *clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg* | 1 | |
| *clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml* | 2 | |
| *clindamycin phos (twice-daily) external gel 1 %* | 2 | QL (75 grams per prescription.) |
| *clindamycin phos-benzoyl perox external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| *clindamycin phosphate external foam 1 %* | 3 | |
| *clindamycin phosphate external lotion 1 %* | 3 | |
| *clindamycin phosphate external solution 1 %* | 1 | |
| *clindamycin phosphate external swab 1 %* | 1 | |
| *clindamycin phosphate vaginal cream 2 %* | 2 | |
| CLINDESSE VAGINAL CREAM 2 % (*clindamycin phosphate (1 dose)*) | 2 | |
| *neuac external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| XACIATO VAGINAL GEL 2 % (*clindamycin phosphate*) | 2 | QL (1 gel tube (8 grams) per prescription.) |
| **MONOBACTAM ANTIBIOTICS - Antibiotics** | | |
| CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (*aztreonam lysine*) | 4 | PA; ST; QL (84 vials per 56 days.); SP |
| **MONOCLONAL ANTIBODIES (08:18) - Drugs for Viral Infections** | | |
| BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (*nirsevimab-alip*) | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ENFLONSIA INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 105 MG/0.7ML (*clesrovimab-cfor*) | 3 | H |
| **NATURAL PENICILLIN ANTIBIOTICS - Antibiotics** | | |
| *penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml* | 1 | |
| *penicillin v potassium oral tablet 250 mg, 500 mg* | 1 | |
| **NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections** | | |
| *oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg* | 2 | |
| *oseltamivir phosphate oral suspension reconstituted 6 mg/ml* | 2 | |
| RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (*zanamivir*) | 3 | |
| **NITROIMIDAZOLE DERIVATIVE, ANTI-LEISHMAL - Drugs for the Mouth and Throat** | | |
| IMPAVIDO ORAL CAPSULE 50 MG (*miltefosine*) | 2 | QL (84 capsules per course of therapy.) |
| **NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL - Drugs for the Mouth and Throat** | | |
| BENZNIDAZOLE ORAL TABLET 100 MG | 2 | QL (240 tablets per 720 days.) |
| BENZNIDAZOLE ORAL TABLET 12.5 MG | 2 | QL (720 tablets per 720 days.) |
| **NITROIMIDAZOLE DERIVATIVES, MISC - Drugs for the Mouth and Throat** | | |
| LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*) | 3 | |
| *metronidazole external cream 0.75 %* | 1 | |
| *metronidazole external gel 0.75 %* | 1 | |
| *metronidazole external lotion 0.75 %* | 1 | |
| *metronidazole oral capsule 375 mg* | 1 | |
| *metronidazole oral tablet 250 mg, 500 mg* | 1 | |
| *metronidazole vaginal gel 0.75 %* | 2 | |
| VANDAZOLE VAGINAL GEL 0.75 % (*metronidazole*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections** | | |
| *acyclovir external ointment 5 %* | 3 | |
| *acyclovir oral capsule 200 mg* | 1 | |
| *acyclovir oral suspension 200 mg/5ml* | 1 | |
| *acyclovir oral tablet 400 mg, 800 mg* | 1 | |
| *adefovir dipivoxil oral tablet 10 mg* | 2 | |
| BARACLUDE ORAL SOLUTION 0.05 MG/ML (*entecavir*) | 2 | |
| COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*) | 3 | QL (1 tablet per day.) |
| DESCOVY ORAL TABLET 120-15 MG (*emtricitabine-tenofovir af*) | 3 | QL (1 tablet per day.) |
| DESCOVY ORAL TABLET 200-25 MG (*emtricitabine-tenofovir af*) | 3 | QL (1 tablet per day.); H |
| *emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg* | 1 | QL (1 tablet per day.) |
| *emtricitabine-tenofovir df oral tablet 200-300 mg* | 1 | QL (1 tablet per day.); H |
| *emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg* | 3 | QL (1 tablet per day.) |
| *entecavir oral tablet 0.5 mg, 1 mg* | 1 | |
| *famciclovir oral tablet 125 mg, 250 mg, 500 mg* | 2 | |
| LAGEVRIO ORAL CAPSULE 200 MG (*molnupiravir*) | 2 | SM |
| ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*) | 3 | QL (1 tablet per day.) |
| *ribavirin oral capsule 200 mg* | 1 | |
| *ribavirin oral tablet 200 mg* | 1 | |
| TEMBEXA ORAL SUSPENSION 10 MG/ML (*brincidofovir*) | 3 | |
| TEMBEXA ORAL TABLET 100 MG (*brincidofovir*) | 3 | |
| TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (*emtricitabine-tenofovir df*) | 4 | QL (1 tablet per day.) |
| *valacyclovir hcl oral tablet 1 gm* | 1 | QL (31 tablets per prescription) |
| *valacyclovir hcl oral tablet 500 mg* | 1 | |
| *valganciclovir hcl oral solution reconstituted 50 mg/ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *valganciclovir hcl oral tablet 450 mg* | 1 | |
| VEMLIDY ORAL TABLET 25 MG (*tenofovir alafenamide fumarate*) | 3 | PA |
| ZIRGAN OPHTHALMIC GEL 0.15 % (*ganciclovir*) | 3 | |
| **OTHER MACROLIDE ANTIBIOTICS - Antibiotics** | | |
| *azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml* | 1 | |
| *azithromycin oral tablet 250 mg, 500 mg, 600 mg* | 1 | |
| *clarithromycin er oral tablet extended release 24 hour 500 mg* | 2 | |
| *clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 2 | |
| *clarithromycin oral tablet 250 mg, 500 mg* | 1 | |
| DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fidaxomicin*) | 3 | QL (136 mL per 10 days.) |
| *fidaxomicin oral tablet 200 mg* | 3 | QL (20 tablets per 7 days) |
| VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (*amoxicill-clarithro-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*azithromycin*) | 3 | |
| ZITHROMAX ORAL TABLET 250 MG, 500 MG (*azithromycin*) | 3 | |
| ZITHROMAX TRI-PAK ORAL TABLET 500 MG (*azithromycin*) | 3 | |
| ZITHROMAX Z-PAK ORAL TABLET 250 MG (*azithromycin*) | 3 | |
| **OTHER MACROLIDES (8:12.12.92) - Antibiotics** | | |
| *azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml* | 1 | |
| *azithromycin oral tablet 250 mg, 500 mg, 600 mg* | 1 | |
| *clarithromycin er oral tablet extended release 24 hour 500 mg* | 2 | |
| *clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 2 | |
| *clarithromycin oral tablet 250 mg, 500 mg* | 1 | |
| DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fidaxomicin*) | 3 | QL (136 mL per 10 days.) |
| *fidaxomicin oral tablet 200 mg* | 3 | QL (20 tablets per 7 days) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (*amoxicill-clarithro-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*azithromycin*) | 3 | |
| ZITHROMAX ORAL TABLET 250 MG, 500 MG (*azithromycin*) | 3 | |
| ZITHROMAX TRI-PAK ORAL TABLET 500 MG (*azithromycin*) | 3 | |
| ZITHROMAX Z-PAK ORAL TABLET 250 MG (*azithromycin*) | 3 | |
| **OXAZOLIDINONE ANTIBIOTICS - Antibiotics** | | |
| *linezolid oral suspension reconstituted 100 mg/5ml* | 2 | |
| *linezolid oral tablet 600 mg* | 2 | |
| SIVEXTRO ORAL TABLET 200 MG (*tedizolid phosphate*) | 3 | QL (6 tablets per prescription.) |
| **PENICILLINASE-RESISTANT PENICILLINS - Antibiotics** | | |
| *dicloxacillin sodium oral capsule 250 mg, 500 mg* | 1 | |
| **POLYENE ANTIFUNGALS - Drugs for Fungus** | | |
| *klayesta external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |
| *nystatin external cream 100000 unit/gm* | 1 | QL (90 grams per prescription.) |
| *nystatin external ointment 100000 unit/gm* | 1 | QL (90 grams per prescription.) |
| *nystatin external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |
| *nystatin mouth/throat suspension 100000 unit/ml* | 1 | |
| *nystatin oral tablet 500000 unit* | 1 | |
| *nystatin-triamcinolone external cream 100000-0.1 unit/gm-%* | 2 | |
| *nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%* | 2 | |
| *nystop external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |
| **POLYMYXIN ANTIBIOTICS - Antibiotics** | | |
| *colistimethate sodium (cba) injection solution reconstituted 150 mg* | 1 | |
| COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (*colistimethate sodium*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%* | 1 | |
| **PYRIMIDINE ANTIFUNGALS - Drugs for Fungus** | | |
| ANCOBON ORAL CAPSULE 250 MG, 500 MG (*flucytosine*) | 3 | |
| *flucytosine oral capsule 250 mg, 500 mg* | 1 | |
| **QUINOLONE ANTIBIOTICS - Antibiotics** | | |
| BAXDELA ORAL TABLET 450 MG (*delafloxacin meglumine*) | 3 | |
| CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (*ciprofloxacin*) | 3 | |
| CIPRO ORAL TABLET 250 MG, 500 MG (*ciprofloxacin hcl*) | 3 | |
| *ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg* | 1 | |
| *levofloxacin ophthalmic solution 0.5 %, 1.5 %* | 1 | |
| *levofloxacin oral solution 25 mg/ml* | 1 | |
| *levofloxacin oral tablet 250 mg, 500 mg, 750 mg* | 1 | |
| *moxifloxacin hcl (2x day) ophthalmic solution 0.5 %* | 3 | |
| *moxifloxacin hcl ophthalmic solution 0.5 %* | 3 | |
| *moxifloxacin hcl oral tablet 400 mg* | 3 | |
| OCUFLOX OPHTHALMIC SOLUTION 0.3 % (*ofloxacin*) | 3 | |
| *ofloxacin ophthalmic solution 0.3 %* | 1 | |
| *ofloxacin oral tablet 300 mg, 400 mg* | 1 | |
| *ofloxacin otic solution 0.3 %* | 2 | |
| **RIFAMYCIN ANTIBIOTICS - Antibiotics** | | |
| PRIFTIN ORAL TABLET 150 MG (*rifapentine*) | 2 | |
| *rifabutin oral capsule 150 mg* | 1 | |
| *rifampin oral capsule 150 mg, 300 mg* | 1 | |
| RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (*rifampin*) | 3 | PA |
| XIFAXAN ORAL TABLET 200 MG (*rifaximin*) | 3 | PA; QL (9 tablets per prescription) |
| XIFAXAN ORAL TABLET 550 MG (*rifaximin*) | 3 | PA; QL (62 tablets per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **SULFONAMIDES - Antibiotics** | | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*) | 3 | |
| BACTRIM DS ORAL TABLET 800-160 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| BACTRIM ORAL TABLET 400-80 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| *sulfadiazine oral tablet 500 mg* | 1 | |
| *sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml* | 1 | |
| *sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg* | 1 | |
| *sulfasalazine oral tablet 500 mg* | 1 | |
| *sulfasalazine oral tablet delayed release 500 mg* | 1 | |
| *sulfatrim pediatric oral suspension 200-40 mg/5ml* | 1 | |
| **TETRACYCLINE ANTIBIOTICS - Antibiotics** | | |
| AMZEEQ EXTERNAL FOAM 4 % (*minocycline hcl micronized*) | 3 | QL (30 grams per prescription.) |
| AVIDOXY DK COMBINATION KIT 100 MG (*doxycycline-suncreen-sal acid*) | 3 | |
| AVIDOXY ORAL TABLET 100 MG | 3 | |
| *bis subcit-metronid-tetracyc oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *demeclocycline hcl oral tablet 150 mg, 300 mg* | 1 | |
| *doxycycline hyclate oral capsule 100 mg, 50 mg* | 2 | |
| *doxycycline hyclate oral tablet 100 mg* | 2 | |
| *doxycycline hyclate oral tablet 20 mg* | 1 | |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | 1 | |
| *doxycycline monohydrate oral suspension reconstituted 25 mg/5ml* | 3 | |
| *doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg* | 2 | |
| *minocycline hcl oral capsule 100 mg, 50 mg, 75 mg* | 1 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*) | 3 | QL (120 capsules per 180 days.) |
| *tetracycline hcl oral capsule 250 mg, 500 mg* | 3 | |
| ZILXI EXTERNAL FOAM 1.5 % (*minocycline hcl micronized*) | 3 | PA; ST; QL (30 grams per prescription.) |
| **TRIAZAACENAPHTHYLENES - Antibiotics** | | |
| BLUJEPA ORAL TABLET 750 MG (*gepotidacin mesylate*) | 4 | QL (20 tablets per course of therapy.) |
| **URINARY ANTI-INFECTIVES - Drugs for the Urinary System** | | |
| BACTRIM DS ORAL TABLET 800-160 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| BACTRIM ORAL TABLET 400-80 MG (*sulfamethoxazole-trimethoprim*) | 3 | |
| *fosfomycin tromethamine oral packet 3 gm* | 3 | |
| MACROBID ORAL CAPSULE 100 MG (*nitrofurantoin monohyd macro*) | 3 | |
| *me/naphos/mb/hyo1 oral tablet 81.6 mg* | 1 | |
| *methenamine hippurate oral tablet 1 gm* | 1 | |
| *methenamine mandelate oral tablet 0.5 gm, 1 gm* | 1 | |
| *nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *nitrofurantoin monohydrate macrocrystals oral capsule 100 mg* | 1 | |
| *nitrofurantoin oral suspension 25 mg/5ml* | 3 | |
| ORLYNVAH ORAL TABLET 500-500 MG (*sulopenem etzadrox-probenecid*) | 4 | QL (10 tablets per course of therapy.) |
| *sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml* | 1 | |
| *sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg* | 1 | |
| *sulfatrim pediatric oral suspension 200-40 mg/5ml* | 1 | |
| *trimethoprim oral tablet 100 mg* | 1 | |
| URELLE ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *uretron d/s oral tablet 81.6 mg* | 1 | |
| UROGESIC-BLUE ORAL TABLET 81.6 MG (*methen-hyosc-meth blue-na phos*) | 2 | |
| VILEVEV MB ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| **ANTINEOPLASTIC AGENTS - Drugs for Cancer** | | |
| **ANTINEOPLASTIC AGENTS - Drugs for Cancer** | | |
| *abiraterone acetate oral tablet 250 mg* | 2 | QL (4 tablets per day.); SP; CM |
| *abirtega oral tablet 250 mg* | 2 | QL (4 tablets per day.); SP; CM |
| AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (*niraparib-abiraterone acetate*) | 4 | PA; ST; QL (2 tablets per day.); SP; CM |
| ALECENSA ORAL CAPSULE 150 MG (*alectinib hcl*) | 2 | PA; QL (8 capsules per day.); SP; CM |
| ALUNBRIG ORAL TABLET 180 MG, 90 MG (*brigatinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| ALUNBRIG ORAL TABLET 30 MG (*brigatinib*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (*brigatinib*) | 2 | PA; QL (30 packs per year.); SP; CM |
| *anastrozole oral tablet 1 mg* | 1 | H-N |
| AUGTYRO ORAL CAPSULE 160 MG (*repotrectinib*) | 2 | PA; QL (60 capsules per month.); SP; CM |
| AUGTYRO ORAL CAPSULE 40 MG (*repotrectinib*) | 2 | PA; QL (8 capsules per day.); SP; CM |
| AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (*avutometinib-defactinib*) | 4 | PA; QL (66 capsules/tablets per month.); SP; CM |
| AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (*avapritinib*) | 3 | PA; QL (1 tablet per day.); SP; CM |
| BALVERSA ORAL TABLET 3 MG (*erdafitinib*) | 4 | PA; QL (3 tablets per day.); SP; CM |
| BALVERSA ORAL TABLET 4 MG (*erdafitinib*) | 4 | PA; QL (2 tablets per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BALVERSA ORAL TABLET 5 MG (*erdafitinib*) | 4 | PA; QL (1 tablet per day.); SP; CM |
| BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; SP; CM |
| BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; QL (0.08 ml per day.); SP; CM |
| *bexarotene external gel 1 %* | 4 | QL (60 grams per prescription.); SP |
| *bexarotene oral capsule 75 mg* | 2 | CM |
| *bicalutamide oral tablet 50 mg* | 1 | CM |
| BOSULIF ORAL CAPSULE 100 MG (*bosutinib*) | 4 | PA; ST; QL (3 Capsules per day.); SP; CM |
| BOSULIF ORAL CAPSULE 50 MG (*bosutinib*) | 4 | PA; ST; QL (1 Capsule per day.); SP; CM |
| BOSULIF ORAL TABLET 100 MG (*bosutinib*) | 4 | PA; ST; QL (4 tablets per day.); SP; CM |
| BOSULIF ORAL TABLET 400 MG, 500 MG (*bosutinib*) | 4 | PA; ST; QL (1 tablet per day.); SP; CM |
| *bosutinib oral tablet 100 mg* | 2 | PA; ST; QL (4 tablets per day.); SP; CM |
| *bosutinib oral tablet 400 mg, 500 mg* | 2 | PA; ST; QL (1 tablet per day.); SP; CM |
| BRAFTOVI ORAL CAPSULE 75 MG (*encorafenib*) | 3 | PA; ST; QL (6 capsules per day.); SP; CM |
| BRUKINSA ORAL CAPSULE 80 MG (*zanubrutinib*) | 3 | PA; ST; QL (60 capsules per month.); SP; CM |
| BRUKINSA ORAL TABLET 160 MG (*zanubrutinib*) | 4 | PA; ST; QL (60 tablets per month.); SP; CM |
| CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (*cabozantinib s-malate*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| CALQUENCE ORAL TABLET 100 MG (*acalabrutinib maleate*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| *capecitabine oral tablet 150 mg, 500 mg* | 1 | SP; CM |
| CAPRELSA ORAL TABLET 100 MG (*vandetanib*) | 2 | PA; QL (2 tablets per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CAPRELSA ORAL TABLET 300 MG (*vandetanib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| *cladribine (10 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (4 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (5 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (6 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (7 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (8 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (9 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| COMETRIQ ORAL KIT 20 MG (*cabozantinib s-malate*) | 2 | PA; QL (93 capsules per month.); SP; CM |
| COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (*cabozantinib s-malate*) | 2 | PA; QL (124 capsules per month.); SP; CM |
| COMETRIQ ORAL KIT 80 & 20 MG (*cabozantinib s-malate*) | 2 | PA; QL (62 capsules per month.); SP; CM |
| COPIKTRA ORAL CAPSULE 15 MG, 25 MG (*duvelisib*) | 3 | PA; QL (2 capsules per day.); SP; CM |
| COTELLIC ORAL TABLET 20 MG (*cobimetinib fumarate*) | 2 | PA; QL (63 tablets per 21 days); SP; CM |
| *cyclophosphamide oral capsule 25 mg, 50 mg* | 2 | CM |
| CYCLOPHOSPHAMIDE ORAL TABLET 50 MG | 2 | CM |
| *dasatinib tablet 100 mg oral* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *dasatinib tablet 140 mg oral* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *dasatinib tablet 20 mg oral* | 2 | PA; QL (90 tablets per month.); SP; CM |
| *dasatinib tablet 50 mg oral* | 2 | PA; QL (1 tablet per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dasatinib tablet 70 mg oral* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *dasatinib tablet 80 mg oral* | 2 | PA; QL (1 tablet per day.); SP; CM |
| DAURISMO ORAL TABLET 100 MG, 25 MG (*glasdegib maleate*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (*hydroxyurea*) | 1 | CM |
| ENSACOVE ORAL CAPSULE 100 MG, 25 MG (*ensartinib hcl*) | 2 | PA; QL (60 capsules per month.); SP; CM |
| ERIVEDGE ORAL CAPSULE 150 MG (*vismodegib*) | 2 | PA; QL (1 capsule per day.); SP; CM |
| ERLEADA ORAL TABLET 240 MG (*apalutamide*) | 2 | PA; QL (1 tablet per day.) |
| ERLEADA ORAL TABLET 60 MG (*apalutamide*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| *erlotinib hcl oral tablet 100 mg, 150 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *erlotinib hcl oral tablet 25 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *etoposide oral capsule 50 mg* | 1 | SP; CM |
| *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg* | 3 | |
| *everolimus oral tablet 10 mg, 7.5 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *everolimus oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *everolimus oral tablet soluble 2 mg, 3 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *exemestane oral tablet 25 mg* | 2 | H-N |
| FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (*degarelix acetate*) | 3 | SP |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (*degarelix acetate*) | 3 | SP |
| *fluorouracil external cream 5 %* | 1 | |
| *fluorouracil external solution 2 %, 5 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (*tivozanib hcl*) | 4 | PA; QL (0.75 capsules per day.); SP; CM |
| FRUZAQLA ORAL CAPSULE 1 MG (*fruquintinib*) | 4 | PA; ST; QL (84 capsules per 21 days.); SP; CM |
| FRUZAQLA ORAL CAPSULE 5 MG (*fruquintinib*) | 4 | PA; ST; QL (21 capsules per 21 days.); SP; CM |
| GAVRETO ORAL CAPSULE 100 MG (*pralsetinib*) | 3 | PA; QL (4 capsules per day.); SP; CM |
| *gefitinib oral tablet 250 mg* | 3 | PA; QL (2 tablets per day.); SP; CM |
| GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (*afatinib dimaleate*) | 3 | PA; QL (1 tablet per day.); SP; CM |
| GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (*lomustine*) | 2 | SP; CM |
| GOMEKLI ORAL CAPSULE 1 MG (*mirdametinib*) | 3 | PA; QL (42 capsules per 4 weeks.); SP |
| GOMEKLI ORAL CAPSULE 2 MG (*mirdametinib*) | 3 | PA; QL (84 capsules per 4 weeks.); SP |
| GOMEKLI ORAL TABLET SOLUBLE 1 MG (*mirdametinib*) | 3 | PA; QL (168 tablets per 4 weeks.) |
| HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (*melphalan hcl*) | 3 | |
| HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (*melphalan hcl*) | 3 | |
| HERNEXEOS ORAL TABLET 60 MG (*zongertinib*) | 4 | PA; QL (90 tablets per month.); SP; CM |
| HYCAMTIN ORAL CAPSULE 0.25 MG (*topotecan hcl*) | 2 | PA; QL (20 capsules per three weeks.); SP; CM |
| HYCAMTIN ORAL CAPSULE 1 MG (*topotecan hcl*) | 2 | PA; QL (30 capsules per 3 weeks.); SP; CM |
| *hydroxyurea oral capsule 500 mg* | 1 | CM |
| HYRNUO ORAL TABLET 10 MG (*sevabertinib*) | 4 | PA; QL (120 tablets per month.); SP; CM |
| IBRANCE ORAL CAPSULE 125 MG (*palbociclib*) | 4 | PA; ST; QL (21 capsules per month.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (*palbociclib*) | 4 | PA; ST; QL (0.75 tablets per day.); SP; CM |
| IBTROZI ORAL CAPSULE 200 MG (*taletrectinib adipate*) | 4 | PA; ST; QL (90 capsules per month.); SP; CM |
| ICLUSIG ORAL TABLET 15 MG, 45 MG (*ponatinib hcl*) | 3 | PA; QL (1 tablet per day.); SP; CM |
| IDHIFA ORAL TABLET 100 MG, 50 MG (*enasidenib mesylate*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| *imatinib mesylate oral tablet 400 mg* | 1 | QL (1 tablet per day.); SP; CM |
| *imatinib mesylate tablet 100 mg oral* | 1 | QL (6 tablets per day.); SP; CM |
| IMBRUVICA ORAL CAPSULE 140 MG (*ibrutinib*) | 2 | PA; QL (4 capsules per day.); SP; CM |
| IMBRUVICA ORAL CAPSULE 70 MG (*ibrutinib*) | 2 | PA; QL (1 capsule per day.); SP; CM |
| IMBRUVICA ORAL SUSPENSION 70 MG/ML (*ibrutinib*) | 2 | PA; QL (7.2 ml per day.); SP; CM |
| IMBRUVICA ORAL TABLET 420 MG (*ibrutinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| IMKELDI ORAL SOLUTION 80 MG/ML | 4 | PA; QL (280 ml (2 bottles) per month.); SP; CM |
| INLURIYO ORAL TABLET 200 MG (*imlunestrant tosylate*) | 2 | PA; QL (56 tablets per month.); SP; CM |
| INLYTA ORAL TABLET 1 MG (*axitinib*) | 3 | PA; QL (6 tablets per day.); SP; CM |
| INLYTA ORAL TABLET 5 MG (*axitinib*) | 3 | PA; QL (124 tablets per 30 days.); SP; CM |
| INQOVI ORAL TABLET 35-100 MG (*decitabine-cedazuridine*) | 3 | PA; QL (5 tablets per month.); SP; CM |
| INREBIC ORAL CAPSULE 100 MG (*fedratinib hcl*) | 3 | PA; ST; QL (4 capsules per day.); SP; CM |
| IRESSA ORAL TABLET 250 MG (*gefitinib*) | 3 | PA; QL (2 tablets per day.); SP; CM |
| ITOVEBI ORAL TABLET 3 MG (*inavolisib*) | 2 | PA; QL (56 tablets per month.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ITOVEBI ORAL TABLET 9 MG (*inavolisib*) | 2 | PA; QL (28 tablets per month.); SP; CM |
| IWILFIN ORAL TABLET 192 MG (*eflornithine hcl*) | 2 | PA; QL (8 tablets per day.); SP; CM |
| JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (*ruxolitinib phosphate*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (*ruxolitinib phosphate*) | 2 | PA; SP; CM |
| JAYPIRCA ORAL TABLET 100 MG (*pirtobrutinib*) | 3 | PA; QL (3 tablets per day.); SP; CM |
| JAYPIRCA ORAL TABLET 50 MG (*pirtobrutinib*) | 3 | PA; QL (1 tablet per day.); SP; CM |
| JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*) | 3 | PA; CM |
| KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*) | 2 | PA; QL (21 tablets per month.); SP; CM |
| KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*) | 2 | PA; QL (42 tablets per 21 days.); SP; CM |
| KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*) | 2 | PA; QL (63 tablets per 21 days.); SP; CM |
| KOMZIFTI ORAL CAPSULE 200 MG (*ziftomenib*) | 4 | PA; QL (90 capsules per month.); SP; CM |
| KOSELUGO ORAL CAPSULE 10 MG (*selumetinib sulfate*) | 3 | PA; QL (8 capsules per day.); SP; CM |
| KOSELUGO ORAL CAPSULE 25 MG (*selumetinib sulfate*) | 3 | PA; QL (4 capsules per day.); SP; CM |
| KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (*selumetinib sulfate*) | 3 | PA |
| KRAZATI ORAL TABLET 200 MG (*adagrasib*) | 4 | PA; QL (6 tablets per day.); SP; CM |
| *lapatinib ditosylate oral tablet 250 mg* | 2 | PA; QL (186 tablets per month.); SP; CM |
| LAZCLUZE ORAL TABLET 240 MG (*lazertinib mesylate*) | 4 | PA; QL (30 tablets per month.); SP; CM |
| LAZCLUZE ORAL TABLET 80 MG (*lazertinib mesylate*) | 4 | PA; QL (60 tablets per month.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg* | 2 | PA; QL (28 capsules per 21 days.); SP; CM |
| *lenalidomide oral capsule 20 mg, 25 mg* | 2 | PA; QL (21 capsules per 21 days.); SP; CM |
| LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (*lenvatinib mesylate*) | 2 | PA; QL (2 capsules per day.); SP; CM |
| LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG (*lenvatinib mesylate*) | 2 | PA; QL (3 capsules per day.); SP; CM |
| LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (*lenvatinib mesylate*) | 2 | PA; QL (1 capsule per day.); SP; CM |
| *letrozole oral tablet 2.5 mg* | 1 | H-N |
| LEUKERAN ORAL TABLET 2 MG (*chlorambucil*) | 2 | CM |
| *leuprolide acetate injection kit 1 mg/0.2ml* | 1 | PA |
| LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (1 carton (18 capsules) per 28 days.); SP; CM |
| LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (3 blister paks (18 capsules) per 28 days.); SP; CM |
| LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (9 blister paks (18 capsules) per 28 days.); SP; CM |
| LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (1 carton (27 capsules) per 28 days.); SP; CM |
| LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (3 blister paks (27 capsules) per 28 days.); SP; CM |
| LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (*relacorilant*) | 4 | PA; QL (9 blister paks (27 capsules) per 28 days.); SP; CM |
| *lomustine oral capsule 10 mg, 100 mg, 40 mg* | 2 | SP; CM |
| LONSURF ORAL TABLET 15-6.14 MG (*trifluridine-tipiracil*) | 4 | PA; QL (100 tablets per month.); SP; CM |
| LONSURF ORAL TABLET 20-8.19 MG (*trifluridine-tipiracil*) | 4 | PA; QL (80 tablets per 21 days.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LORBRENA ORAL TABLET 100 MG (*lorlatinib*) | 3 | PA; ST; QL (30 tablets per month.); SP; CM |
| LORBRENA ORAL TABLET 25 MG (*lorlatinib*) | 3 | PA; ST; QL (90 tablets per month.); SP; CM |
| LUMAKRAS ORAL TABLET 120 MG (*sotorasib*) | 4 | PA; QL (240 tablets per month.); SP; CM |
| LUMAKRAS ORAL TABLET 240 MG (*sotorasib*) | 4 | PA; QL (120 tablets per month.); SP; CM |
| LUMAKRAS ORAL TABLET 320 MG (*sotorasib*) | 4 | PA; QL (3 tablets per day.); SP; CM |
| LYNPARZA ORAL TABLET 100 MG, 150 MG (*olaparib*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| LYSODREN ORAL TABLET 500 MG (*mitotane*) | 2 | CM |
| LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*) | 3 | PA; QL (84 tablets per month.); SP; CM |
| LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*) | 3 | PA; QL (112 tablets per month.); SP; CM |
| LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*) | 3 | PA; QL (140 tablets per month.); SP; CM |
| MATULANE ORAL CAPSULE 50 MG (*procarbazine hcl*) | 2 | SP; CM |
| MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (*cladribine*) | 4 | PA; ST; QL (40 tablets per 720 days.) |
| *megestrol acetate oral suspension 40 mg/ml* | 1 | |
| *megestrol acetate oral suspension 625 mg/5ml* | 3 | |
| *megestrol acetate oral tablet 20 mg, 40 mg* | 1 | |
| MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (*trametinib dimethyl sulfoxide*) | 4 | ST; QL (17.4 ml per day.); SP; CM |
| MEKINIST ORAL TABLET 0.5 MG (*trametinib dimethyl sulfoxide*) | 4 | PA; ST; QL (2 tablets per day.); SP; CM |
| MEKINIST ORAL TABLET 2 MG (*trametinib dimethyl sulfoxide*) | 4 | PA; ST; QL (1 tablet per day.); SP; CM |
| MEKTOVI ORAL TABLET 15 MG (*binimetinib*) | 3 | PA; ST; QL (6 tablets per day.); SP; CM |
| *mercaptopurine oral suspension 2000 mg/100ml* | 1 | SP; CM |
| *mercaptopurine oral tablet 50 mg* | 1 | CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution reconstituted 1 gm* | 1 | |
| *methotrexate sodium oral tablet 2.5 mg* | 1 | CM |
| MODEYSO ORAL CAPSULE 125 MG (*dordaviprone hcl*) | 4 | PA; QL (20 capsules per month.); SP; CM |
| MYLERAN ORAL TABLET 2 MG (*busulfan*) | 2 | CM |
| NERLYNX ORAL TABLET 40 MG (*neratinib maleate*) | 2 | PA; QL (6 tablets per day.); SP; CM |
| *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg* | 2 | PA; ST; QL (4 capsules per day.); SP; CM |
| NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (*ixazomib citrate*) | 2 | PA; QL (3 capsules per prescription.); SP; CM |
| NUBEQA ORAL TABLET 300 MG (*darolutamide*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| ODOMZO ORAL CAPSULE 200 MG (*sonidegib phosphate*) | 2 | PA; QL (1 capsule per day.); SP; CM |
| OGSIVEO ORAL TABLET 100 MG, 150 MG (*nirogacestat hydrobromide*) | 2 | PA; QL (56 tablets per month.); SP; CM |
| OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (*tovorafenib*) | 4 | PA; QL (96 ml per month.); SP; CM |
| OJEMDA ORAL TABLET 100 MG (*tovorafenib*) | 4 | PA; QL (24 tablets per month.); SP; CM |
| OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (*momelotinib dihydrochloride*) | 4 | PA; ST; QL (1 tablet per day.); SP; CM |
| ONUREG ORAL TABLET 200 MG, 300 MG (*azacitidine*) | 2 | PA; QL (14 tablets per 24 days.); SP; CM |
| OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*) | 3 | PA; QL (240 grams per prescription and 1200 grams per 365 days.); SP |
| ORGOVYX ORAL TABLET 120 MG (*relugolix*) | 3 | PA; QL (1 tablet per day); SP; CM |
| ORSERDU ORAL TABLET 345 MG (*elacestrant hydrochloride*) | 2 | PA; QL (1 tablet per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ORSERDU ORAL TABLET 86 MG (*elacestrant hydrochloride*) | 2 | PA; QL (3 tablets per day.); SP; CM |
| *pazopanib hcl oral tablet 200 mg* | 3 | PA; QL (4 tablets per day.); SP; CM |
| *pazopanib hcl oral tablet 400 mg* | 3 | PA; CM |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*) | 2 | SP |
| PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*) | 2 | SP |
| PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (*pemigatinib*) | 3 | PA; QL (31 tablets per month.); SP; CM |
| PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (*alpelisib*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| PIQRAY ORAL TABLET THERAPY PACK 200 MG (*alpelisib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| *pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg* | 4 | PA; QL (21 capsules per 21 days.); SP; CM |
| PURIXAN ORAL SUSPENSION 2000 MG/100ML (*mercaptopurine*) | 3 | SP; CM |
| QINLOCK ORAL TABLET 50 MG (*ripretinib*) | 3 | PA; QL (3 tablets per day.); SP; CM |
| RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (*selpercatinib*) | 4 | PA; QL (60 tablets per month.); SP; CM |
| RETEVMO ORAL TABLET 40 MG (*selpercatinib*) | 4 | PA; QL (90 tablets per month.); SP; CM |
| REVUFORJ ORAL TABLET 110 MG (*revumenib citrate*) | 4 | PA; QL (120 tablets per month.); SP; CM |
| REVUFORJ ORAL TABLET 160 MG (*revumenib citrate*) | 4 | PA; QL (60 tablets per month.); SP; CM |
| REVUFORJ ORAL TABLET 25 MG (*revumenib citrate*) | 4 | PA; QL (240 tablets per month.); SP; CM |
| REZLIDHIA ORAL CAPSULE 150 MG (*olutasidenib*) | 2 | PA; QL (2 capsules per day.); SP; CM |
| ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (*vimseltinib*) | 2 | PA; QL (8 capsules per 4 weeks.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (*entrectinib*) | 2 | PA; QL (3 capsules per day.); SP; CM |
| ROZLYTREK ORAL PACKET 50 MG (*entrectinib*) | 2 | PA; QL (84 packets (2 boxes) per month.); SP; CM |
| RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (*rucaparib camsylate*) | 3 | PA; ST; QL (4 tablets per day.); SP; CM |
| RYDAPT ORAL CAPSULE 25 MG (*midostaurin*) | 2 | PA; QL (8 capsules per day.); SP; CM |
| SCEMBLIX ORAL TABLET 100 MG (*asciminib hcl*) | 4 | PA; QL (120 tablets per month.); SP; CM |
| SCEMBLIX ORAL TABLET 20 MG, 40 MG (*asciminib hcl*) | 4 | PA; QL (2 tablets per day.); SP; CM |
| *sorafenib tosylate oral tablet 200 mg* | 2 | PA; QL (4 tablets per day.); SP; CM |
| STIVARGA ORAL TABLET 40 MG (*regorafenib*) | 2 | PA; QL (84 tablets per 21 days.); SP; CM |
| *sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg* | 2 | PA; QL (1 capsule per day.); SP; CM |
| TABLOID ORAL TABLET 40 MG (*thioguanine*) | 2 | SP; CM |
| TABRECTA ORAL TABLET 150 MG, 200 MG (*capmatinib hcl*) | 3 | PA; QL (4 tablets per day.); SP; CM |
| TAFINLAR ORAL CAPSULE 50 MG, 75 MG (*dabrafenib mesylate*) | 4 | PA; ST; QL (4 capsules per day.); SP; CM |
| TAFINLAR ORAL TABLET SOLUBLE 10 MG (*dabrafenib mesylate*) | 4 | ST; QL (420 tablets per month.); SP; CM |
| TAGRISSO ORAL TABLET 40 MG, 80 MG (*osimertinib mesylate*) | 3 | PA; QL (1 tablet per day.); SP; CM |
| TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (*talazoparib tosylate*) | 3 | PA; ST; QL (1 capsule per day.); SP; CM |
| *tamoxifen citrate oral tablet 10 mg* | 1 | |
| *tamoxifen citrate oral tablet 20 mg* | 1 | H-N |
| *temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg* | 1 | SP; CM |
| TEPMETKO ORAL TABLET 225 MG (*tepotinib hcl*) | 4 | PA; QL (2 tablets per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| THALOMID ORAL CAPSULE 100 MG, 50 MG (*thalidomide*) | 2 | PA; QL (28 capsules per prescription.); SP; CM |
| TIBSOVO ORAL TABLET 250 MG (*ivosidenib*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| *toremifene citrate oral tablet 60 mg* | 2 | CM |
| *torpenz oral tablet 10 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *torpenz oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *torpenz tablet 7.5 mg oral* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *tretinoin external cream 0.025 %, 0.05 %, 0.1 %* | 3 | QL (20 grams per prescription.) |
| *tretinoin oral capsule 10 mg* | 2 | QL (279 capsules per prescription.); SP; CM |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*) | 2 | CM |
| TRUQAP ORAL TABLET 200 MG (*capivasertib*) | 2 | PA; QL (64 tablets per month.); SP |
| TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (*capivasertib*) | 2 | PA; QL (64 tablets every month.); SP; CM |
| TUKYSA ORAL TABLET 150 MG (*tucatinib*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| TUKYSA ORAL TABLET 50 MG (*tucatinib*) | 2 | PA; QL (10 tablets per day.); SP; CM |
| TURALIO ORAL CAPSULE 125 MG (*pexidartinib hcl*) | 2 | PA; QL (4 capsules per day.); SP; CM |
| VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (*quizartinib dihydrochloride*) | 4 | PA; QL (2 tablets per day.); SP; CM |
| VENCLEXTA ORAL TABLET 10 MG (*venetoclax*) | 2 | PA; QL (14 tablets per month.); SP; CM |
| VENCLEXTA ORAL TABLET 100 MG (*venetoclax*) | 2 | PA; QL (4 tablets per day.); SP; CM |
| VENCLEXTA ORAL TABLET 50 MG (*venetoclax*) | 2 | PA; QL (1 tablet per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (*venetoclax*) | 2 | PA; QL (42 tablets per year.); SP; CM |
| VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*abemaciclib*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| VITRAKVI ORAL CAPSULE 100 MG (*larotrectinib sulfate*) | 2 | PA; QL (2 capsules per day.); SP; CM |
| VITRAKVI ORAL CAPSULE 25 MG (*larotrectinib sulfate*) | 2 | PA; QL (6 capsules per day.); SP; CM |
| VITRAKVI ORAL SOLUTION 20 MG/ML (*larotrectinib sulfate*) | 2 | PA; QL (10 mL per day.); SP; CM |
| VONJO ORAL CAPSULE 100 MG (*pacritinib citrate*) | 3 | PA; QL (4 capsules per day.); SP; CM |
| VORANIGO ORAL TABLET 10 MG (*vorasidenib*) | 2 | PA; QL (62 tablets per month.); SP; CM |
| VORANIGO ORAL TABLET 40 MG (*vorasidenib*) | 2 | PA; QL (31 tablets per month.); SP; CM |
| WELIREG ORAL TABLET 40 MG (*belzutifan*) | 4 | PA; QL (3 tablets day.); SP; CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*) | 3 | PA; CM |
| XOSPATA ORAL TABLET 40 MG (*gilteritinib fumarate*) | 3 | PA; QL (3 tablets per day.); SP; CM |
| XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (*selinexor*) | 4 | PA; QL (0.26 tablet per day.); SP; CM |
| XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (*selinexor*) | 4 | PA; QL (16 tablets per month.); SP; CM |
| XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (*selinexor*) | 4 | PA; QL (0.29 tablet per day.); SP; CM |
| XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (*selinexor*) | 4 | PA; QL (1 therapy pack per month.); SP; CM |
| XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (*selinexor*) | 4 | PA; QL (0.86 tablets per day.); SP; CM |
| XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (*selinexor*) | 4 | PA; QL (0.29 tablet per day.); SP; CM |
| XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (*selinexor*) | 4 | PA; QL (4 tablets per month.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (*selinexor*) | 4 | PA; QL (1.15 tablets per day.); SP; CM |
| XROMI ORAL SOLUTION 100 MG/ML (*hydroxyurea*) | 3 | PA |
| XTANDI ORAL CAPSULE 40 MG (*enzalutamide*) | 2 | PA; QL (4 capsules per day.); SP; CM |
| XTANDI ORAL TABLET 40 MG (*enzalutamide*) | 4 | PA; QL (4 tablets per day.); SP; CM |
| XTANDI ORAL TABLET 80 MG (*enzalutamide*) | 4 | PA; QL (2 tablets per day.); SP; CM |
| *yulithira oral tablet 10 mg, 7.5 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *yulithira oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (*niraparib tosylate*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| ZELBORAF ORAL TABLET 240 MG (*vemurafenib*) | 2 | PA; QL (8 tablets per day.); SP; CM |
| ZOLINZA ORAL CAPSULE 100 MG (*vorinostat*) | 2 | PA; QL (4 capsules per day.); SP; CM |
| ZYDELIG ORAL TABLET 100 MG, 150 MG (*idelalisib*) | 3 | PA; QL (60 tablets per month.); SP; CM |
| **ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM** | | |
| **ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM** | | |
| GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (*timothy grass pollen allergen*) | 3 | PA; QL (1 tablet per day.) |
| ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (*dust mite mixed allergen ext*) | 3 | PA; QL (1 tablet per day.) |
| ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (*grass mix pollens allergen ext*) | 3 | PA; QL (3 tablets per year.) |
| ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (*grass mix pollens allergen ext*) | 3 | PA; QL (3 tablets per year.) |
| ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (*grass mix pollens allergen ext*) | 3 | PA; QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (*short ragweed pollen ext*) | 3 | PA; QL (1 tablet per day.) |
| **TOXOIDS - Vaccines** | | |
| ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 3 | H |
| ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 3 | H |
| BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 2 | H |
| DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (*diphth-acell pertussis-tetanus*) | 2 | H |
| INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (*diphth-acell pertussis-tetanus*) | 2 | H |
| INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (*diphth-acell pertussis-tetanus*) | 3 | H |
| PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-hepatitis b recomb-ipv*) | 3 | H |
| PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (*dtap-ipv-hib vaccine*) | 3 | H |
| QUADRACEL INTRAMUSCULAR SUSPENSION (*dtap-ipv vaccine*) | 3 | H |
| TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (*tetanus-diphtheria toxoids td*) | 3 | H |
| VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv-hib-hepatitis b recmb*) | 3 | H |
| **VACCINES - Vaccines** | | |
| ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (*rsv pre-fusion f a&b vac rcmb*) | 3 | H |
| ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (*haemophilus b polysac conj vac*) | 2 | H |
| ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 3 | H |
| ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (*rsvpref3 vac recomb adjuvanted*) | 3 | H |
| BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*meningococcal b recomb omv adj*) | 3 | H |
| BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (*tetanus-diphth-acell pertussis*) | 2 | H |
| CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (*pneumococcal 21-valent conjuga*) | 3 | H |
| DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (*diphth-acell pertussis-tetanus*) | 2 | H |
| DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (*dengue virus vaccine live tetr*) | 3 | H |
| ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (*hepatitis b vac recombinant*) | 2 | H |
| ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (*hepatitis b vac recombinant*) | 2 | H |
| FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac a&b surf ant adj*) | 3 | H |
| FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*) | 3 | H |
| FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac tiss-cult subunt*) | 3 | H |
| FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*) | 3 | H |
| FLUMIST NASAL LIQUID (*influenza virus vaccine live*) | 3 | H |
| FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac split high-dose*) | 3 | H |
| FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*) | 3 | H |
| GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (*hpv 9-valent recomb vaccine*) | 3 | H |
| GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*hpv 9-valent recomb vaccine*) | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (*hepatitis a vaccine*) | 3 | H |
| HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (*hepatitis b vac recomb adj*) | 3 | H |
| HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (*haemophilus b polysac conj vac*) | 3 | H |
| INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (*diphth-acell pertussis-tetanus*) | 2 | H |
| INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (*diphth-acell pertussis-tetanus*) | 3 | H |
| IPOL INJECTION SUSPENSION (*poliovirus vaccine inactivated*) | 2 | H |
| MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (*mening acy&w-135 tetanus conj*) | 3 | H |
| MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (*meningococcal a c y&w-135 olig*) | 3 | H |
| M-M-R II INJECTION SOLUTION RECONSTITUTED (*measles, mumps & rubella vac*) | 2 | H |
| MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (*covid-19 mrna virus vaccine*) | 3 | H |
| PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-hepatitis b recomb-ipv*) | 3 | H |
| PEDVAXHIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (*haemophilus b polysac conj vac*) | 2 | H |
| PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (*mening acyw(tet conj)-b(rcmb)*) | 3 | H |
| PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED | 3 | H |
| PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (*dtap-ipv-hib vaccine*) | 3 | H |
| PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (*pneumococcal vac polyvalent*) | 2 | H |
| PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*pneumococcal 20-val conj vacc*) | 3 | H |
| PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (*measles, mumps & rubella vac*) | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (*measles-mumps-rubella-varicell*) | 3 | H |
| QUADRACEL INTRAMUSCULAR SUSPENSION (*dtap-ipv vaccine*) | 3 | H |
| RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (*hepatitis b vac recombinant*) | 2 | H |
| RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (*hepatitis b vac recombinant*) | 2 | H |
| ROTARIX ORAL SUSPENSION (*rotavirus vaccine live oral*) | 3 | H |
| ROTATEQ ORAL SOLUTION (*rotavirus vac live pentavalent*) | 3 | H |
| SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (*covid-19 mrna virus vaccine*) | 3 | H |
| SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (*covid-19 mrna virus vaccine*) | 3 | H |
| TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*meningococcal b vac (recomb)*) | 3 | H |
| TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (*hepatitis a-hep b recomb vac*) | 3 | H |
| VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (*hepatitis a vaccine*) | 2 | H |
| VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML (*hepatitis a vaccine*) | 2 | H |
| VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (*varicella virus vaccine live*) | 3 | H |
| VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv-hib-hepatitis b recmb*) | 3 | H |
| VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*pneumococcal 15-val conj vacc*) | 3 | H |
| **AUTONOMIC DRUGS** | | |
| **SMOKING CESSATION AGENTS** | | |
| *bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg* | 1 | H |
| *ft nicotine mini mouth/throat lozenge 2 mg, 4 mg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ft nicotine mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *ft nicotine mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr* | 1 | H |
| *goodsense nicotine mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *goodsense nicotine mouth/throat lozenge 4 mg* | 1 | H |
| *goodsense nicotine policrilex mouth/throat gum 4 mg* | 1 | H |
| *habitrol transdermal patch 24 hour 21 mg/24hr* | 1 | H |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (*nicotine polacrilex*) | 2 | H |
| NICORETTE MOUTH/THROAT GUM 2 MG (*nicotine polacrilex*) | 3 | H |
| NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (*nicotine polacrilex*) | 2 | H |
| *nicotine mini mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *nicotine polacrilex mini mouth/throat lozenge 2 mg* | 1 | H |
| *nicotine polacrilex mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *nicotine step 1 transdermal patch 24 hour 21 mg/24hr* | 1 | H |
| *nicotine step 2 transdermal patch 24 hour 14 mg/24hr* | 1 | H |
| *nicotine step 3 transdermal patch 24 hour 7 mg/24hr* | 1 | H |
| *nicotine transdermal kit 21-14-7 mg/24hr* | 1 | H |
| *nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr* | 1 | H |
| NICOTROL NS NASAL SOLUTION 10 MG/ML (*nicotine*) | 3 | H |
| TYRVAYA NASAL SOLUTION 0.03 MG/ACT (*varenicline tartrate*) | 3 | PA; QL (0.28 ml per day.) |
| *varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42* | 3 | H |
| *varenicline tartrate oral tablet 0.5 mg, 1 mg* | 3 | H |
| *varenicline tartrate(continue) oral tablet 1 mg* | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **AUTONOMIC DRUGS - Drugs for the Nervous System** | | |
| **ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs** | | |
| ADRENALIN NASAL SOLUTION 0.1 % (*epinephrine hcl (nasal)*) | 2 | |
| AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (*epinephrine*) | 2 | QL (2 pens per prescription.) |
| AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (*epinephrine*) | 2 | QL (2 injections per prescription.) |
| *droxidopa oral capsule 100 mg* | 3 | PA; QL (90 capsules per month.); SP |
| *droxidopa oral capsule 200 mg, 300 mg* | 3 | PA; QL (180 capsules per month.); SP |
| *epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml* | 1 | QL (2 injections per prescription.) |
| *epinephrine injection solution auto-injector 0.15 mg/0.3ml* | 1 | QL (4 injections per prescription.) |
| EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML | 2 | |
| EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*) | 3 | QL (2 injections per prescription.) |
| LETS KIT | 3 | PA |
| NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (*epinephrine*) | 3 | QL (2 nasal sprays (1 box) per copay.) |
| *pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml* | 1 | |
| **ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs** | | |
| *clonidine hcl er oral tablet extended release 12 hour 0.1 mg* | 2 | |
| *clonidine hcl oral tablet 0.05 mg* | 3 | |
| *clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg* | 1 | |
| *clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr* | 3 | |
| JAVADIN ORAL SOLUTION 0.02 MG/ML (*clonidine hcl*) | 3 | PA |
| *lofexidine hcl oral tablet 0.18 mg* | 3 | QL (192 tablets per year.) |
| *methyldopa oral tablet 250 mg, 500 mg* | 3 | PA; ST |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (*phenylephrine-chlorphen-dm*) | 3 | |
| ONYDA XR ORAL SUSPENSION EXTENDED RELEASE 0.1 MG/ML (*clonidine hcl*) | 3 | QL (120 mL per month.) |
| *promethazine-phenylephrine oral syrup 6.25-5 mg/5ml* | 1 | |
| **ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson** | | |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*) | 3 | QL (2 blisters per day.) |
| *atropine sulfate ophthalmic solution 1 %* | 1 | |
| ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*) | 3 | QL (0.87 grams per day.) |
| *belladonna alkaloids-opium rectal suppository 16.2-60 mg* | 1 | |
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*) | 2 | QL (0.36 grams per day.) |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | QL (0.36 grams per day.) |
| *chlordiazepoxide-clidinium oral capsule 5-2.5 mg* | 3 | |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*) | 3 | QL (0.28 grams per day.) |
| CUVPOSA ORAL SOLUTION 1 MG/5ML (*glycopyrrolate*) | 3 | |
| *dicyclomine hcl oral capsule 10 mg* | 1 | |
| *dicyclomine hcl oral solution 10 mg/5ml* | 1 | |
| *dicyclomine hcl oral tablet 20 mg* | 1 | |
| *diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml* | 1 | |
| *diphenoxylate-atropine oral tablet 2.5-0.025 mg* | 1 | |
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (*aclidinium br-formoterol fum*) | 3 | QL (0.04 mcg per day.) |
| *glycopyrrolate oral solution 1 mg/5ml* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *glycopyrrolate oral tablet 1 mg, 2 mg* | 1 | |
| *hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml* | 1 | PA; QL (120 mL per prescription and 360 ml per month.) |
| *hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg* | 1 | PA |
| *hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg* | 1 | |
| *hyoscyamine sulfate oral elixir 0.125 mg/5ml* | 1 | |
| *hyoscyamine sulfate oral solution 0.125 mg/ml* | 1 | |
| *hyoscyamine sulfate oral tablet 0.125 mg* | 1 | |
| *hyoscyamine sulfate oral tablet dispersible 0.125 mg* | 1 | |
| *hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyoscyamine sulfate sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyosyne oral elixir 0.125 mg/5ml* | 1 | |
| *hyosyne oral solution 0.125 mg/ml* | 1 | |
| *ipratropium bromide hfa inhalation aerosol solution 17 mcg/act* | 3 | QL (0.87 grams per day.) |
| *ipratropium bromide inhalation solution 0.02 %* | 1 | |
| *ipratropium bromide nasal solution 0.03 %, 0.06 %* | 1 | |
| *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml* | 2 | |
| LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (*hyoscyamine sulfate*) | 3 | |
| LEVSIN ORAL TABLET 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| LOMOTIL ORAL TABLET 2.5-0.025 MG (*diphenoxylate-atropine*) | 3 | |
| *me/naphos/mb/hyo1 oral tablet 81.6 mg* | 1 | |
| *methscopolamine bromide oral tablet 2.5 mg, 5 mg* | 1 | |
| NULEV ORAL TABLET DISPERSIBLE 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| OSCIMIN ORAL TABLET 0.125 MG | 3 | |
| OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG | 3 | |
| *scopolamine transdermal patch 72 hour 1 mg/3days* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide*) | 2 | QL (1 capsule per day) |
| SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide*) | 2 | QL (0.15 grams per day.) |
| STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*) | 2 | QL (0.15 grams per day.) |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*) | 3 | QL (2 blisters per day.) |
| URELLE ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| *uretron d/s oral tablet 81.6 mg* | 1 | |
| UROGESIC-BLUE ORAL TABLET 81.6 MG (*methen-hyosc-meth blue-na phos*) | 2 | |
| VILEVEV MB ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (*revefenacin*) | 3 | PA; QL (3 ml per day.) |
| **ANTIPARKINSONIAN AGENTS - Drugs for Parkinson** | | |
| *benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| *trihexyphenidyl hcl oral solution 0.4 mg/ml* | 1 | |
| *trihexyphenidyl hcl oral tablet 2 mg, 5 mg* | 1 | |
| **AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System** | | |
| *ft nicotine mini mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *ft nicotine mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *ft nicotine mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr* | 1 | H |
| *goodsense nicotine mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *goodsense nicotine mouth/throat lozenge 4 mg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *goodsense nicotine policrilex mouth/throat gum 4 mg* | 1 | H |
| *habitrol transdermal patch 24 hour 21 mg/24hr* | 1 | H |
| NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (*nicotine polacrilex*) | 2 | H |
| NICORETTE MOUTH/THROAT GUM 2 MG (*nicotine polacrilex*) | 3 | H |
| NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (*nicotine polacrilex*) | 2 | H |
| *nicotine mini mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *nicotine polacrilex mini mouth/throat lozenge 2 mg* | 1 | H |
| *nicotine polacrilex mouth/throat gum 2 mg, 4 mg* | 1 | H |
| *nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg* | 1 | H |
| *nicotine step 1 transdermal patch 24 hour 21 mg/24hr* | 1 | H |
| *nicotine step 2 transdermal patch 24 hour 14 mg/24hr* | 1 | H |
| *nicotine step 3 transdermal patch 24 hour 7 mg/24hr* | 1 | H |
| *nicotine transdermal kit 21-14-7 mg/24hr* | 1 | H |
| *nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr* | 1 | H |
| NICOTROL NS NASAL SOLUTION 10 MG/ML (*nicotine*) | 3 | H |
| *varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42* | 3 | H |
| *varenicline tartrate oral tablet 0.5 mg, 1 mg* | 3 | H |
| *varenicline tartrate(continue) oral tablet 1 mg* | 3 | H |
| **CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles** | | |
| ATMEKSI ORAL SUSPENSION 750 MG/5ML (*methocarbamol*) | 3 | PA |
| *carisoprodol oral tablet 350 mg* | 1 | |
| *chlorzoxazone oral tablet 500 mg* | 2 | |
| *cyclobenzaprine hcl oral tablet 10 mg, 5 mg* | 1 | |
| ENOVARX-CYCLOBENZAPRINE HCL TRANSDERMAL CREAM 20 MG/GM | 3 | PA |
| *metaxalone oral tablet 400 mg, 800 mg* | 3 | |
| *methocarbamol oral tablet 500 mg, 750 mg* | 1 | |
| ONTRALFY ORAL SOLUTION 2 MG/5ML (*tizanidine hcl*) | 4 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TABRADOL FUSEPAQ ORAL SUSPENSION 1 MG/ML (*cyclobenzaprine hcl-msm*) | 3 | PA |
| TANLOR ORAL TABLET 1000 MG (*methocarbamol*) | 3 | |
| *tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg* | 2 | |
| *tizanidine hcl oral tablet 2 mg, 4 mg* | 1 | |
| TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (*cyclobenzaprine hcl (fibromy)*) | 4 | PA; QL (60 sublingual tablets per month.) |
| VP FC KIT EXTERNAL CREAM | 3 | PA |
| ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (*tizanidine hcl*) | 3 | |
| ZANAFLEX ORAL TABLET 4 MG (*tizanidine hcl*) | 3 | |
| **DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles** | | |
| DANTRIUM ORAL CAPSULE 25 MG (*dantrolene sodium*) | 3 | |
| *dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| **GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles** | | |
| *baclofen oral solution 10 mg/5ml* | 3 | PA |
| *baclofen oral solution 5 mg/5ml* | 3 | |
| *baclofen oral suspension 25 mg/5ml* | 3 | PA |
| *baclofen oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| ENOVARX-BACLOFEN EXTERNAL CREAM 1 % | 3 | PA |
| FBL KIT EXTERNAL CREAM 15-4-5 % | 3 | PA |
| K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (*ketoprofen-baclofen-gabap-lido*) | 3 | PA |
| OZOBAX DS ORAL SOLUTION 10 MG/5ML (*baclofen*) | 3 | PA |
| **INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles** | | |
| *orphenadrine citrate er oral tablet extended release 12 hour 100 mg* | 2 | |
| **NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart** | | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BETIMOL OPHTHALMIC SOLUTION 0.5 % (*timolol hemihydrate*) | 3 | QL (5 ml per prescription.) |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*) | 3 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | |
| *pindolol oral tablet 10 mg, 5 mg* | 1 | |
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| *timolol hemihydrate ophthalmic solution 0.5 %* | 2 | QL (5 ml per prescription.) |
| *timolol maleate (once-daily) ophthalmic solution 0.5 %* | 3 | |
| *timolol maleate ocudose ophthalmic solution 0.5 %* | 2 | |
| *timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate ophthalmic solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *timolol maleate pf ophthalmic solution 0.25 %, 0.5 %* | 2 | |
| TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*) | 3 | |
| **NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| *doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg* | 1 | |
| *prazosin hcl oral capsule 1 mg, 2 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |
| TEZRULY ORAL SOLUTION 1 MG/ML (*terazosin hcl*) | 3 | PA |
| **NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart** | | |
| CAFERGOT ORAL TABLET 1-100 MG (*ergotamine-caffeine*) | 3 | |
| *dihydroergotamine mesylate injection solution 1 mg/ml* | 1 | |
| *dihydroergotamine mesylate nasal solution 4 mg/ml* | 3 | ST; QL (8 mL per prescription.) |
| ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (*ergotamine tartrate*) | 3 | ST; QL (5 tablets per prescription.) |
| *ergotamine-caffeine oral tablet 1-100 mg* | 3 | |
| MIGERGOT RECTAL SUPPOSITORY 2-100 MG (*ergotamine-caffeine*) | 3 | |
| *phenoxybenzamine hcl oral capsule 10 mg* | 2 | |
| **PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS) - Drugs for Bladder Incontinence** | | |
| *bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg* | 1 | |
| *cevimeline hcl oral capsule 30 mg* | 1 | |
| *donepezil hcl oral tablet 10 mg, 5 mg* | 1 | |
| *donepezil hcl oral tablet 23 mg* | 2 | |
| *donepezil hcl oral tablet dispersible 10 mg, 5 mg* | 1 | |
| FIRDAPSE ORAL TABLET 10 MG (*amifampridine phosphate*) | 2 | PA; QL (300 tablets per month.); SP |
| *galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg* | 1 | |
| *galantamine hydrobromide oral solution 4 mg/ml* | 1 | |
| *galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg* | 1 | |
| *memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg* | 3 | |
| MESTINON ORAL SOLUTION 60 MG/5ML (*pyridostigmine bromide*) | 3 | |
| NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %* | 1 | |
| *pilocarpine hcl oral tablet 5 mg, 7.5 mg* | 1 | |
| *pyridostigmine bromide er oral tablet extended release 180 mg* | 1 | |
| PYRIDOSTIGMINE BROMIDE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG | 3 | |
| *pyridostigmine bromide oral solution 60 mg/5ml* | 3 | |
| *pyridostigmine bromide oral tablet 60 mg* | 1 | |
| *rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg* | 1 | |
| *rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr* | 3 | |
| SALAGEN ORAL TABLET 5 MG, 7.5 MG (*pilocarpine hcl*) | 3 | |
| **SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart** | | |
| *alfuzosin hcl er oral tablet extended release 24 hour 10 mg* | 1 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| *silodosin oral capsule 4 mg, 8 mg* | 3 | |
| *tamsulosin hcl oral capsule 0.4 mg* | 1 | |
| **SELECTIVE BETA-2-ADRENERGIC AGONISTS - Drugs for Heart and Lungs** | | |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*) | 3 | QL (0.4 grams per day.) |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (1 inhaler per copay.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (1 inhaler per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (18 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (6.7 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (8.5 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml* | 1 | |
| *albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation* | 1 | |
| ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION | 3 | |
| *albuterol sulfate oral syrup 2 mg/5ml* | 1 | |
| *albuterol sulfate oral tablet 2 mg, 4 mg* | 3 | PA |
| ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*) | 3 | QL (2 blisters per day.) |
| *arformoterol tartrate inhalation nebulization solution 15 mcg/2ml* | 3 | QL (2 nebules per day) |
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*) | 2 | QL (0.36 grams per day.) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*) | 3 | QL (2 blisters per day.) |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | QL (0.36 grams per day.) |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*) | 3 | QL (0.28 grams per day.) |
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (*aclidinium br-formoterol fum*) | 3 | QL (0.04 mcg per day.) |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | QL (0.04 mcg per day.) |
| *formoterol fumarate inhalation nebulization solution 20 mcg/2ml* | 3 | QL (2 vials per day.) |
| *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml* | 2 | |
| *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml* | 3 | QL (90 ml per prescription.) |
| *levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml* | 3 | QL (30 vials per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT | 3 | QL (15 grams per prescription.) |
| PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (*formoterol fumarate*) | 3 | QL (2 vials per day.) |
| SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*) | 2 | QL (1 diskus (60 blisters) per month.) |
| STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*) | 2 | QL (0.15 grams per day.) |
| STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*) | 2 | QL (0.15 grams per day.) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (*budesonide-formoterol fumarate*) | 3 | QL (0.35 grams per day.) |
| *terbutaline sulfate oral tablet 2.5 mg, 5 mg* | 1 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*) | 3 | QL (2 blisters per day.) |
| *wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (*levalbuterol tartrate*) | 3 | QL (15 grams per prescription.) |
| **SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | 1 | |
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*atenolol*) | 3 | PA |
| *betaxolol hcl ophthalmic solution 0.5 %* | 1 | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | 1 | |
| *bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*) | 3 | |
| LOPRESSOR ORAL SOLUTION 10 MG/ML (*metoprolol tartrate*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg* | 2 | |
| *metoprolol succinate er oral tablet extended release 24 hour 25 mg* | 1 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| **SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles** | | |
| *orphenadrine citrate er oral tablet extended release 12 hour 100 mg* | 2 | |
| **BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood** | | |
| **ANTIANEMIA DRUGS - Vitamins and Minerals** | | |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (*darbepoetin alfa*) | 2 | QL (2 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (*darbepoetin alfa*) | 2 | QL (4 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (*darbepoetin alfa*) | 2 | QL (1.6 ml per month.); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (*darbepoetin alfa*) | 2 | QL (1 prefill syringe per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (*darbepoetin alfa*) | 2 | QL (2 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (*darbepoetin alfa*) | 2 | QL (4 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (*darbepoetin alfa*) | 2 | QL (2 vials per prescription); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (*darbepoetin alfa*) | 2 | QL (2 syringes per month); SP |
| RETACRIT INJECTION SOLUTION 10000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (8 ml per 21 days); SP |
| RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (12 ml per 21 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RETACRIT INJECTION SOLUTION 20000 UNIT/ML (*epoetin alfa-epbx*) | 2 | SP |
| RETACRIT INJECTION SOLUTION 40000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (4 ml per 21 days.); SP |
| **ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots** | | |
| ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (*anticoagulant cit dext soln a*) | 3 | |
| ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML | 3 | |
| *fondaparinux sodium subcutaneous solution 10 mg/0.8ml* | 2 | QL (24 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml* | 2 | QL (15 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 5 mg/0.4ml* | 2 | QL (12 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml* | 2 | QL (18 ml (30 syringes) per prescription) |
| TRICITRASOL IN VITRO CONCENTRATE 46.7 % (*anticoagulant sodium citrate*) | 3 | |
| **ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots** | | |
| CABLIVI INJECTION KIT 11 MG (*caplacizumab-yhdp*) | 2 | PA; QL (1 vial per day and 58 vials per 120 days.); SP |
| LODOCO ORAL TABLET 0.5 MG (*colchicine*) | 3 | QL (1 tablet per day.) |
| **BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding** | | |
| AQVESME ORAL TABLET 100 MG (*mitapivat sulfate*) | 4 | PA; QL (60 tablets per month.); SP; CM |
| PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (*mitapivat sulfate*) | 3 | PA; QL (56 tablets per 28 days.); SP; CM |
| PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (*mitapivat sulfate*) | 3 | PA; QL (7 tablets per 365 days.); SP; CM |
| PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (*mitapivat sulfate*) | 3 | PA; QL (14 tablets per 365 days.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TAVALISSE ORAL TABLET 100 MG, 150 MG (*fostamatinib disodium*) | 3 | PA; QL (2 tablets per day.); SP |
| WAYRILZ ORAL TABLET 400 MG (*rilzabrutinib*) | 4 | PA; ST; QL (60 tablets per month.); SP |
| **COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots** | | |
| *warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg* | 1 | |
| **DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots** | | |
| ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (*apixaban*) | 2 | QL (152 tablets per month.) |
| ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (*apixaban*) | 2 | QL (152 tablets per month.) |
| ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (*apixaban*) | 2 | QL (2.5 tablets per day.) |
| ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (*apixaban*) | 2 | QL (76 sprinkle capsules per month.) |
| ELIQUIS ORAL TABLET 2.5 MG (*apixaban*) | 2 | QL (2 tablets per day.) |
| ELIQUIS ORAL TABLET 5 MG (*apixaban*) | 2 | QL (2.5 tablets per day.) |
| ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (*apixaban*) | 2 | QL (152 tablets per month.) |
| *rivaroxaban oral suspension reconstituted 1 mg/ml* | 2 | QL (20 ml per day.) |
| *rivaroxaban oral tablet 2.5 mg* | 2 | QL (2 tablets per day.) |
| SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (*edoxaban tosylate*) | 3 | ST; QL (1 tablet per day.) |
| XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (*rivaroxaban*) | 2 | QL (20 ml per day.) |
| XARELTO ORAL TABLET 10 MG (*rivaroxaban*) | 2 | QL (1 tablet per day.) |
| XARELTO ORAL TABLET 15 MG (*rivaroxaban*) | 2 | QL (52 tablets per month initial 1 tablet per day for maintenance.) |
| XARELTO ORAL TABLET 2.5 MG (*rivaroxaban*) | 2 | QL (2 tablets per day.) |
| XARELTO ORAL TABLET 20 MG (*rivaroxaban*) | 2 | QL (31 tablets per 31 days.) |
| XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (*rivaroxaban*) | 2 | QL (51 tablets per year.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots** | | |
| *dabigatran etexilate mesylate oral capsule 110 mg* | 2 | QL (2 capsules per day.) |
| *dabigatran etexilate mesylate oral capsule 150 mg, 75 mg* | 2 | QL (62 capsules per 31 days.) |
| PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (*dabigatran etexilate mesylate*) | 3 | PA; QL (4 packets per day.) |
| PRADAXA ORAL PACKET 150 MG (*dabigatran etexilate mesylate*) | 3 | PA; QL (2 packets per day.) |
| **HEMATOPOIETIC AGENTS - Drugs for Anemia** | | |
| ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (*eltrombopag choline*) | 4 | PA; SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (*darbepoetin alfa*) | 2 | QL (2 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (*darbepoetin alfa*) | 2 | QL (4 syringes per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (*darbepoetin alfa*) | 2 | QL (1.6 ml per month.); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (*darbepoetin alfa*) | 2 | QL (1 prefill syringe per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (*darbepoetin alfa*) | 2 | QL (2 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (*darbepoetin alfa*) | 2 | QL (4 vials per month); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (*darbepoetin alfa*) | 2 | QL (2 vials per prescription); SP |
| ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (*darbepoetin alfa*) | 2 | QL (2 syringes per month); SP |
| DOPTELET ORAL TABLET 20 MG (*avatrombopag maleate*) | 3 | PA; QL (60 tablets per month.); SP |
| DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (*avatrombopag maleate*) | 4 | PA; QL (60 capsules per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *eltrombopag olamine oral packet 12.5 mg* | 1 | PA; QL (6 packets per day.); SP |
| *eltrombopag olamine oral packet 25 mg* | 1 | PA; QL (6 packets per day.) |
| *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg* | 3 | PA; SP |
| LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (*sargramostim*) | 2 | |
| MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (*plerixafor*) | 3 | SP |
| MULPLETA ORAL TABLET 3 MG (*lusutrombopag*) | 4 | PA; QL (7 tablets per prescription.); SP |
| NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim*) | 4 | |
| NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*filgrastim-aafi*) | 2 | SP |
| NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-aafi*) | 2 | SP |
| *plerixafor subcutaneous solution 24 mg/1.2ml* | 2 | SP |
| PROMACTA ORAL PACKET 12.5 MG (*eltrombopag olamine*) | 4 | PA; QL (6 packets per day.); SP |
| PROMACTA ORAL PACKET 25 MG (*eltrombopag olamine*) | 4 | PA; QL (6 packets per day.) |
| RETACRIT INJECTION SOLUTION 10000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (8 ml per 21 days); SP |
| RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (12 ml per 21 days.); SP |
| RETACRIT INJECTION SOLUTION 20000 UNIT/ML (*epoetin alfa-epbx*) | 2 | SP |
| RETACRIT INJECTION SOLUTION 40000 UNIT/ML (*epoetin alfa-epbx*) | 2 | QL (4 ml per 21 days.); SP |
| UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (*pegfilgrastim-cbqv*) | 4 | |
| UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-cbqv*) | 4 | SP |
| VAFSEO ORAL TABLET 150 MG, 300 MG (*vadadustat*) | 3 | PA; QL (31 tablets per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XOLREMDI ORAL CAPSULE 100 MG (*mavorixafor*) | 2 | PA; QL (120 capsules per month.); SP |
| ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-sndz*) | 2 | SP |
| **HEMORRHEOLOGIC AGENTS - Drugs for Blood Flow** | | |
| *pentoxifylline er oral tablet extended release 400 mg* | 1 | |
| **HEMOSTATICS - Drugs to Prevent Bleeding** | | |
| ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*) | 2 | SP |
| ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT | 2 | SP |
| AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact single chain*) | 2 | SP |
| ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor-vwf*) | 2 | SP |
| ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*coagulation factor ix*) | 2 | SP |
| ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*coagulation factor ix (rfixfc)*) | 3 | SP |
| ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact fc-vwf-xten-ehtl*) | 2 | SP |
| *aminocaproic acid oral solution 0.25 gm/ml* | 3 | |
| *aminocaproic acid oral tablet 1000 mg, 500 mg* | 3 | |
| ASTRINGYN EXTERNAL SOLUTION 259 MG/GM (*ferric subsulfate*) | 3 | |
| BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*) | 2 | SP |
| COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (*coagulation factor x (human)*) | 2 | SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (*factor xiii concentrate human*) | 2 | SP |
| CRENESSITY ORAL CAPSULE 100 MG, 50 MG (*crinecerfont*) | 4 | PA; QL (62 capsules per month.); SP |
| CRENESSITY ORAL SOLUTION 50 MG/ML (*crinecerfont*) | 4 | PA; QL (120 mL (4 bottles) per month.); SP |
| DESMODA ORAL SOLUTION 0.05 MG/ML (*desmopressin acetate*) | 4 | PA |
| *desmopressin ace spray refrig nasal solution 0.01 %* | 1 | |
| *desmopressin acetate injection solution 4 mcg/ml* | 1 | |
| DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML | 3 | |
| *desmopressin acetate oral tablet 0.1 mg, 0.2 mg* | 1 | |
| *desmopressin acetate pf injection solution 4 mcg/ml* | 1 | |
| *desmopressin acetate spray nasal solution 0.01 %* | 1 | |
| ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (*antihem fact (bdd-rfviiifc)*) | 2 | SP |
| FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (*antiinhibitor coagulant cmplx*) | 2 | SP |
| GELFILM OPHTHALMIC FILM (*gelatin adsorbable*) | 2 | |
| HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (*emicizumab-kxwh*) | 2 | PA; SP |
| HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*) | 2 | |
| HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT (*antihemophilic factor*) | 2 | SP |
| HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (*antihemophilic factor-vwf*) | 2 | SP |
| HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*marstacimab-hncq*) | 2 | PA; QL (4 mL (4 Auto-injectors) per month.); SP |
| HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (*marstacimab-hncq*) | 2 | PA; SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (*coagulation factor ix (rix-fp)*) | 3 | SP |
| JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*ahf (bdd-rfviii peg-aucl)*) | 4 | SP |
| KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*) | 2 | |
| KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (*antihemophilic factor*) | 2 | |
| KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*) | 2 | SP |
| MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION | 3 | |
| NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact bd truncated*) | 2 | SP |
| NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (*coagulation factor viia recomb*) | 2 | SP |
| NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*) | 2 | SP |
| NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*) | 2 | SP |
| OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT | 3 | SP |
| PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*factor ix complex*) | 2 | SP |
| QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (*fitusiran sodium*) | 4 | PA; ST; QL (0.2 mL (1 vial) per month.); SP |
| QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*fitusiran sodium*) | 4 | PA; ST; QL (0.5 mL (1 pen) per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (*antihem factor recomb (rfviii)*) | 2 | SP |
| RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 5000 UNIT (*thrombin (recombinant)*) | 3 | |
| RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT (*thrombin (recombinant)*) | 3 | |
| RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | 2 | SP |
| THROMBIN-JMI EPISTAXIS EXTERNAL KIT 5000 UNIT (*thrombin*) | 3 | |
| THROMBIN-JMI EXTERNAL KIT 20000 UNIT, 5000 UNIT (*thrombin*) | 3 | |
| THROMBOGEN EXTERNAL KIT 10000 UNIT (*thrombin*) | 3 | |
| THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED 1000 UNIT, 10000 UNIT (*thrombin*) | 3 | |
| *tranexamic acid oral tablet 650 mg* | 2 | QL (Benefit maximum quantity 1 per day.) |
| TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (*coagulation factor xiii a-sub*) | 3 | SP |
| VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (*von willebrand factor (recomb)*) | 2 | SP |
| WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (*antihemophilic factor-vwf*) | 2 | SP |
| XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*) | 4 | PA; ST; SP |
| XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*) | 4 | PA; ST; SP |
| **HEPARINS - Drugs to Prevent Blood Clots** | | |
| *enoxaparin sodium injection solution 300 mg/3ml* | 2 | QL (42 ml (14 vials) per prescription) |
| *enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml* | 2 | QL (30 syringes per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml* | 2 | QL (24 ml (30 syringes) per prescription) |
| *enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml* | 2 | QL (9 ml (30 syringes) per prescription) |
| *enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml* | 2 | QL (12 ml (30 syringes) per prescription) |
| *enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml* | 2 | QL (18 ml (30 syringes) per prescription) |
| FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (*dalteparin sodium*) | 3 | |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML (*dalteparin sodium*) | 3 | QL (10 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12500 UNIT/0.5ML (*dalteparin sodium*) | 3 | QL (5 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 15000 UNIT/0.6ML (*dalteparin sodium*) | 3 | QL (6 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 18000 UNT/0.72ML (*dalteparin sodium*) | 3 | QL (8 ml (10 syringes) per prescription) |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML, 5000 UNIT/0.2ML (*dalteparin sodium*) | 3 | QL (2 ml (10 syringes) per prescription.) |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 7500 UNIT/0.3ML (*dalteparin sodium*) | 3 | QL (3 ml (10 syringes) per prescription.) |
| *heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml* | 1 | |
| *heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml* | 1 | |
| *heparin sodium (porcine) +rfid injection solution 1000 unit/ml* | 1 | |
| *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml* | 1 | |
| *heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml* | 1 | |
| *heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml, 5000 unit/ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **INDIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots** | | |
| *fondaparinux sodium subcutaneous solution 10 mg/0.8ml* | 2 | QL (24 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml* | 2 | QL (15 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 5 mg/0.4ml* | 2 | QL (12 ml (30 syringes) per prescription) |
| *fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml* | 2 | QL (18 ml (30 syringes) per prescription) |
| **IRON PREPARATIONS - Vitamins and Minerals** | | |
| ELITE-OB ORAL TABLET 50-1.25 MG (*prenatal vit-iron carbonyl-fa*) | 3 | |
| ENBRACE HR ORAL CAPSULE (*prenat vit-fe gly cys-fa-omega*) | 3 | |
| HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG | 3 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| *multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml* | 1 | |
| NATAL PNV ORAL TABLET 6-0.5 MG | 3 | |
| NEONATAL COMPLETE ORAL TABLET 27-1 MG | 3 | |
| NEONATAL PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| NESTABS ONE ORAL CAPSULE 38-1-225 MG (*prenat-fe-methylfol-dha w/o a*) | 3 | |
| NESTABS ORAL TABLET 32-1 MG (*prenat-fe bisgly-fa-w/o vit a*) | 3 | |
| ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG | 3 | |
| ONENATAL RX ORAL TABLET 1 MG (*prenatal multivit-min-fe-fa*) | 3 | |
| *pnv 27-ca/fe/fa oral tablet 60-1 mg* | 1 | |
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (*ped multivitamins-fl-iron*) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (*ped multivitamins-fl-iron*) | 3 | |
| *prenatal oral tablet 27-1 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (*prenatal-feaspgly-methylfol-fa*) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (*prenat-fecbn-feasp-meth-fa-dha*) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (*prenatal vit-fe psac cmplx-fa*) | 3 | |
| TRINATE ORAL TABLET (*prenatal vit-fe fumarate-fa*) | 3 | |
| TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (*prenat-fe poly-methfol-fa-dha*) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (*prenatal mv-min-fe fum-fa-dha*) | 3 | |
| VITATHELY WITH GINGER ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG | 3 | |
| WESNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| **LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals** | | |
| *cyanocobalamin injection solution 1000 mcg/ml* | 1 | |
| CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML | 3 | |
| *cyanocobalamin nasal solution 500 mcg/0.1ml* | 3 | |
| NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (*cyanocobalamin*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots** | | |
| *aspirin 81 oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin childrens oral tablet chewable 81 mg* | E | H |
| *aspirin ec adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin low dose oral tablet chewable 81 mg* | E | H |
| *aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin oral tablet chewable 81 mg* | E | H |
| *aspirin oral tablet delayed release 81 mg* | E | H |
| *aspirin regimen oral tablet delayed release 81 mg* | E | H |
| *aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg* | 3 | |
| *cilostazol oral tablet 100 mg, 50 mg* | 1 | |
| *clopidogrel bisulfate oral tablet 300 mg, 75 mg* | 1 | |
| *dipyridamole oral tablet 25 mg, 50 mg, 75 mg* | 1 | |
| *ft aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin oral tablet chewable 81 mg* | E | H |
| *goodsense aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *mm aspirin oral tablet delayed release 81 mg* | E | H |
| *prasugrel hcl oral tablet 10 mg, 5 mg* | 3 | |
| ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (*aspirin*) | E | H |
| ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (*aspirin*) | E | H |
| *ticagrelor oral tablet 60 mg, 90 mg* | 3 | QL (2 tablets per day.) |
| ZONTIVITY ORAL TABLET 2.08 MG (*vorapaxar sulfate*) | 3 | QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots** | | |
| *anagrelide hcl oral capsule 0.5 mg, 1 mg* | 1 | |
| **THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots** | | |
| *aspirin 81 oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin childrens oral tablet chewable 81 mg* | E | H |
| *aspirin ec adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin low dose oral tablet chewable 81 mg* | E | H |
| *aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin oral tablet chewable 81 mg* | E | H |
| *aspirin oral tablet delayed release 81 mg* | E | H |
| *aspirin regimen oral tablet delayed release 81 mg* | E | H |
| *ft aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin oral tablet chewable 81 mg* | E | H |
| *goodsense aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *mm aspirin oral tablet delayed release 81 mg* | E | H |
| ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (*aspirin*) | E | H |
| ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (*aspirin*) | E | H |
| **VON WILLEBRAND FACTOR-RELATED ANTITHROMB - Drugs to Prevent Blood Clots** | | |
| CABLIVI INJECTION KIT 11 MG (*caplacizumab-yhdp*) | 2 | PA; QL (1 vial per day and 58 vials per 120 days.); SP |
| **CARDIOVASCULAR DRUGS** | | |
| **BRADYKININ RECEPTORS ANTAGONISTS** | | |
| *icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml* | 2 | PA; QL (0.6 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CARBONIC ANHYDRASE INHIBITORS (24:36)** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | 1 | |
| *acetazolamide oral tablet 125 mg, 250 mg* | 1 | |
| *dichlorphenamide oral tablet 50 mg* | 2 | PA; QL (4 tablets per day.); SP |
| *methazolamide oral tablet 25 mg, 50 mg* | 1 | |
| **FACTOR XIIA INHIBITORS** | | |
| ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (*garadacimab-gxii*) | 2 | PA; QL (1 auto-injector per month.); SP |
| **KALLIKREIN INHIBITORS (24:48:08)** | | |
| TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*lanadelumab-flyo*) | 2 | PA; QL (0.0375 ml per day.); SP |
| TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*lanadelumab-flyo*) | 2 | PA; QL (0.072 ml per day.); SP |
| **LOOP DIURETICS (24:36)** | | |
| *bumetanide oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| BUMEX ORAL TABLET 0.5 MG (*bumetanide*) | 3 | |
| ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (*bumetanide*) | 4 | PA; QL (12 nasal sprays per copay.) |
| *ethacrynic acid oral tablet 25 mg* | 3 | |
| *furosemide oral solution 10 mg/ml, 8 mg/ml* | 1 | |
| *furosemide oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (*furosemide*) | 4 | PA |
| LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (*furosemide*) | 3 | |
| *torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg* | 1 | |
| **OSMOTIC DIURETICS (24:36)** | | |
| DERMACINRX UREA EXTERNAL CREAM 41 % (*urea*) | 3 | |
| DERMACURE EXTERNAL CREAM 41 % (*urea*) | 3 | |
| HYDRO 40 EXTERNAL FOAM 40 % (*urea*) | 3 | |
| *urea external cream 20 %, 40 %* | 1 | |
| *urea external cream 41 %* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *urea external lotion 40 %* | 1 | |
| **POTASSIUM-SPARING DIURETICS (24:36)** | | |
| *amiloride hcl oral tablet 5 mg* | 1 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *spironolactone-hctz oral tablet 25-25 mg* | 1 | |
| *triamterene oral capsule 100 mg, 50 mg* | 3 | |
| **THIAZIDE DIURETICS (24:36)** | | |
| *hydrochlorothiazide oral capsule 12.5 mg* | 1 | |
| *hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*hydrochlorothiazide*) | 3 | PA |
| **THIAZIDE-LIKE DIURETICS (24:36)** | | |
| *chlorthalidone oral tablet 25 mg, 50 mg* | 1 | |
| *indapamide oral tablet 1.25 mg, 2.5 mg* | 1 | |
| *metolazone oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| **CARDIOVASCULAR DRUGS - Drugs for the Heart** | | |
| **ACL INHIBITORS - Drugs for Cholesterol** | | |
| NEXLETOL ORAL TABLET 180 MG (*bempedoic acid*) | 2 | PA; ST; QL (1 tablet per day.) |
| NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*) | 2 | PA; ST; QL (1 tablet per day.) |
| **ALPHA-ADRENERGIC BLOCKING AGENTS (24:16) - Drugs for Varicose Veins** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| *doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *prazosin hcl oral capsule 1 mg, 2 mg, 5 mg* | 1 | |
| *terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |
| TEZRULY ORAL SOLUTION 1 MG/ML (*terazosin hcl*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| *doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg* | 1 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg* | 1 | |
| *prazosin hcl oral capsule 1 mg, 2 mg, 5 mg* | 1 | |
| *terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |
| **ANGIOTENSIN II RECEP ANTAGONIST/NEPROLYS - Drugs for the Heart** | | |
| ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month.) |
| ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month) |
| *sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg* | 2 | PA; QL (2 tablets per day.) |
| **ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN) - Drugs for High Blood Pressure & Angina** | | |
| *candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg* | 3 | |
| *irbesartan oral tablet 150 mg, 300 mg, 75 mg* | 1 | |
| *losartan potassium oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg* | 2 | |
| *telmisartan oral tablet 20 mg, 40 mg, 80 mg* | 2 | |
| *valsartan oral solution 4 mg/ml* | 3 | PA |
| *valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg* | 2 | |
| **ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs for the Heart** | | |
| *amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg* | 2 | |
| *amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ARBLI ORAL SUSPENSION 10 MG/ML (*losartan potassium*) | 3 | PA |
| *candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg* | 3 | |
| *candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg* | 3 | |
| ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month.) |
| ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month) |
| *irbesartan oral tablet 150 mg, 300 mg, 75 mg* | 1 | |
| *irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg* | 1 | |
| *losartan potassium oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg* | 1 | |
| *olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg* | 2 | |
| *olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg* | 2 | |
| *sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg* | 2 | PA; QL (2 tablets per day.) |
| *telmisartan oral tablet 20 mg, 40 mg, 80 mg* | 2 | |
| *telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg* | 2 | |
| *valsartan oral solution 4 mg/ml* | 3 | PA |
| *valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg* | 2 | |
| *valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg* | 1 | |
| **ANGIOTENSIN-CONVERT.ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina** | | |
| *benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 1 | |
| *captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg* | 1 | |
| *enalapril maleate oral solution 1 mg/ml* | 3 | PA |
| *enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 1 | |
| *fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg* | 1 | |
| *lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (*benazepril hcl*) | 3 | |
| *moexipril hcl oral tablet 15 mg, 7.5 mg* | 1 | |
| *perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg* | 2 | |
| *quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 1 | |
| *ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg* | 1 | |
| *trandolapril oral tablet 1 mg, 2 mg, 4 mg* | 1 | |
| **ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart** | | |
| *amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg* | 1 | |
| *benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 1 | |
| *benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg* | 1 | |
| *captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg* | 1 | |
| *captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg* | 1 | |
| *enalapril maleate oral solution 1 mg/ml* | 3 | PA |
| *enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 1 | |
| *enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg* | 1 | |
| *fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg* | 1 | |
| *fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg* | 1 | |
| *lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg* | 1 | |
| *lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | 1 | |
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*benazepril-hydrochlorothiazide*) | 3 | |
| LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (*benazepril hcl*) | 3 | |
| *moexipril hcl oral tablet 15 mg, 7.5 mg* | 1 | |
| *perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg* | 2 | |
| QBRELIS ORAL SOLUTION 1 MG/ML (*lisinopril*) | 3 | PA |
| *quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | 2 | |
| *ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg* | 1 | |
| *trandolapril oral tablet 1 mg, 2 mg, 4 mg* | 1 | |
| *trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg* | 3 | |
| **ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina** | | |
| *digoxin oral solution 0.05 mg/ml* | 1 | |
| *digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg* | 1 | |
| LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (*digoxin*) | 3 | |
| **ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol** | | |
| JUXTAPID ORAL CAPSULE 10 MG, 5 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (1 capsule per day.); SP |
| JUXTAPID ORAL CAPSULE 20 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (60 capsules per month.); SP |
| JUXTAPID ORAL CAPSULE 30 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (62 capsules per month.); SP |
| NEXLETOL ORAL TABLET 180 MG (*bempedoic acid*) | 2 | PA; ST; QL (1 tablet per day.) |
| NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*) | 2 | PA; ST; QL (1 tablet per day.) |
| *niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg* | 2 | |
| *omega-3-acid ethyl esters oral capsule 1 gm* | 2 | |
| TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*olezarsen sodium*) | 3 | PA; QL (1 Auto-injector (0.8 mL) per month.); SP |
| **BETA-ADRENERGIC BLOCKING AGENTS (24:20) - Drugs for High Blood Pressure** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | 1 | |
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*atenolol*) | 3 | PA |
| *atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | 1 | |
| BETIMOL OPHTHALMIC SOLUTION 0.5 % (*timolol hemihydrate*) | 3 | QL (5 ml per prescription.) |
| *bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg* | 1 | |
| CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*doxazosin mesylate*) | 3 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| *doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg* | 1 | |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*) | 3 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*) | 3 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| LOPRESSOR ORAL SOLUTION 10 MG/ML (*metoprolol tartrate*) | 3 | PA |
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg* | 2 | |
| *metoprolol succinate er oral tablet extended release 24 hour 25 mg* | 1 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | |
| *pindolol oral tablet 10 mg, 5 mg* | 1 | |
| *prazosin hcl oral capsule 1 mg, 2 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| *terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |
| *timolol hemihydrate ophthalmic solution 0.5 %* | 2 | QL (5 ml per prescription.) |
| *timolol maleate (once-daily) ophthalmic solution 0.5 %* | 3 | |
| *timolol maleate ocudose ophthalmic solution 0.5 %* | 2 | |
| *timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate ophthalmic solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *timolol maleate pf ophthalmic solution 0.25 %, 0.5 %* | 2 | |
| TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*) | 3 | |
| **BILE ACID SEQUESTRANTS - Drugs for Cholesterol** | | |
| *cholestyramine light oral packet 4 gm* | 1 | |
| *cholestyramine light oral powder 4 gm/dose* | 1 | |
| *cholestyramine oral packet 4 gm* | 1 | |
| *cholestyramine oral powder 4 gm/dose* | 1 | |
| CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (*clindamycin-tretinoin-cholesty*) | 3 | PA |
| *colesevelam hcl oral packet 3.75 gm* | 2 | |
| *colesevelam hcl oral tablet 625 mg* | 2 | |
| COLESTID ORAL GRANULES 5 GM (*colestipol hcl*) | 3 | |
| COLESTID ORAL TABLET 1 GM (*colestipol hcl*) | 3 | |
| *colestipol hcl oral granules 5 gm* | 1 | |
| *colestipol hcl oral packet 5 gm* | 1 | |
| *colestipol hcl oral tablet 1 gm* | 1 | |
| *prevalite oral packet 4 gm* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *prevalite oral powder 4 gm/dose* | 1 | |
| QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (*cholestyramine light*) | 3 | |
| QUESTRAN ORAL PACKET 4 GM (*cholestyramine*) | 3 | |
| QUESTRAN ORAL POWDER 4 GM/DOSE (*cholestyramine*) | 3 | |
| **CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 2 | |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg* | 2 | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | 1 | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| *dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*) | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg* | 1 | |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | 1 | |
| **CALCIUM-CHANNEL BLOCKING AGENTS - Drugs for High Blood Pressure & Angina** | | |
| CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (*etripamil*) | 4 | PA; QL (1 box (2 bottles) per copay.) |
| *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 2 | |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg* | 2 | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | 1 | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| *dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*) | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg* | 1 | |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | 1 | |
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CALCIUM-CHANNEL BLOCKING AGENTS, MISC. - Drugs for High Blood Pressure & Angina** | | |
| *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 2 | |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg* | 2 | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | 1 | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| *dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*) | 3 | |
| *trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg* | 1 | |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | 1 | |
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | 1 | |
| *acetazolamide oral tablet 125 mg, 250 mg* | 1 | |
| *methazolamide oral tablet 25 mg, 50 mg* | 1 | |
| **CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina** | | |
| ATTRUBY ORAL TABLET THERAPY PACK 356 MG (*acoramidis hcl*) | 2 | PA; QL (124 tablets per month.); SP |
| CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (*mavacamten*) | 3 | PA; QL (1 capsule per day.); SP |
| CORLANOR ORAL SOLUTION 5 MG/5ML (*ivabradine hcl*) | 3 | PA; QL (20 ml per day.) |
| CORLANOR ORAL TABLET 5 MG, 7.5 MG (*ivabradine hcl*) | 3 | PA; QL (2 tablets per day.) |
| *ivabradine hcl oral tablet 5 mg, 7.5 mg* | 3 | PA; QL (2 tablets per day.) |
| *ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg* | 2 | |
| VYNDAMAX ORAL CAPSULE 61 MG (*tafamidis*) | 2 | PA; QL (1 capsule per day.); SP |
| **CARDIOTONIC AGENTS - Drugs for Angina** | | |
| CORLANOR ORAL SOLUTION 5 MG/5ML (*ivabradine hcl*) | 3 | PA; QL (20 ml per day.) |
| CORLANOR ORAL TABLET 5 MG, 7.5 MG (*ivabradine hcl*) | 3 | PA; QL (2 tablets per day.) |
| *digoxin oral solution 0.05 mg/ml* | 1 | |
| *digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg* | 1 | |
| *ivabradine hcl oral tablet 5 mg, 7.5 mg* | 3 | PA; QL (2 tablets per day.) |
| LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (*digoxin*) | 3 | |
| **CENTRAL ALPHA-AGONISTS - Drugs for Abnormal Heart Rhythms** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | 1 | |
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*atenolol*) | 3 | PA |
| *atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | 1 | |
| *bisoprolol fumarate oral tablet 10 mg, 5 mg* | 1 | |
| *bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg* | 1 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| *clonidine hcl oral tablet 0.05 mg* | 3 | |
| *clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg* | 1 | |
| *clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr* | 3 | |
| *guanfacine hcl oral tablet 1 mg, 2 mg* | 1 | |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| JAVADIN ORAL SOLUTION 0.02 MG/ML (*clonidine hcl*) | 3 | PA |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*) | 3 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg* | 1 | |
| *methyldopa oral tablet 250 mg, 500 mg* | 3 | PA; ST |
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg* | 2 | |
| *metoprolol succinate er oral tablet extended release 24 hour 25 mg* | 1 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | |
| *pindolol oral tablet 10 mg, 5 mg* | 1 | |
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| **CGMP SYNTHESIS AGENT - Drugs for High Blood Pressure & Angina** | | |
| VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (*vericiguat*) | 3 | PA; QL (1 tablet per day.) |
| **CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol** | | |
| *ezetimibe oral tablet 10 mg* | 2 | |
| *ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg* | 3 | |
| NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*) | 2 | PA; ST; QL (1 tablet per day.) |
| **CLASS IA ANTIARRHYTHMICS - Drugs for Angina** | | |
| *disopyramide phosphate oral capsule 100 mg, 150 mg* | 1 | |
| NORPACE ORAL CAPSULE 100 MG, 150 MG (*disopyramide phosphate*) | 3 | |
| *quinidine gluconate er oral tablet extended release 324 mg* | 1 | |
| *quinidine sulfate oral tablet 200 mg, 300 mg* | 1 | |
| **CLASS IB ANTIARRHYTHMICS - Drugs for Angina** | | |
| DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (*phenytoin*) | 3 | |
| DILANTIN ORAL CAPSULE 100 MG, 30 MG (*phenytoin sodium extended*) | 3 | |
| DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (*phenytoin*) | 3 | |
| *mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg* | 1 | |
| *phenytek oral capsule 200 mg, 300 mg* | 1 | |
| *phenytoin infatabs oral tablet chewable 50 mg* | 1 | |
| *phenytoin oral suspension 125 mg/5ml* | 1 | |
| *phenytoin oral tablet chewable 50 mg* | 1 | |
| *phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CLASS IC ANTIARRHYTHMICS - Drugs for Angina** | | |
| *flecainide acetate oral tablet 100 mg, 150 mg, 50 mg* | 1 | |
| *propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg* | 3 | |
| *propafenone hcl oral tablet 150 mg, 225 mg, 300 mg* | 1 | |
| **CLASS II ANTIARRHYTHMICS - Drugs for Angina** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | 1 | |
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*atenolol*) | 3 | PA |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |
| *betaxolol hcl ophthalmic solution 0.5 %* | 1 | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | 1 | |
| BETIMOL OPHTHALMIC SOLUTION 0.5 % (*timolol hemihydrate*) | 3 | QL (5 ml per prescription.) |
| *bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*) | 3 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*) | 3 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| LOPRESSOR ORAL SOLUTION 10 MG/ML (*metoprolol tartrate*) | 3 | PA |
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg* | 2 | |
| *metoprolol succinate er oral tablet extended release 24 hour 25 mg* | 1 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | |
| *pindolol oral tablet 10 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| *timolol hemihydrate ophthalmic solution 0.5 %* | 2 | QL (5 ml per prescription.) |
| *timolol maleate (once-daily) ophthalmic solution 0.5 %* | 3 | |
| *timolol maleate ocudose ophthalmic solution 0.5 %* | 2 | |
| *timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate ophthalmic solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *timolol maleate pf ophthalmic solution 0.25 %, 0.5 %* | 2 | |
| TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*) | 3 | |
| **CLASS III ANTIARRHYTHMICS - Drugs for Angina** | | |
| *amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg* | 1 | |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |
| *dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg* | 2 | |
| MULTAQ ORAL TABLET 400 MG (*dronedarone hcl*) | 3 | PA |
| PACERONE ORAL TABLET 100 MG, 200 MG (*amiodarone hcl*) | 3 | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (*dofetilide*) | 3 | |
| **CLASS IV ANTIARRHYTHMICS - Drugs for Angina** | | |
| CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (*etripamil*) | 4 | PA; QL (1 box (2 bottles) per copay.) |
| *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg* | 2 | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | 1 | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| *dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*) | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg* | 1 | |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | 1 | |
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | 1 | |
| **DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina** | | |
| AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| *amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg* | 1 | |
| *amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg* | 3 | |
| *felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg* | 1 | |
| *isradipine oral capsule 2.5 mg, 5 mg* | 1 | |
| *nicardipine hcl oral capsule 20 mg, 30 mg* | 1 | |
| *nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine oral capsule 10 mg, 20 mg* | 1 | |
| *nimodipine oral capsule 30 mg* | 1 | |
| NIMODIPINE ORAL SOLUTION 60 MG/20ML | 2 | |
| *nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg* | 2 | |
| NORLIQVA ORAL SOLUTION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| NYMALIZE ORAL SOLUTION 6 MG/ML (*nimodipine*) | 2 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (*nisoldipine*) | 3 | |
| **DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina** | | |
| AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| *amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg* | 1 | |
| *isradipine oral capsule 2.5 mg, 5 mg* | 1 | |
| *nicardipine hcl oral capsule 20 mg, 30 mg* | 1 | |
| *nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine oral capsule 10 mg, 20 mg* | 1 | |
| *nimodipine oral capsule 30 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| NIMODIPINE ORAL SOLUTION 60 MG/20ML | 2 | |
| *nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg* | 2 | |
| NORLIQVA ORAL SOLUTION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| NYMALIZE ORAL SOLUTION 6 MG/ML (*nimodipine*) | 2 | |
| SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (*nisoldipine*) | 3 | |
| **DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina** | | |
| CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| *clonidine hcl er oral tablet extended release 12 hour 0.1 mg* | 2 | |
| *clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg* | 1 | |
| *clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr* | 3 | |
| EDEX (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| *guanfacine hcl oral tablet 1 mg, 2 mg* | 1 | |
| *hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg* | 1 | |
| *isosorb dinitrate-hydralazine oral tablet 20-37.5 mg* | 2 | |
| *methyldopa oral tablet 250 mg, 500 mg* | 3 | PA; ST |
| *minoxidil oral tablet 10 mg, 2.5 mg* | 1 | |
| **DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina** | | |
| *elixophyllin oral elixir 80 mg/15ml* | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*) | 3 | |
| *theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | 1 | |
| *theophylline oral elixir 80 mg/15ml* | 1 | |
| *theophylline oral solution 80 mg/15ml* | 1 | |
| **FIBRIC ACID DERIVATIVES - Drugs for Cholesterol** | | |
| *fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg* | 2 | |
| *fenofibrate oral capsule 134 mg, 200 mg, 67 mg* | 2 | |
| *fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg* | 2 | |
| *fenofibric acid oral capsule delayed release 135 mg, 45 mg* | 2 | |
| *gemfibrozil oral tablet 600 mg* | 1 | |
| LOPID ORAL TABLET 600 MG (*gemfibrozil*) | 3 | |
| **HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol** | | |
| ATORVALIQ ORAL SUSPENSION 20 MG/5ML (*atorvastatin calcium*) | 3 | PA |
| *atorvastatin calcium oral tablet 10 mg, 20 mg* | 1 | H-N |
| *atorvastatin calcium oral tablet 40 mg, 80 mg* | 1 | |
| *ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg* | 3 | |
| FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML | 3 | PA |
| *fluvastatin sodium er oral tablet extended release 24 hour 80 mg* | 3 | ST |
| *fluvastatin sodium oral capsule 20 mg, 40 mg* | 1 | |
| *lovastatin oral tablet 10 mg, 20 mg, 40 mg* | 1 | H-N |
| *pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg* | 1 | |
| *rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 2 | |
| *simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | 1 | H-N |
| *simvastatin oral tablet 80 mg* | 1 | |
| **LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina** | | |
| *bumetanide oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| BUMEX ORAL TABLET 0.5 MG (*bumetanide*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ethacrynic acid oral tablet 25 mg* | 3 | |
| *furosemide oral solution 10 mg/ml, 8 mg/ml* | 1 | |
| *furosemide oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (*furosemide*) | 3 | |
| *torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg* | 1 | |
| **MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart** | | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| KERENDIA ORAL TABLET 10 MG, 20 MG (*finerenone*) | 3 | PA; QL (1 tablet per day.) |
| KERENDIA ORAL TABLET 40 MG (*finerenone*) | 3 | PA; QL (30 tablets per month.) |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *spironolactone-hctz oral tablet 25-25 mg* | 1 | |
| **MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina** | | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| **MTP PROTEIN INHIBITORS - Drugs for Cholesterol** | | |
| JUXTAPID ORAL CAPSULE 10 MG, 5 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (1 capsule per day.); SP |
| JUXTAPID ORAL CAPSULE 2 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (30 capsules per month.) |
| JUXTAPID ORAL CAPSULE 20 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (60 capsules per month.); SP |
| JUXTAPID ORAL CAPSULE 30 MG (*lomitapide mesylate*) | 3 | PA; ST; QL (62 capsules per month.); SP |
| **NITRATES AND NITRITES - Drugs for High Blood Pressure & Angina** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*atenolol*) | 3 | PA |
| BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*) | 4 | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | 1 | |
| *bisoprolol fumarate oral tablet 10 mg, 5 mg* | 1 | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | 1 | |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| *isosorb dinitrate-hydralazine oral tablet 20-37.5 mg* | 2 | |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | 1 | |
| *isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg* | 1 | |
| *isosorbide mononitrate oral tablet 10 mg, 20 mg* | 1 | |
| KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*) | 3 | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg* | 1 | |
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg* | 2 | |
| *metoprolol succinate er oral tablet extended release 24 hour 25 mg* | 1 | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| *nitro-bid transdermal ointment 2 %* | 2 | |
| NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (*nitroglycerin*) | 3 | |
| *nitroglycerin rectal ointment 0.4 %* | 3 | QL (30 grams per month.) |
| *nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg* | 1 | |
| *nitroglycerin transdermal ointment 2 %* | 2 | |
| *nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (*nitroglycerin*) | 3 | |
| NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (*nitroglycerin*) | 3 | |
| *pindolol oral tablet 10 mg, 5 mg* | 1 | |
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| RECTIV RECTAL OINTMENT 0.4 % (*nitroglycerin*) | 3 | QL (30 grams per month.) |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | 1 | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | 1 | |
| SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*) | 3 | PA |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| **NITRATES AND NITRITES - Drugs for the Heart** | | |
| *isosorb dinitrate-hydralazine oral tablet 20-37.5 mg* | 2 | |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | 1 | |
| *isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg* | 1 | |
| *isosorbide mononitrate oral tablet 10 mg, 20 mg* | 1 | |
| *nitro-bid transdermal ointment 2 %* | 2 | |
| NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (*nitroglycerin*) | 3 | |
| *nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg* | 1 | |
| *nitroglycerin transdermal ointment 2 %* | 2 | |
| *nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr* | 1 | |
| NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (*nitroglycerin*) | 3 | |
| NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (*nitroglycerin*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol** | | |
| *omega-3-acid ethyl esters oral capsule 1 gm* | 2 | |
| **PCSK9 INHIBITORS - Drugs for Cholesterol** | | |
| REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (*evolocumab*) | 2 | QL (2 pens per month.) |
| **PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina** | | |
| *alyq oral tablet 20 mg* | 2 | PA; QL (2 tablets per day); SP |
| *aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg* | 3 | |
| *avanafil oral tablet 100 mg, 200 mg, 50 mg* | 3 | PA; QL (3 tablets per month.) |
| *cilostazol oral tablet 100 mg, 50 mg* | 1 | |
| *dipyridamole oral tablet 25 mg, 50 mg, 75 mg* | 1 | |
| *sildenafil citrate oral suspension reconstituted 10 mg/ml* | 3 | PA; QL (186 ml per month.); SP |
| *sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg* | 2 | QL (0.5 tablet per day.) |
| *sildenafil citrate oral tablet 20 mg* | 1 | QL (0.5 tablet per day.); SP |
| STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (*avanafil*) | 3 | PA; QL (3 tablets per month.) |
| *tadalafil (pah) oral tablet 20 mg* | 1 | PA; QL (2 tablets per day); SP |
| *tadalafil oral tablet 10 mg, 20 mg* | 2 | QL (0.5 tablet per day.) |
| *tadalafil oral tablet 2.5 mg, 5 mg* | 2 | QL (1 tablet per day.) |
| TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*) | 3 | PA; QL (10 ml per day.); SP |
| *vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | QL (3 tablets per month.) |
| *vardenafil hcl oral tablet dispersible 10 mg* | 3 | QL (3 tablets per month.) |
| VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (*sildenafil citrate*) | 3 | |
| **PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart** | | |
| *alyq oral tablet 20 mg* | 2 | PA; QL (2 tablets per day); SP |
| *avanafil oral tablet 100 mg, 200 mg, 50 mg* | 3 | PA; QL (3 tablets per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *cilostazol oral tablet 100 mg, 50 mg* | 1 | |
| *sildenafil citrate oral suspension reconstituted 10 mg/ml* | 3 | PA; QL (186 ml per month.); SP |
| *sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg* | 2 | QL (0.5 tablet per day.) |
| *sildenafil citrate oral tablet 20 mg* | 1 | QL (0.5 tablet per day.); SP |
| STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (*avanafil*) | 3 | PA; QL (3 tablets per month.) |
| *tadalafil (pah) oral tablet 20 mg* | 1 | PA; QL (2 tablets per day); SP |
| *tadalafil oral tablet 10 mg, 20 mg* | 2 | QL (0.5 tablet per day.) |
| *tadalafil oral tablet 2.5 mg, 5 mg* | 2 | QL (1 tablet per day.) |
| TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*) | 3 | PA; QL (10 ml per day.); SP |
| *vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | QL (3 tablets per month.) |
| *vardenafil hcl oral tablet dispersible 10 mg* | 3 | QL (3 tablets per month.) |
| **POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina** | | |
| *amiloride hcl oral tablet 5 mg* | 1 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *triamterene oral capsule 100 mg, 50 mg* | 3 | |
| **RENIN INHIBITORS - Drugs for the Heart** | | |
| *aliskiren fumarate oral tablet 150 mg, 300 mg* | 3 | |
| TEKTURNA ORAL TABLET 150 MG, 300 MG (*aliskiren fumarate*) | 3 | |
| **RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart** | | |
| ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month.) |
| ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (*sacubitril-valsartan*) | 3 | PA; QL (240 sprinkle capsules (pellets) per month) |
| FILSPARI ORAL TABLET 200 MG, 400 MG (*sparsentan*) | 4 | PA; QL (60 tablets per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg* | 2 | PA; QL (2 tablets per day.) |
| **STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart** | | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *spironolactone-hctz oral tablet 25-25 mg* | 1 | |
| **THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina** | | |
| *hydrochlorothiazide oral capsule 12.5 mg* | 1 | |
| *hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| **THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure & Angina** | | |
| *chlorthalidone oral tablet 25 mg, 50 mg* | 1 | |
| *indapamide oral tablet 1.25 mg, 2.5 mg* | 1 | |
| *metolazone oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| **VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina** | | |
| *phenoxybenzamine hcl oral capsule 10 mg* | 2 | |
| VECAMYL ORAL TABLET 2.5 MG (*mecamylamine hcl*) | 3 | PA |
| **VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart** | | |
| *ambrisentan oral tablet 10 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP |
| AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| *amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *bosentan oral tablet 125 mg, 62.5 mg* | 2 | PA; QL (2 tablets per day.); SP |
| *bosentan oral tablet soluble 32 mg* | 2 | PA; QL (4 tablets per day.); SP |
| *cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| CORLANOR ORAL SOLUTION 5 MG/5ML (*ivabradine hcl*) | 3 | PA; QL (20 ml per day.) |
| CORLANOR ORAL TABLET 5 MG, 7.5 MG (*ivabradine hcl*) | 3 | PA; QL (2 tablets per day.) |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg* | 2 | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | 1 | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| *dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | |
| *dipyridamole oral tablet 25 mg, 50 mg, 75 mg* | 1 | |
| EDEX (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (*alprostadil (vasodilator)*) | 3 | QL (6 units per month.) |
| *ivabradine hcl oral tablet 5 mg, 7.5 mg* | 3 | PA; QL (2 tablets per day.) |
| *macitentan oral tablet 10 mg* | 2 | PA; QL (1 tablet per day.); SP |
| *matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| *nicardipine hcl oral capsule 20 mg, 30 mg* | 1 | |
| *nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | 1 | |
| *nifedipine oral capsule 10 mg, 20 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *nimodipine oral capsule 30 mg* | 1 | |
| NIMODIPINE ORAL SOLUTION 60 MG/20ML | 2 | |
| NORLIQVA ORAL SOLUTION 1 MG/ML (*amlodipine besylate*) | 3 | PA |
| NYMALIZE ORAL SOLUTION 6 MG/ML (*nimodipine*) | 2 | |
| ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (168 tablets per year.); SP |
| ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (336 tablets per year.); SP |
| ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*) | 3 | PA; QL (252 tablets per year.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (*treprostinil diolamine*) | 3 | PA; QL (6 tablets per day.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (*treprostinil diolamine*) | 3 | PA; QL (744 tablets per month.); SP |
| *tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | 2 | |
| TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*) | 3 | |
| TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*) | 4 | PA; QL (4 tablets per day.); SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (*treprostinil*) | 2 | PA; QL (224 cartidges per month.); SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (*treprostinil*) | 2 | PA; SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (*treprostinil*) | 2 | PA; QL (112 cartridges per month.); SP |
| TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (*treprostinil*) | 2 | PA; QL (252 cartridges per 365 days.); SP |
| TYVASO INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg* | 3 | |
| *verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg* | 1 | |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | 1 | |
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | 1 | |
| VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (*vericiguat*) | 3 | PA; QL (1 tablet per day.) |
| YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (*treprostinil sodium*) | 2 | PA; QL (140 capsules per month.); SP |
| **CENTRAL NERVOUS SYSTEM AGENTS** | | |
| **AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT** | | |
| RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (*edaravone*) | 3 | PA; QL (50 ml per month.); SP |
| RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (*edaravone*) | 3 | PA; QL (1 starter kit per year.); SP |
| *riluzole oral tablet 50 mg* | 1 | |
| TEGLUTIK ORAL SUSPENSION 50 MG/10ML (*riluzole*) | 3 | PA; SP |
| TIGLUTIK ORAL SUSPENSION 50 MG/10ML (*riluzole*) | 3 | PA; SP |
| **CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System** | | |
| **ADAMANTANES (CNS) - Drugs for Parkinson** | | |
| *amantadine hcl oral capsule 100 mg* | 1 | |
| *amantadine hcl oral solution 50 mg/5ml* | 1 | |
| *amantadine hcl oral tablet 100 mg* | 1 | |
| **ADENOSINE A2A RECEPTOR ANTAGONISTS - Drugs for Parkinson** | | |
| NOURIANZ ORAL TABLET 20 MG, 40 MG (*istradefylline*) | 3 | PA; QL (1 tablet per day.) |
| **AMPHETAMINE DERIVATIVES - Drugs for the Nervous System** | | |
| *diethylpropion hcl er oral tablet extended release 24 hour 75 mg* | 1 | PA |
| *diethylpropion hcl oral tablet 25 mg* | 1 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LOMAIRA ORAL TABLET 8 MG (*phentermine hcl*) | 3 | PA |
| *phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg* | 1 | PA |
| *phendimetrazine tartrate oral tablet 35 mg* | 1 | PA |
| *phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg* | 1 | PA |
| *phentermine hcl oral tablet 37.5 mg* | 1 | PA |
| *phentermine hcl oral tablet 8 mg* | 3 | PA |
| **AMPHETAMINES - Drugs for the Nervous System** | | |
| *amphetamine sulfate oral tablet 10 mg, 5 mg* | 2 | |
| *amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg* | 2 | QL (2 capsules per day.) |
| *amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg* | 1 | |
| *amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg* | 3 | QL (1 capsule per day.) |
| *benzphetamine hcl oral tablet 50 mg* | 1 | PA |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg* | 3 | QL (5 capsules per day.) |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg* | 3 | QL (4 capsules per day.) |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg* | 2 | QL (10 capsules per day.) |
| *dextroamphetamine sulfate oral solution 5 mg/5ml* | 1 | |
| *dextroamphetamine sulfate oral tablet 10 mg, 5 mg* | 2 | |
| *lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg* | 3 | QL (2 capsules per day.) |
| *lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg* | 3 | QL (1 capsule per day) |
| *lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg* | 3 | QL (2 tablets per day.) |
| *lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg* | 3 | QL (1 tablet per day.) |
| *methamphetamine hcl oral tablet 5 mg* | 1 | |
| PROCENTRA ORAL SOLUTION 5 MG/5ML (*dextroamphetamine sulfate*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (*dextroamphetamine*) | 3 | PA; QL (1 patch per day.) |
| **ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain** | | |
| *acetaminophen-codeine oral solution 120-12 mg/5ml* | 1 | NTT |
| *acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg* | 1 | NTT |
| *apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg* | 3 | NTT |
| *bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-acetaminophen oral tablet 50-325 mg* | 1 | |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | 1 | QL (Benefit maximum quantity 6 per day.) |
| *butalbital-apap-caffeine oral capsule 50-300-40 mg* | 3 | QL (6 capsules per day) |
| *butalbital-apap-caffeine oral capsule 50-325-40 mg* | 1 | QL (6 capsules per day) |
| BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML | 2 | |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (*gabapentin*) | 3 | PA |
| FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*) | 3 | QL (6 capsules per day) |
| *gabapentin oral capsule 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| *gabapentin oral solution 250 mg/5ml* | 1 | |
| *gabapentin oral tablet 600 mg, 800 mg* | 1 | |
| *hydrocodone-acetaminophen oral solution 10-300 mg/15ml* | 1 | NTT |
| *hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml* | 2 | NTT |
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| JOURNAVX ORAL TABLET 50 MG (*suzetrigine*) | 3 | QL (30 tablets per 90 days.) |
| NEURAPTINE EXTERNAL CREAM 10 % (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*) | 4 | PA |
| NEURORUB EXTERNAL CREAM 10 % (*gabapentin*) | 3 | PA |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| TENCON ORAL TABLET 50-325 MG (*butalbital-acetaminophen*) | 3 | |
| *tramadol-acetaminophen oral tablet 37.5-325 mg* | 1 | NTT |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (*apap-caff-dihydrocodeine*) | 3 | NTT |
| URELLE ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| *uretron d/s oral tablet 81.6 mg* | 1 | |
| VILEVEV MB ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| **ANOREXIGENIC AGENTS - Drugs for the Nervous System** | | |
| CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (*naltrexone-bupropion hcl*) | 3 | PA; QL (4 tablets per day.) |
| *phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg* | 3 | PA; QL (1 capsule per day.) |
| QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (*phentermine-topiramate*) | 3 | PA; QL (1 capsule per day.) |
| **ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System** | | |
| *phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg* | 3 | PA; QL (1 capsule per day.) |
| QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (*phentermine-topiramate*) | 3 | PA; QL (1 capsule per day.) |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (*diazoxide choline*) | 4 | PA; QL (90 tablets per month.); SP |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (*diazoxide choline*) | 4 | PA; QL (120 tablets per month.); SP |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (*diazoxide choline*) | 4 | PA; QL (210 tablets per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System** | | |
| CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (*naltrexone-bupropion hcl*) | 3 | PA; QL (4 tablets per day.) |
| *liraglutide solution pen-injector 18 mg/3ml subcutaneous* | 2 | PA; QL (2 pens (6 mL) per month.) |
| *liraglutide solution pen-injector 18 mg/3ml subcutaneous* | 3 | PA; QL (3 pens (9 mL) per month.) |
| *liraglutide -weight management subcutaneous solution pen-injector 18 mg/3ml* | 3 | PA; QL (0.6 ml per day.) |
| SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide -weight management*) | 3 | PA; QL (0.6 ml per day.) |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (*diazoxide choline*) | 4 | PA; QL (90 tablets per month.); SP |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (*diazoxide choline*) | 4 | PA; QL (120 tablets per month.); SP |
| VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (*diazoxide choline*) | 4 | PA; QL (210 tablets per month.); SP |
| WEGOVY HD SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.2 MG/0.75ML (*semaglutide-weight management*) | 3 | PA |
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (*semaglutide-weight management*) | 3 | PA; QL (0.08 ml per day and 4 ml per 365 days.) |
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (*semaglutide-weight management*) | 3 | PA; QL (0.11 ml per day.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (2 mL (4 vials) per month.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (2 mL (4 vials) per month.  4 mL (8 vials) per 365 days.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (4 pens per month.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (4 pens per month and  8 pens per year.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson** | | |
| *benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| *orphenadrine citrate er oral tablet extended release 12 hour 100 mg* | 2 | |
| *trihexyphenidyl hcl oral solution 0.4 mg/ml* | 1 | |
| *trihexyphenidyl hcl oral tablet 2 mg, 5 mg* | 1 | |
| **ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | 1 | |
| *acetazolamide oral tablet 125 mg, 250 mg* | 1 | |
| APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (*eslicarbazepine acetate*) | 3 | PA |
| BANZEL ORAL SUSPENSION 40 MG/ML (*rufinamide*) | 3 | PA |
| BANZEL ORAL TABLET 200 MG, 400 MG (*rufinamide*) | 3 | PA |
| *brivaracetam oral solution 10 mg/ml* | 2 | PA |
| *brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg* | 2 | PA |
| BRIVIACT ORAL SOLUTION 10 MG/ML (*brivaracetam*) | 3 | PA |
| BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (*brivaracetam*) | 3 | PA |
| *carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg* | 2 | |
| *carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg* | 2 | |
| *carbamazepine oral suspension 100 mg/5ml* | 1 | |
| *carbamazepine oral tablet 200 mg* | 1 | |
| *carbamazepine oral tablet chewable 100 mg, 200 mg* | 1 | |
| CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine*) | 3 | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (*divalproex sodium*) | 3 | PA |
| DIACOMIT ORAL CAPSULE 250 MG, 500 MG (*stiripentol*) | 3 | PA; SP |
| DIACOMIT ORAL PACKET 250 MG, 500 MG (*stiripentol*) | 3 | PA; SP |
| *divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg* | 2 | |
| *divalproex sodium oral capsule delayed release sprinkle 125 mg* | 2 | |
| *divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg* | 1 | |
| EPIDIOLEX ORAL SOLUTION 100 MG/ML (*cannabidiol*) | 3 | PA; SP |
| EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine (antipsychotic)*) | 3 | |
| *eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg* | 3 | PA |
| FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (*gabapentin*) | 3 | PA |
| *felbamate oral suspension 600 mg/5ml* | 1 | |
| *felbamate oral tablet 400 mg, 600 mg* | 1 | |
| FELBATOL ORAL TABLET 400 MG, 600 MG (*felbamate*) | 3 | PA |
| FINTEPLA ORAL SOLUTION 2.2 MG/ML (*fenfluramine hcl*) | 3 | PA |
| FYCOMPA ORAL SUSPENSION 0.5 MG/ML (*perampanel*) | 3 | PA |
| FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*perampanel*) | 3 | PA |
| *gabapentin oral capsule 100 mg, 300 mg, 400 mg* | 1 | |
| *gabapentin oral solution 250 mg/5ml* | 1 | |
| *gabapentin oral tablet 600 mg, 800 mg* | 1 | |
| KEPPRA ORAL SOLUTION 100 MG/ML (*levetiracetam*) | 4 | PA |
| KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (*levetiracetam*) | 3 | PA |
| KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (*levetiracetam*) | 4 | PA |
| *lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg* | 2 | |
| LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (*lamotrigine*) | 3 | PA |
| LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (*lamotrigine*) | 3 | PA |
| LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (*lamotrigine*) | 3 | PA |
| *lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg* | 3 | |
| *lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg* | 3 | PA |
| *lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg* | 3 | PA |
| *lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg* | 1 | |
| *lamotrigine oral tablet chewable 25 mg, 5 mg* | 1 | |
| *lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg* | 3 | PA |
| *lamotrigine starter kit-blue oral kit 35 x 25 mg* | 1 | |
| *lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg* | 1 | |
| *lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg* | 1 | |
| *levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg* | 2 | |
| *levetiracetam oral solution 100 mg/ml, 500 mg/5ml* | 1 | |
| *levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg* | 1 | |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*) | 3 | PA |
| MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*lacosamide*) | 3 | PA |
| NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*) | 4 | PA |
| *oxcarbazepine oral suspension 300 mg/5ml* | 1 | |
| *oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg* | 1 | |
| *perampanel oral suspension 0.5 mg/ml* | 3 | PA |
| *perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg* | 2 | PA |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg* | 2 | |
| *pregabalin oral solution 20 mg/ml* | 2 | |
| *roweepra oral tablet 500 mg* | 1 | |
| *rufinamide oral suspension 40 mg/ml* | 3 | |
| *rufinamide oral tablet 200 mg, 400 mg* | 3 | PA |
| SUBVENITE ORAL SUSPENSION 10 MG/ML (*lamotrigine*) | 4 | PA |
| *subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg* | 1 | |
| *subvenite starter kit-blue oral kit 35 x 25 mg* | 1 | |
| *subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg* | 1 | |
| *subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg* | 1 | |
| TEGRETOL ORAL SUSPENSION 100 MG/5ML (*carbamazepine*) | 3 | |
| TEGRETOL ORAL TABLET 200 MG (*carbamazepine*) | 3 | |
| TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (*carbamazepine*) | 3 | |
| *tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg* | 1 | |
| TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*) | 3 | PA |
| TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (*topiramate*) | 3 | PA |
| *topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg* | 1 | |
| TRILEPTAL ORAL SUSPENSION 300 MG/5ML (*oxcarbazepine*) | 3 | PA |
| TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (*oxcarbazepine*) | 3 | PA |
| *valproic acid oral capsule 250 mg* | 1 | |
| *valproic acid oral solution 250 mg/5ml* | 1 | |
| *vigabatrin oral packet 500 mg* | 2 | PA; QL (6 packets per day.) |
| *vigabatrin oral tablet 500 mg* | 2 | PA; QL (6 tablets per day.); SP |
| VIGADRONE ORAL PACKET 500 MG (*vigabatrin*) | 2 | PA; QL (6 packets per day.) |
| VIGADRONE ORAL TABLET 500 MG (*vigabatrin*) | 2 | PA; QL (6 tablets per day.); SP |
| VIMPAT ORAL SOLUTION 10 MG/ML (*lacosamide*) | 3 | PA |
| VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*lacosamide*) | 3 | PA |
| XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*) | 3 | PA |
| XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (*cenobamate*) | 3 | PA |
| ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (*zonisamide*) | 4 | PA |
| ZONISADE ORAL SUSPENSION 100 MG/5ML (*zonisamide*) | 3 | PA |
| *zonisamide oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| ZTALMY ORAL SUSPENSION 50 MG/ML (*ganaxolone*) | 3 | PA; SP |
| **ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis** | | |
| AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (*dextromethorphan-bupropion*) | 3 | ST; QL (2 tablets per day.) |
| AUVELITY TITRATION PACK ORAL TABLET EXTENDED RELEASE THERAPY PACK 30-105 MG & 45-105 MG (*dextromethorphan-bupropion*) | 3 | ST; QL (1 titration pack every 365 days.) |
| *bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg* | 1 | |
| *bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg* | 1 | |
| *bupropion hcl oral tablet 100 mg, 75 mg* | 1 | |
| *mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg* | 1 | |
| *mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg* | 1 | |
| SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*) | 3 | PA; QL (8 devices (4 kits) per month.) |
| SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*) | 3 | PA; QL (12 devices (4 kits) per month.) |
| ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (*zuranolone*) | 2 | PA; QL (28 capsules per year.); SP |
| ZURZUVAE ORAL CAPSULE 30 MG (*zuranolone*) | 2 | PA; QL (14 capsules per year.); SP |
| **ANTIMANIC AGENTS - Drugs for Personality Disorder** | | |
| *aripiprazole oral solution 1 mg/ml* | 2 | |
| *aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg* | 2 | |
| *aripiprazole oral tablet dispersible 10 mg, 15 mg* | 2 | QL (1 tablet per day.) |
| *asenapine maleate sublingual tablet sublingual 10 mg, 5 mg* | 3 | QL (2 tablets per day) |
| *asenapine maleate sublingual tablet sublingual 2.5 mg* | 3 | QL (2 tablets per day.) |
| *carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg* | 2 | |
| *carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg* | 2 | |
| *carbamazepine oral suspension 100 mg/5ml* | 1 | |
| *carbamazepine oral tablet 200 mg* | 1 | |
| *carbamazepine oral tablet chewable 100 mg, 200 mg* | 1 | |
| CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine*) | 3 | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (*divalproex sodium*) | 3 | PA |
| *divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg* | 2 | |
| *divalproex sodium oral capsule delayed release sprinkle 125 mg* | 2 | |
| *divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg* | 1 | |
| EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine (antipsychotic)*) | 3 | |
| LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (*lamotrigine*) | 3 | PA |
| LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (*lamotrigine*) | 4 | PA |
| LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (*lamotrigine*) | 3 | PA |
| LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (*lamotrigine*) | 3 | PA |
| *lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg* | 3 | |
| *lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg* | 3 | PA |
| *lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg* | 3 | PA |
| *lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg* | 1 | |
| *lamotrigine oral tablet chewable 25 mg, 5 mg* | 1 | |
| *lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg* | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *lamotrigine starter kit-blue oral kit 35 x 25 mg* | 1 | |
| *lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg* | 1 | |
| *lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg* | 1 | |
| *lithium carbonate er oral tablet extended release 300 mg, 450 mg* | 1 | |
| *lithium carbonate oral capsule 150 mg, 300 mg, 600 mg* | 1 | |
| *lithium carbonate oral tablet 300 mg* | 1 | |
| *lithium oral solution 8 meq/5ml* | 1 | |
| LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (*lithium carbonate*) | 3 | PA |
| *olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg* | 1 | |
| *olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg* | 2 | |
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg* | 2 | QL (1 capsule per day) |
| *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg* | 2 | |
| *quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg* | 1 | |
| *risperidone oral solution 1 mg/ml* | 1 | |
| *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg* | 1 | |
| *risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg* | 1 | |
| SUBVENITE ORAL SUSPENSION 10 MG/ML (*lamotrigine*) | 4 | PA |
| *subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg* | 1 | |
| *subvenite starter kit-blue oral kit 35 x 25 mg* | 1 | |
| *subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg* | 1 | |
| *subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg* | 1 | |
| TEGRETOL ORAL SUSPENSION 100 MG/5ML (*carbamazepine*) | 3 | |
| TEGRETOL ORAL TABLET 200 MG (*carbamazepine*) | 3 | |
| TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (*carbamazepine*) | 3 | |
| *valproic acid oral capsule 250 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *valproic acid oral solution 250 mg/5ml* | 1 | |
| *ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg* | 2 | |
| **ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment** | | |
| *aspirin 81 oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin childrens oral tablet chewable 81 mg* | E | H |
| *aspirin ec adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin low dose oral tablet chewable 81 mg* | E | H |
| *aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin oral tablet chewable 81 mg* | E | H |
| *aspirin oral tablet delayed release 81 mg* | E | H |
| *aspirin regimen oral tablet delayed release 81 mg* | E | H |
| *butorphanol tartrate nasal solution 10 mg/ml* | 2 | QL (7.5 ml (3 bottles) per prescription.) |
| CAFERGOT ORAL TABLET 1-100 MG (*ergotamine-caffeine*) | 3 | |
| *caffeine citrate oral solution 60 mg/3ml* | 1 | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (*divalproex sodium*) | 3 | PA |
| *dihydroergotamine mesylate injection solution 1 mg/ml* | 1 | |
| *dihydroergotamine mesylate nasal solution 4 mg/ml* | 3 | ST; QL (8 mL per prescription.) |
| *divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg* | 2 | |
| *divalproex sodium oral capsule delayed release sprinkle 125 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg* | 1 | |
| ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (*ergotamine tartrate*) | 3 | ST; QL (5 tablets per prescription.) |
| *ergotamine-caffeine oral tablet 1-100 mg* | 3 | |
| *ft aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin oral tablet chewable 81 mg* | E | H |
| *goodsense aspirin low dose oral tablet delayed release 81 mg* | E | H |
| HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*) | 3 | |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | 1 | |
| MIGERGOT RECTAL SUPPOSITORY 2-100 MG (*ergotamine-caffeine*) | 3 | |
| *mm aspirin oral tablet delayed release 81 mg* | E | H |
| *naproxen dr oral tablet delayed release 500 mg* | 1 | |
| *naproxen oral tablet 250 mg, 375 mg, 500 mg* | 1 | |
| *naproxen oral tablet delayed release 375 mg, 500 mg* | 1 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 2 | |
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | 2 | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | 1 | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | 1 | |
| ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (*aspirin*) | E | H |
| ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (*aspirin*) | E | H |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*) | 3 | PA |
| TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (*topiramate*) | 3 | PA |
| *topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg* | 1 | |
| *topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *valproic acid oral capsule 250 mg* | 1 | |
| *valproic acid oral solution 250 mg/5ml* | 1 | |
| **ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis** | | |
| COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (*xanomeline-trospium chloride*) | 3 | PA; QL (62 capsules per month.) |
| COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (*xanomeline-trospium chloride*) | 3 | PA; QL (1 starter pack per year.) |
| *loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg* | 1 | |
| *molindone hcl oral tablet 10 mg, 25 mg, 5 mg* | 3 | |
| *pimozide oral tablet 1 mg, 2 mg* | 2 | |
| **ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC - Drugs for Anxiety & Sleep Disorder** | | |
| BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*suvorexant*) | 3 | QL (1 tablet per day.) |
| *buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg* | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| *eszopiclone oral tablet 1 mg, 2 mg, 3 mg* | 2 | |
| HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (*tasimelteon*) | 4 | PA; QL (5.1 mL per day.); SP |
| HETLIOZ ORAL CAPSULE 20 MG (*tasimelteon*) | 3 | PA; QL (1 capsule per day.); SP |
| *hydroxyzine hcl oral syrup 10 mg/5ml* | 1 | |
| *hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg* | 1 | |
| *hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *meprobamate oral tablet 200 mg, 400 mg* | 1 | |
| *promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml* | 1 | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |
| *ramelteon oral tablet 8 mg* | 3 | QL (1 tablet per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *tasimelteon oral capsule 20 mg* | 3 | PA; QL (1 capsule per day.); SP |
| *zaleplon oral capsule 10 mg, 5 mg* | 1 | |
| *zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg* | 2 | |
| *zolpidem tartrate oral tablet 10 mg, 5 mg* | 1 | |
| **ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis** | | |
| *aripiprazole oral solution 1 mg/ml* | 2 | |
| *aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg* | 2 | |
| *aripiprazole oral tablet dispersible 10 mg, 15 mg* | 2 | QL (1 tablet per day.) |
| *asenapine maleate sublingual tablet sublingual 10 mg, 5 mg* | 3 | QL (2 tablets per day) |
| *asenapine maleate sublingual tablet sublingual 2.5 mg* | 3 | QL (2 tablets per day.) |
| CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (*lumateperone tosylate*) | 4 | PA; ST; QL (1 capsule per day.) |
| *clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg* | 1 | |
| *clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg* | 1 | |
| CLOZARIL ORAL TABLET 100 MG, 25 MG (*clozapine*) | 3 | |
| FANAPT ORAL TABLET 1 MG (*iloperidone*) | 3 | QL (86 tablets per year.) |
| FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (*iloperidone*) | 3 | QL (2 tablets per day) |
| FANAPT ORAL TABLET 2 MG (*iloperidone*) | 3 | QL (56 tablets per year.) |
| FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG (*iloperidone*) | 3 | QL (8 tablets (1 pack) per 365 days.) |
| FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG (*iloperidone*) | 3 | QL (1 pack (12 tablets) per 365 days.) |
| FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (*iloperidone*) | 3 | QL (2 pack (8 tablets) per 365 days.) |
| *lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg* | 2 | QL (1 tablet per day.) |
| *lurasidone hcl oral tablet 40 mg* | 2 | QL (1 tablet per day) |
| *lurasidone hcl oral tablet 80 mg* | 2 | QL (2 tablets per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| NUPLAZID ORAL CAPSULE 34 MG (*pimavanserin tartrate*) | 3 | PA; QL (31 capsules per month.) |
| NUPLAZID ORAL TABLET 10 MG (*pimavanserin tartrate*) | 3 | PA; QL (31 tablets per month.) |
| *olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg* | 1 | |
| *olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg* | 2 | |
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg* | 2 | QL (1 capsule per day) |
| *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg* | 3 | QL (1 tablet per day) |
| *paliperidone er oral tablet extended release 24 hour 6 mg* | 3 | QL (2 tablets per day) |
| *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg* | 2 | |
| *quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg* | 1 | |
| REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (*brexpiprazole*) | 4 | QL (1 tablet per day.) |
| *risperidone oral solution 1 mg/ml* | 1 | |
| *risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg* | 1 | |
| *risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg* | 1 | |
| VRAYLAR ORAL CAPSULE 0.5 MG (*cariprazine hcl*) | 4 | QL (60 capsules per month.) |
| VRAYLAR ORAL CAPSULE 0.75 MG (*cariprazine hcl*) | 4 | QL (30 capsules per month.) |
| VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (*cariprazine hcl*) | 4 | |
| VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (*cariprazine hcl*) | 4 | QL (1 capsule per day.) |
| *ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg* | 2 | |
| **BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures** | | |
| MYSOLINE ORAL TABLET 250 MG, 50 MG (*primidone*) | 2 | |
| *phenobarbital oral elixir 20 mg/5ml* | 1 | |
| *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg* | 1 | |
| *primidone oral tablet 125 mg, 250 mg, 50 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder** | | |
| *ascomp-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-acetaminophen oral tablet 50-325 mg* | 1 | |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | 1 | QL (Benefit maximum quantity 6 per day.) |
| *butalbital-apap-caffeine oral capsule 50-300-40 mg* | 3 | QL (6 capsules per day) |
| *butalbital-apap-caffeine oral capsule 50-325-40 mg* | 1 | QL (6 capsules per day) |
| BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML | 2 | |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *butalbital-aspirin-caffeine oral capsule 50-325-40 mg* | 1 | |
| FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*) | 3 | QL (6 capsules per day) |
| *phenobarbital oral elixir 20 mg/5ml* | 1 | |
| *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg* | 1 | |
| TENCON ORAL TABLET 50-325 MG (*butalbital-acetaminophen*) | 3 | |
| **BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures** | | |
| *clobazam oral suspension 2.5 mg/ml* | 3 | PA |
| *clobazam oral tablet 10 mg, 20 mg* | 2 | PA |
| *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| *clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg* | 1 | |
| *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg* | 1 | |
| *diazepam intensol oral concentrate 5 mg/ml* | 1 | |
| *diazepam oral concentrate 5 mg/ml* | 1 | |
| *diazepam oral solution 5 mg/5ml* | 1 | |
| *diazepam oral tablet 10 mg, 2 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *diazepam rectal gel 10 mg, 2.5 mg, 20 mg* | 1 | QL (1 box (2 doses/box) per prescription) |
| *lorazepam intensol oral concentrate 2 mg/ml* | 1 | |
| *lorazepam oral concentrate 2 mg/ml* | 1 | |
| *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*) | 3 | PA; QL (1 box per prescription.) |
| ONFI ORAL SUSPENSION 2.5 MG/ML (*clobazam*) | 3 | PA |
| ONFI ORAL TABLET 10 MG, 20 MG (*clobazam*) | 3 | PA |
| SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (*clobazam*) | 3 | PA |
| VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (*diazepam*) | 3 | PA; QL (1 box (5 doses/box) per month.) |
| VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML (*diazepam*) | 3 | PA; QL (1 box (5 doses/box) per month.) |
| VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML (*diazepam*) | 3 | PA; QL (1 box (5 doses/box) per month.) |
| VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (*diazepam*) | 3 | PA; QL (1 box (5 doses/box) per month.) |
| **BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder** | | |
| *alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg* | 1 | |
| *alprazolam intensol oral concentrate 1 mg/ml* | 1 | |
| *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg* | 1 | |
| *alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg* | 1 | |
| *alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg* | 1 | |
| *chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg* | 1 | |
| *chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg* | 1 | |
| *chlordiazepoxide-clidinium oral capsule 5-2.5 mg* | 3 | |
| *clobazam oral suspension 2.5 mg/ml* | 3 | PA |
| *clobazam oral tablet 10 mg, 20 mg* | 2 | PA |
| *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg* | 1 | |
| *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg* | 1 | |
| *diazepam intensol oral concentrate 5 mg/ml* | 1 | |
| *diazepam oral concentrate 5 mg/ml* | 1 | |
| *diazepam oral solution 5 mg/5ml* | 1 | |
| *diazepam oral tablet 10 mg, 2 mg, 5 mg* | 1 | |
| *diazepam rectal gel 10 mg, 2.5 mg, 20 mg* | 1 | QL (1 box (2 doses/box) per prescription) |
| *estazolam oral tablet 1 mg, 2 mg* | 1 | |
| *flurazepam hcl oral capsule 15 mg, 30 mg* | 1 | |
| *lorazepam intensol oral concentrate 2 mg/ml* | 1 | |
| *lorazepam oral concentrate 2 mg/ml* | 1 | |
| *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| *midazolam hcl oral syrup 2 mg/ml* | 1 | |
| MIDAZOLAM+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (*midazolam*) | 3 | PA |
| NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*) | 3 | PA; QL (1 box per prescription.) |
| ONFI ORAL SUSPENSION 2.5 MG/ML (*clobazam*) | 3 | PA |
| ONFI ORAL TABLET 10 MG, 20 MG (*clobazam*) | 3 | PA |
| *oxazepam oral capsule 10 mg, 15 mg, 30 mg* | 1 | |
| RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (*temazepam*) | 3 | |
| SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (*clobazam*) | 3 | PA |
| *temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg* | 1 | |
| *triazolam oral tablet 0.125 mg, 0.25 mg* | 1 | |
| **BUTYROPHENONES - Drugs for Depression & Psychosis** | | |
| *haloperidol lactate oral concentrate 2 mg/ml* | 1 | |
| *haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment** | | |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (*erenumab-aooe*) | 2 | PA; QL (1 pen per month.) |
| EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (*galcanezumab-gnlm*) | 2 | PA; QL (0.04 ml per day.) |
| EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*galcanezumab-gnlm*) | 2 | PA; QL (0.1 mL per day.) |
| EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*galcanezumab-gnlm*) | 2 | PA; QL (0.04 ml per day.) |
| NURTEC ORAL TABLET DISPERSIBLE 75 MG (*rimegepant sulfate*) | 4 | PA; QL (0.27 tablets per day for acute use; 0.6 tablets per day for preventive use with PA.) |
| QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (*atogepant*) | 2 | PA; QL (1 tablet per day.) |
| UBRELVY ORAL TABLET 100 MG, 50 MG (*ubrogepant*) | 2 | PA; ST; QL (0.27 tablets per day.) |
| ZAVZPRET NASAL SOLUTION 10 MG/ACT (*zavegepant hcl*) | 3 | PA; ST; QL (6 mg per prescription.) |
| **CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson** | | |
| *carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg* | 1 | |
| *entacapone oral tablet 200 mg* | 1 | |
| *tolcapone oral tablet 100 mg* | 3 | |
| **CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder** | | |
| *acamprosate calcium oral tablet delayed release 333 mg* | 1 | |
| ADDYI ORAL TABLET 100 MG (*flibanserin*) | 3 | PA; QL (1 tablet per day.) |
| *atomoxetine hcl oral capsule 10 mg, 25 mg* | 3 | QL (3 capsules per day.) |
| *atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg* | 3 | QL (1 capsule per day) |
| *atomoxetine hcl oral capsule 18 mg* | 3 | QL (5 capsules per day.) |
| *atomoxetine hcl oral capsule 40 mg* | 3 | QL (2 capsules per day) |
| DAYBUE ORAL SOLUTION 200 MG/ML (*trofinetide*) | 4 | PA; QL (120 ml per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DAYBUE STIX ORAL PACKET 5000 MG, 6000 MG, 8000 MG (*trofinetide*) | 2 | PA; QL (120 packets per month.) |
| *dextromethorphan-quinidine oral capsule 20-10 mg* | 2 | PA; QL (2 capsules per day.) |
| *guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg* | 2 | |
| *guanfacine hcl oral tablet 1 mg, 2 mg* | 1 | |
| LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (*sodium oxybate*) | 4 | PA; QL (1 packet per day.); SP |
| LYNKUET ORAL CAPSULE 60 MG (*elinzanetant*) | 3 | PA; QL (60 capsules per month.) |
| *memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg* | 3 | |
| *memantine hcl oral solution 2 mg/ml* | 3 | |
| *memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg* | 1 | |
| *memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg* | 3 | |
| NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*) | 3 | |
| NOURIANZ ORAL TABLET 20 MG, 40 MG (*istradefylline*) | 3 | PA; QL (1 tablet per day.) |
| NUEDEXTA ORAL CAPSULE 20-10 MG (*dextromethorphan-quinidine*) | 2 | PA; QL (2 capsules per day.) |
| RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (*edaravone*) | 3 | PA; QL (50 ml per month.); SP |
| RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (*edaravone*) | 3 | PA; QL (1 starter kit per year.); SP |
| *riluzole oral tablet 50 mg* | 1 | |
| *sodium oxybate oral solution 500 mg/ml* | 3 | PA; QL (18 ml per day.); SP |
| TEGLUTIK ORAL SUSPENSION 50 MG/10ML (*riluzole*) | 3 | PA; SP |
| TIGLUTIK ORAL SUSPENSION 50 MG/10ML (*riluzole*) | 3 | PA; SP |
| VEOZAH ORAL TABLET 45 MG (*fezolinetant*) | 3 | PA; QL (1 tablet per day.) |
| VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (*bremelanotide acetate*) | 3 | PA; QL (4 autoinjector pens (1.2mls) per month.) |
| VYNDAMAX ORAL CAPSULE 61 MG (*tafamidis*) | 2 | PA; QL (1 capsule per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XYWAV ORAL SOLUTION 500 MG/ML (*ca, mg, k, and na oxybates*) | 3 | PA; QL (18 mL per day.); SP |
| **CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain** | | |
| *celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg* | 2 | |
| VYSCOXA ORAL SUSPENSION 10 MG/ML (*celecoxib*) | 4 | PA |
| **DIBENZOXAPINES - Drugs for Depression & Psychosis** | | |
| *loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg* | 1 | |
| **DIHYDROINDOLONES - Drugs for Depression & Psychosis** | | |
| *molindone hcl oral tablet 10 mg, 25 mg, 5 mg* | 3 | |
| **DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis** | | |
| *pimozide oral tablet 1 mg, 2 mg* | 2 | |
| **DOPAMINE PRECURSORS - Drugs for Parkinson** | | |
| *carbidopa oral tablet 25 mg* | 1 | |
| *carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg* | 1 | |
| *carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg* | 1 | |
| *carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg* | 1 | |
| *carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg* | 1 | |
| CREXONT ORAL CAPSULE EXTENDED RELEASE 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG (*carbidopa-levodopa*) | 3 | ST |
| DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (*carbidopa-levodopa*) | 3 | PA |
| INBRIJA INHALATION CAPSULE 42 MG (*levodopa*) | 3 | PA; QL (10 tablets per day.); SP |
| SINEMET ORAL TABLET 10-100 MG, 25-100 MG (*carbidopa-levodopa*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson** | | |
| *bromocriptine mesylate oral capsule 5 mg* | 1 | |
| *bromocriptine mesylate oral tablet 2.5 mg* | 1 | |
| *cabergoline oral tablet 0.5 mg* | 2 | |
| **FIBROMYALGIA AGENTS - Drugs for Nerve Pain** | | |
| *duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg* | 2 | |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*) | 3 | PA |
| LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*) | 3 | PA |
| *milnacipran hcl oral 12.5 & 25 & 50 mg* | 3 | QL (1 pack per 365 days.) |
| *milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg* | 3 | QL (2 tablets per day) |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg* | 2 | |
| *pregabalin oral solution 20 mg/ml* | 2 | |
| SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (*milnacipran hcl*) | 3 | QL (2 tablets per day) |
| SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (*milnacipran hcl*) | 3 | QL (1 pack per 365 days.) |
| TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (*cyclobenzaprine hcl (fibromy)*) | 4 | PA; QL (60 sublingual tablets per month.) |
| **GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures** | | |
| DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*) | 3 | PA |
| DIACOMIT ORAL CAPSULE 250 MG, 500 MG (*stiripentol*) | 3 | PA; SP |
| DIACOMIT ORAL PACKET 250 MG, 500 MG (*stiripentol*) | 3 | PA; SP |
| *divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg* | 2 | |
| *divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *gabapentin oral capsule 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| *gabapentin oral solution 250 mg/5ml* | 1 | |
| *gabapentin oral tablet 600 mg, 800 mg* | 1 | |
| LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*) | 3 | PA |
| LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*) | 3 | PA |
| NEURAPTINE EXTERNAL CREAM 10 % (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*) | 3 | PA |
| NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*) | 4 | PA |
| NEURORUB EXTERNAL CREAM 10 % (*gabapentin*) | 3 | PA |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg* | 2 | |
| *pregabalin oral solution 20 mg/ml* | 2 | |
| *tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg* | 1 | |
| *valproic acid oral solution 250 mg/5ml* | 1 | |
| *vigabatrin oral packet 500 mg* | 2 | PA; QL (6 packets per day.) |
| *vigabatrin oral tablet 500 mg* | 2 | PA; QL (6 tablets per day.); SP |
| VIGADRONE ORAL PACKET 500 MG (*vigabatrin*) | 2 | PA; QL (6 packets per day.) |
| VIGADRONE ORAL TABLET 500 MG (*vigabatrin*) | 2 | PA; QL (6 tablets per day.); SP |
| VIGAFYDE ORAL SOLUTION 100 MG/ML (*vigabatrin*) | 2 | PA; QL (900 mL per month.); SP |
| ZTALMY ORAL SUSPENSION 50 MG/ML (*ganaxolone*) | 3 | PA; SP |
| **HYDANTOINS - Drugs for Seizures** | | |
| DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (*phenytoin*) | 3 | |
| DILANTIN ORAL CAPSULE 100 MG, 30 MG (*phenytoin sodium extended*) | 3 | |
| DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (*phenytoin*) | 3 | |
| *phenytek oral capsule 200 mg, 300 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *phenytoin infatabs oral tablet chewable 50 mg* | 1 | |
| *phenytoin oral suspension 125 mg/5ml* | 1 | |
| *phenytoin oral tablet chewable 50 mg* | 1 | |
| *phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg* | 1 | |
| **INHALATION ANESTHETICS - Anesthetics** | | |
| FORANE INHALATION SOLUTION (*isoflurane*) | 2 | |
| *isoflurane inhalation solution* | 1 | |
| *sevoflurane inhalation solution* | 1 | |
| *terrell inhalation solution* | 1 | |
| ULTANE INHALATION SOLUTION (*sevoflurane*) | 3 | |
| **ION CHANNEL INHIBITION AGENTS - Drugs for Seizures** | | |
| APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (*eslicarbazepine acetate*) | 3 | PA |
| BANZEL ORAL SUSPENSION 40 MG/ML (*rufinamide*) | 3 | PA |
| BANZEL ORAL TABLET 200 MG, 400 MG (*rufinamide*) | 3 | PA |
| *eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg* | 3 | PA |
| *lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml* | 2 | |
| *lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg* | 2 | |
| MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*lacosamide*) | 3 | PA |
| *oxcarbazepine oral suspension 300 mg/5ml* | 1 | |
| *oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg* | 1 | |
| *rufinamide oral suspension 40 mg/ml* | 3 | |
| *rufinamide oral tablet 200 mg, 400 mg* | 3 | PA |
| TRILEPTAL ORAL SUSPENSION 300 MG/5ML (*oxcarbazepine*) | 3 | PA |
| TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (*oxcarbazepine*) | 3 | PA |
| VIMPAT ORAL SOLUTION 10 MG/ML (*lacosamide*) | 3 | PA |
| VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*lacosamide*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*) | 3 | PA |
| XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (*cenobamate*) | 3 | PA |
| ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (*zonisamide*) | 4 | PA |
| ZONISADE ORAL SUSPENSION 100 MG/5ML (*zonisamide*) | 3 | PA |
| *zonisamide oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| **MELATONIN RECEPTOR AGONISTS - Drugs for Anxiety & Sleep Disorder** | | |
| HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (*tasimelteon*) | 4 | PA; QL (5.1 mL per day.); SP |
| HETLIOZ ORAL CAPSULE 20 MG (*tasimelteon*) | 3 | PA; QL (1 capsule per day.); SP |
| *ramelteon oral tablet 8 mg* | 3 | QL (1 tablet per day) |
| *tasimelteon oral capsule 20 mg* | 3 | PA; QL (1 capsule per day.); SP |
| **MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson** | | |
| EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (*selegiline*) | 3 | |
| *rasagiline mesylate oral tablet 0.5 mg, 1 mg* | 2 | |
| *selegiline hcl oral capsule 5 mg* | 1 | |
| *selegiline hcl oral tablet 5 mg* | 1 | |
| ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (*selegiline hcl*) | 3 | |
| **MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis** | | |
| EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (*selegiline*) | 3 | |
| MARPLAN ORAL TABLET 10 MG (*isocarboxazid*) | 3 | |
| NARDIL ORAL TABLET 15 MG (*phenelzine sulfate*) | 3 | |
| PARNATE ORAL TABLET 10 MG (*tranylcypromine sulfate*) | 3 | |
| *phenelzine sulfate oral tablet 15 mg* | 1 | |
| *rasagiline mesylate oral tablet 0.5 mg, 1 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *selegiline hcl oral capsule 5 mg* | 1 | |
| *selegiline hcl oral tablet 5 mg* | 1 | |
| *tranylcypromine sulfate oral tablet 10 mg* | 1 | |
| ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (*selegiline hcl*) | 3 | |
| **NMDA ANTAGONISTS - Drugs for Depression & Psychosis** | | |
| SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*) | 3 | PA; QL (8 devices (4 kits) per month.) |
| SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*) | 3 | PA; QL (12 devices (4 kits) per month.) |
| **NON-BENZODIAZEPINE ANXIOLYTICS - Drugs for Anxiety & Sleep Disorder** | | |
| *buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg* | 1 | |
| *buspirone hcl oral tablet 12.5 mg, 2.5 mg* | 3 | |
| *meprobamate oral tablet 200 mg, 400 mg* | 1 | |
| **NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder** | | |
| *eszopiclone oral tablet 1 mg, 2 mg, 3 mg* | 2 | |
| *zaleplon oral capsule 10 mg, 5 mg* | 1 | |
| *zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg* | 2 | |
| *zolpidem tartrate oral tablet 10 mg, 5 mg* | 1 | |
| **NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson** | | |
| APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (*apomorphine hcl*) | 4 | PA; QL (3 ml per day.); SP |
| *apomorphine hcl subcutaneous solution cartridge 30 mg/3ml* | 3 | PA; QL (3 ml per day.); SP |
| NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (*rotigotine*) | 3 | |
| *pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg* | 1 | |
| *ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg* | 1 | |
| **NON-OPIOID ANALGESICS - Drugs for Pain** | | |
| *acetaminophen-codeine oral solution 120-12 mg/5ml* | 1 | NTT |
| *acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg* | 1 | NTT |
| *apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg* | 3 | NTT |
| *bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-acetaminophen oral tablet 50-325 mg* | 1 | |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | 1 | QL (Benefit maximum quantity 6 per day.) |
| *butalbital-apap-caffeine oral capsule 50-300-40 mg* | 3 | QL (6 capsules per day) |
| *butalbital-apap-caffeine oral capsule 50-325-40 mg* | 1 | QL (6 capsules per day) |
| BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML | 2 | |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*) | 3 | QL (6 capsules per day) |
| *hydrocodone-acetaminophen oral solution 10-300 mg/15ml* | 1 | NTT |
| *hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml* | 2 | NTT |
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| TENCON ORAL TABLET 50-325 MG (*butalbital-acetaminophen*) | 3 | |
| *tramadol-acetaminophen oral tablet 37.5-325 mg* | 1 | NTT |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (*apap-caff-dihydrocodeine*) | 3 | NTT |
| **NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC - Drugs for Pain** | | |
| *diclofenac potassium oral tablet 50 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *diclofenac sodium er oral tablet extended release 24 hour 100 mg* | 3 | |
| *diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg* | 1 | |
| *diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg* | 3 | |
| *diflunisal oral tablet 500 mg* | 3 | |
| *etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg* | 3 | |
| *etodolac oral capsule 200 mg, 300 mg* | 2 | |
| *etodolac oral tablet 400 mg, 500 mg* | 2 | |
| *flurbiprofen oral tablet 100 mg, 50 mg* | 1 | |
| *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg* | 1 | NTT |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | 1 | |
| *indomethacin er oral capsule extended release 75 mg* | 2 | |
| *indomethacin oral capsule 25 mg, 50 mg* | 1 | |
| *indomethacin oral suspension 25 mg/5ml* | 3 | PA |
| *indomethacin rectal suppository 50 mg* | 3 | PA |
| K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (*ketoprofen-baclofen-gabap-lido*) | 3 | PA |
| *ketorolac tromethamine oral tablet 10 mg* | 1 | |
| LURBIRO ORAL TABLET 100 MG (*flurbiprofen*) | 3 | |
| *meclofenamate sodium oral capsule 100 mg, 50 mg* | 3 | |
| *mefenamic acid oral capsule 250 mg* | 3 | |
| MELOXICAM ORAL SUSPENSION 7.5 MG/5ML | 3 | PA |
| *meloxicam oral tablet 15 mg, 7.5 mg* | 1 | |
| *nabumetone oral tablet 500 mg, 750 mg* | 1 | |
| *naproxen dr oral tablet delayed release 500 mg* | 1 | |
| *naproxen oral tablet 250 mg, 375 mg, 500 mg* | 1 | |
| *naproxen oral tablet delayed release 375 mg, 500 mg* | 1 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 2 | |
| *oxaprozin oral tablet 600 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *piroxicam oral capsule 10 mg, 20 mg* | 2 | |
| SPRIX NASAL SOLUTION 15.75 MG/SPRAY (*ketorolac tromethamine*) | 3 | ST; QL (5 bottles per prescription.) |
| *sulindac oral tablet 150 mg, 200 mg* | 1 | |
| **OPIOID AGONISTS (28:08) - Drugs for Pain** | | |
| *acetaminophen-codeine oral solution 120-12 mg/5ml* | 1 | NTT |
| *acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg* | 1 | NTT |
| *apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg* | 3 | NTT |
| *ascomp-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *belladonna alkaloids-opium rectal suppository 16.2-60 mg* | 1 | |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | 1 | QL (Benefit maximum quantity 6 per day.) |
| *butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *codeine sulfate oral tablet 15 mg, 30 mg, 60 mg* | 1 | NTT |
| *diskets oral tablet soluble 40 mg* | 1 | QL (1.5 tablets per day.) |
| *endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| *fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr* | 2 | PA; QL (0.34 patches per day.) |
| *fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr* | 2 | PA; QL (15 patches per 31 days.) |
| *hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg* | 3 | PA; QL (2 capsules per day.) |
| *hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg* | 3 | PA; QL (0 tablets per 100 days, diagnosis review required.) |
| *hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg* | 3 | PA; QL (1 tablet per day.) |
| *hydrocodone-acetaminophen oral solution 10-300 mg/15ml* | 1 | NTT |
| *hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml* | 2 | NTT |
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg* | 1 | NTT |
| *hydromorphone hcl er oral tablet extended release 24 hour 12 mg* | 3 | PA; QL (2 tablets per day.) |
| *hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg* | 3 | PA; QL (1 tablet per day.) |
| *hydromorphone hcl er oral tablet extended release 24 hour 32 mg* | 3 | PA; QL (0 tablet per 100 days, diagnosis review required.) |
| *hydromorphone hcl oral liquid 1 mg/ml* | 1 | NTT |
| *hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg* | 1 | NTT |
| *hydromorphone hcl rectal suppository 3 mg* | 1 | NTT |
| *levorphanol tartrate oral tablet 2 mg, 3 mg* | 3 | ST; NTT |
| *meperidine hcl oral solution 50 mg/5ml* | 1 | NTT |
| *meperidine hcl oral tablet 50 mg* | 1 | NTT |
| *methadone hcl intensol oral concentrate 10 mg/ml* | 1 | QL (6 ml per day.) |
| *methadone hcl oral concentrate 10 mg/ml* | 1 | QL (6 ml per day.) |
| *methadone hcl oral solution 10 mg/5ml* | 1 | PA; QL (11.3 ml per day.) |
| *methadone hcl oral solution 5 mg/5ml* | 1 | PA; QL (22.6 ml per day.) |
| *methadone hcl oral tablet 10 mg* | 1 | PA; QL (2 tablets per day.) |
| *methadone hcl oral tablet 5 mg* | 1 | PA; QL (4 tablets per day.) |
| *methadone hcl oral tablet soluble 40 mg* | 1 | QL (1.5 tablets per day.) |
| METHADOSE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*) | 3 | QL (6 ml per day.) |
| *methadose oral tablet soluble 40 mg* | 1 | QL (1.5 tablets per day.) |
| METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*) | 3 | QL (6 ml per day.) |
| *morphine sulfate (concentrate) oral solution 100 mg/5ml* | 1 | NTT |
| *morphine sulfate er beads oral capsule extended release 24 hour 120 mg* | 3 | PA; QL (0 capsule per 100 days, diagnosis review required.) |
| *morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg* | 3 | PA; QL (1 capsule per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg* | 1 | PA; QL (0 tablets per 100 days, diagnosis review required.) |
| *morphine sulfate er oral tablet extended release 15 mg, 30 mg* | 1 | PA; QL (93 tablets per 31 days.) |
| *morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml* | 1 | NTT |
| *morphine sulfate oral tablet 15 mg, 30 mg* | 1 | NTT |
| *morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg* | 1 | NTT |
| NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (*tapentadol hcl*) | 3 | PA; QL (2 tablets per day) |
| NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (*tapentadol hcl*) | 3 | PA; QL (0 tablets per 100 days, diagnosis review required.) |
| NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (*tapentadol hcl*) | 3 | QL (6 tablets per day); NTT |
| *opium oral tincture 10 mg/ml (1%)* | 1 | |
| *oxycodone hcl oral capsule 5 mg* | 1 | NTT |
| *oxycodone hcl oral concentrate 100 mg/5ml* | 1 | NTT |
| *oxycodone hcl oral solution 5 mg/5ml* | 1 | NTT |
| *oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg* | 1 | NTT |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 1 | NTT |
| *oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg* | 3 | PA; QL (2 tablets per day.) |
| *oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg* | 3 | PA; QL (0 tablet per 100 days.) |
| *oxymorphone hcl oral tablet 10 mg, 5 mg* | 2 | NTT |
| SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*tramadol hcl*) | 3 | PA; NTT |
| *tapentadol hcl oral tablet 100 mg, 50 mg, 75 mg* | 3 | QL (6 tablets per day); NTT |
| *tramadol hcl (er biphasic) oral tablet extended release 24 hour 200 mg, 300 mg* | 2 | QL (1 tablet per day) |
| *tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg* | 2 | QL (1 tablet per day) |
| *tramadol hcl oral tablet 50 mg* | 1 | NTT |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *tramadol-acetaminophen oral tablet 37.5-325 mg* | 1 | NTT |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (*apap-caff-dihydrocodeine*) | 3 | NTT |
| XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (*oxycodone*) | 3 | PA; QL (2 capsules per day.) |
| XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (*oxycodone*) | 3 | PA; QL (0 capsules per 100 days, diagnosis review required.) |
| *xyvona oral tablet 2 mg, 3 mg* | 3 | ST; NTT |
| **OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning** | | |
| *buprenorphine hcl-naloxone hcl sublingual film 12-3 mg* | 1 | QL (2 films per day.) |
| *buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg* | 1 | QL (1 film per day.) |
| *buprenorphine hcl-naloxone hcl sublingual film 8-2 mg* | 1 | QL (3 films per day.) |
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg* | 1 | |
| *ft naloxone hcl nasal liquid 4 mg/0.1ml* | 1 | QL (2 auto-injectors per prescription.) |
| KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*) | 1 | QL (2 devices per prescription.) |
| *naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml* | 1 | |
| *naloxone hcl injection solution cartridge 0.4 mg/ml* | 1 | |
| *naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml* | 1 | |
| *naloxone hcl nasal liquid 4 mg/0.1ml* | 1 | QL (2 auto-injectors per prescription.) |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| NARCAN NASAL LIQUID 4 MG/0.1ML (*naloxone hcl*) | 1 | QL (2 auto-injectors per prescription.) |
| OPVEE NASAL SOLUTION 2.7 MG/0.1ML (*nalmefene hcl*) | 1 | QL (2 spray bottles per prescription.) |
| *pentazocine-naloxone hcl oral tablet 50-0.5 mg* | 1 | NTT |
| RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.4 ml per day.) |
| REXTOVY NASAL LIQUID 4 MG/0.25ML (*naloxone hcl*) | 1 | QL (one package (2 devices) per prescription.) |
| REZENOPY NASAL LIQUID 10 MG/0.11ML (*naloxone hcl*) | 3 | |
| RIVIVE NASAL LIQUID 3 MG/0.1ML (*naloxone hcl*) | 2 | QL (1 package (2 devices) per prescription.) |
| SUBOXONE SUBLINGUAL FILM 12-3 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (2 films per day.) |
| SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (1 film per day.) |
| SUBOXONE SUBLINGUAL FILM 8-2 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (3 films per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (1 tablet per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (3 tablets per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (2 tablets per day.) |
| ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (*nalmefene hcl*) | 3 | QL (2 auto-injector pens per copay per prescription.) |
| **OPIOID PARTIAL AGONISTS - Drugs for Pain** | | |
| BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (*buprenorphine hcl*) | 3 | PA; QL (2 Films per day.) |
| BELBUCA BUCCAL FILM 750 MCG (*buprenorphine hcl*) | 3 | PA; QL (2 films per day.) |
| *buprenorphine hcl sublingual tablet sublingual 2 mg* | 1 | QL (3 sublingual tablets per day.) |
| *buprenorphine hcl sublingual tablet sublingual 8 mg* | 1 | QL (3 tablets per day.) |
| *buprenorphine hcl-naloxone hcl sublingual film 12-3 mg* | 1 | QL (2 films per day.) |
| *buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg* | 1 | QL (1 film per day.) |
| *buprenorphine hcl-naloxone hcl sublingual film 8-2 mg* | 1 | QL (3 films per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg* | 1 | |
| *buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr* | 3 | PA; QL (4 patches per 28 days.) |
| *buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr* | 3 | PA; QL (4 patches per month.) |
| *butorphanol tartrate nasal solution 10 mg/ml* | 2 | QL (7.5 ml (3 bottles) per prescription.) |
| *pentazocine-naloxone hcl oral tablet 50-0.5 mg* | 1 | NTT |
| SUBOXONE SUBLINGUAL FILM 12-3 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (2 films per day.) |
| SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (1 film per day.) |
| SUBOXONE SUBLINGUAL FILM 8-2 MG (*buprenorphine hcl-naloxone hcl*) | 3 | PA; ST; QL (3 films per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (1 tablet per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (3 tablets per day.) |
| ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*) | 1 | QL (2 tablets per day.) |
| **OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder** | | |
| BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*suvorexant*) | 3 | QL (1 tablet per day.) |
| **PHENOTHIAZINES - Drugs for Depression & Psychosis** | | |
| *chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml* | 3 | PA |
| *chlorpromazine hcl oral tablet 10 mg, 25 mg* | 1 | QL (6 tablets per day.) |
| *chlorpromazine hcl oral tablet 100 mg, 50 mg* | 1 | QL (4 tablets per day.) |
| *chlorpromazine hcl oral tablet 200 mg* | 1 | QL (2 tablets per day.) |
| COMPRO RECTAL SUPPOSITORY 25 MG (*prochlorperazine*) | 3 | |
| *fluphenazine hcl oral concentrate 5 mg/ml* | 1 | |
| *fluphenazine hcl oral elixir 2.5 mg/5ml* | 1 | |
| *fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg* | 1 | |
| *perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg* | 1 | |
| *prochlorperazine maleate oral tablet 10 mg, 5 mg* | 1 | |
| *prochlorperazine rectal suppository 25 mg* | 1 | |
| *thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg* | 1 | |
| *trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |
| **RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System** | | |
| *apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg* | 3 | NTT |
| *ascomp-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *atomoxetine hcl oral capsule 10 mg, 25 mg* | 3 | QL (3 capsules per day.) |
| *atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg* | 3 | QL (1 capsule per day) |
| *atomoxetine hcl oral capsule 18 mg* | 3 | QL (5 capsules per day.) |
| *atomoxetine hcl oral capsule 40 mg* | 3 | QL (2 capsules per day) |
| AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (*serdexmethylphen-dexmethylphen*) | 3 | ST; QL (1 capsule per day.) |
| *bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | 1 | QL (Benefit maximum quantity 6 per day.) |
| *butalbital-apap-caffeine oral capsule 50-300-40 mg* | 3 | QL (6 capsules per day) |
| *butalbital-apap-caffeine oral capsule 50-325-40 mg* | 1 | QL (6 capsules per day) |
| BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML | 2 | |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | 1 | QL (6 tablets per day) |
| *butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *butalbital-aspirin-caffeine oral capsule 50-325-40 mg* | 1 | |
| CAFERGOT ORAL TABLET 1-100 MG (*ergotamine-caffeine*) | 3 | |
| *caffeine citrate oral solution 60 mg/3ml* | 1 | |
| *dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg* | 2 | QL (2 capsules per day.) |
| *dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg* | 2 | QL (31 capsules per 31 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *elixophyllin oral elixir 80 mg/15ml* | 3 | |
| *ergotamine-caffeine oral tablet 1-100 mg* | 3 | |
| FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*) | 3 | QL (6 capsules per day) |
| FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (*dexmethylphenidate hcl*) | 3 | |
| METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (*methylphenidate hcl*) | 3 | |
| *methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg* | 2 | QL (2 capsules per day.) |
| *methylphenidate hcl er (cd) oral capsule extended release 60 mg* | 2 | QL (31 capsules per 31 days.) |
| *methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg* | 2 | QL (5 capsules per day.) |
| *methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg* | 2 | QL (5capsules per day.) |
| *methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg* | 2 | QL (3 capsules per day.) |
| *methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg* | 2 | QL (2 capsules per day.) |
| *methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg* | 2 | QL (31 capsules per month.) |
| *methylphenidate hcl er (osm) oral tablet extended release 27 mg, 36 mg, 54 mg* | 2 | QL (2 tablets per day.) |
| *methylphenidate hcl er oral tablet extended release 10 mg* | 2 | QL (10 tablets per day.) |
| *methylphenidate hcl er oral tablet extended release 20 mg* | 2 | QL (5 tablets per day.) |
| *methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml* | 1 | |
| *methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg* | 3 | |
| MIGERGOT RECTAL SUPPOSITORY 2-100 MG (*ergotamine-caffeine*) | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg* | 1 | |
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | 1 | |
| *theophylline oral elixir 80 mg/15ml* | 1 | |
| *theophylline oral solution 80 mg/15ml* | 1 | |
| TREZIX ORAL CAPSULE 320.5-30-16 MG (*apap-caff-dihydrocodeine*) | 3 | NTT |
| **REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain** | | |
| ACULAR LS OPHTHALMIC SOLUTION 0.4 % (*ketorolac tromethamine*) | 3 | |
| ACULAR OPHTHALMIC SOLUTION 0.5 % (*ketorolac tromethamine*) | 3 | |
| *diclofenac sodium external gel 3 %* | 2 | PA; QL (100 grams per prescription.) |
| *diflunisal oral tablet 500 mg* | 3 | |
| *etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg* | 3 | |
| *etodolac oral capsule 200 mg, 300 mg* | 2 | |
| *etodolac oral tablet 400 mg, 500 mg* | 2 | |
| *flurbiprofen oral tablet 100 mg, 50 mg* | 1 | |
| *flurbiprofen sodium ophthalmic solution 0.03 %* | 1 | |
| *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg* | 1 | NTT |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | 1 | |
| *indomethacin er oral capsule extended release 75 mg* | 2 | |
| *indomethacin oral capsule 25 mg, 50 mg* | 1 | |
| *indomethacin oral suspension 25 mg/5ml* | 3 | PA |
| *indomethacin rectal suppository 50 mg* | 3 | PA |
| *ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %* | 1 | |
| *ketorolac tromethamine oral tablet 10 mg* | 1 | |
| LURBIRO ORAL TABLET 100 MG (*flurbiprofen*) | 3 | |
| *meclofenamate sodium oral capsule 100 mg, 50 mg* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *mefenamic acid oral capsule 250 mg* | 3 | |
| MELOXICAM ORAL SUSPENSION 7.5 MG/5ML | 3 | PA |
| *meloxicam oral tablet 15 mg, 7.5 mg* | 1 | |
| *nabumetone oral tablet 500 mg, 750 mg* | 1 | |
| *naproxen dr oral tablet delayed release 500 mg* | 1 | |
| *naproxen oral tablet 250 mg, 375 mg, 500 mg* | 1 | |
| *naproxen oral tablet delayed release 375 mg, 500 mg* | 1 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 2 | |
| *oxaprozin oral tablet 600 mg* | 2 | |
| *piroxicam oral capsule 10 mg, 20 mg* | 2 | |
| SPRIX NASAL SOLUTION 15.75 MG/SPRAY (*ketorolac tromethamine*) | 3 | ST; QL (5 bottles per prescription.) |
| *sulindac oral tablet 150 mg, 200 mg* | 1 | |
| **SALICYLATES - Drugs for Pain** | | |
| *ascomp-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *aspirin 81 oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin adult low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin childrens oral tablet chewable 81 mg* | E | H |
| *aspirin ec adult low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin ec low strength oral tablet delayed release 81 mg* | E | H |
| *aspirin low dose oral tablet chewable 81 mg* | E | H |
| *aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *aspirin oral tablet chewable 81 mg* | E | H |
| *aspirin oral tablet delayed release 81 mg* | E | H |
| *aspirin regimen oral tablet delayed release 81 mg* | E | H |
| *aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg* | 3 | |
| *butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg* | 1 | |
| *butalbital-aspirin-caffeine oral capsule 50-325-40 mg* | 1 | |
| *ft aspirin adult low dose oral tablet delayed release 81 mg* | E | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ft aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *ft aspirin oral tablet chewable 81 mg* | E | H |
| *goodsense aspirin low dose oral tablet delayed release 81 mg* | E | H |
| *mm aspirin oral tablet delayed release 81 mg* | E | H |
| *salsalate oral tablet 500 mg, 750 mg* | 1 | |
| ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (*aspirin*) | E | H |
| ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (*aspirin*) | E | H |
| **SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis** | | |
| *desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg* | 3 | |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (*duloxetine hcl*) | 3 | QL (2 capsules per day.) |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (*duloxetine hcl*) | 3 | QL (1 capsule per day.) |
| *duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg* | 2 | |
| FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (*levomilnacipran hcl*) | 3 | ST; QL (1 capsule per day.) |
| FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (*levomilnacipran hcl*) | 3 | ST; QL (28 capsules per year.) |
| *milnacipran hcl oral 12.5 & 25 & 50 mg* | 3 | QL (1 pack per 365 days.) |
| *milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg* | 3 | QL (2 tablets per day) |
| SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (*milnacipran hcl*) | 3 | QL (2 tablets per day) |
| SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (*milnacipran hcl*) | 3 | QL (1 pack per 365 days.) |
| *venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg* | 1 | |
| *venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg* | 1 | |
| **SELECTIVE SEROTONIN AGONISTS - Migraine Treatment** | | |
| *almotriptan malate oral tablet 12.5 mg, 6.25 mg* | 3 | QL (10 tablets per copay.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *eletriptan hydrobromide oral tablet 20 mg, 40 mg* | 2 | QL (10 tablets per copay.) |
| *frovatriptan succinate oral tablet 2.5 mg* | 3 | QL (10 tablets per copay.) |
| *naratriptan hcl oral tablet 1 mg, 2.5 mg* | 1 | QL (10 per prescription.) |
| *rizatriptan benzoate oral tablet 10 mg, 5 mg* | 1 | QL (10 tablets per copay.) |
| *rizatriptan benzoate oral tablet dispersible 10 mg* | 1 | QL (10 per prescription.) |
| *rizatriptan benzoate oral tablet dispersible 5 mg* | 1 | QL (10 tablets per copay.) |
| *sumatriptan nasal solution 20 mg/act, 5 mg/act* | 2 | QL (6 spray bottles per prescription) |
| *sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg* | 1 | QL (10 tablets per prescription.) |
| *sumatriptan succinate subcutaneous solution 6 mg/0.5ml* | 1 | QL (2 kits per prescription) |
| *sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml* | 1 | QL (2 kits per prescription) |
| *zolmitriptan oral tablet 2.5 mg, 5 mg* | 2 | QL (10 tablets per copay.) |
| *zolmitriptan oral tablet dispersible 2.5 mg, 5 mg* | 3 | QL (10 tablets per copay.) |
| ZOMIG NASAL SOLUTION 2.5 MG (*zolmitriptan*) | 3 | QL (6 units per prescription.) |
| ZOMIG NASAL SOLUTION 5 MG (*zolmitriptan*) | 2 | QL (1 box per prescription) |
| **SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis** | | |
| *citalopram hydrobromide oral solution 10 mg/5ml* | 1 | |
| *citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg* | 1 | |
| *escitalopram oxalate oral solution 5 mg/5ml* | 2 | |
| *escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg* | 1 | |
| *fluoxetine hcl oral capsule delayed release 90 mg* | 3 | QL (4 capsules per 28 days.) |
| *fluoxetine hcl oral solution 20 mg/5ml* | 1 | |
| *fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg* | 3 | |
| *fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg* | 3 | |
| *fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg* | 2 | QL (1 capsule per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg* | 3 | |
| *paroxetine hcl oral suspension 10 mg/5ml* | 3 | |
| *paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg* | 1 | |
| *sertraline hcl oral concentrate 20 mg/ml* | 1 | |
| *sertraline hcl oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| **SEROTONIN MODULATORS - Drugs for Depression & Psychosis** | | |
| EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG (*gepirone hcl*) | 4 | ST; QL (31 tablets per month.) |
| EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG (*gepirone hcl*) | 4 | ST; QL (31 tablets per month.) |
| *mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg* | 1 | |
| *mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg* | 1 | |
| *nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg* | 1 | |
| RALDESY ORAL SOLUTION 10 MG/ML (*trazodone hcl*) | 3 | PA |
| *trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg* | 1 | |
| TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (*vortioxetine hbr*) | 3 | ST; QL (1 tablet per day.) |
| *vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg* | 3 | |
| **SUCCINIMIDES - Drugs for Seizures** | | |
| CELONTIN ORAL CAPSULE 300 MG (*methsuximide*) | 3 | |
| *ethosuximide oral capsule 250 mg* | 1 | |
| *ethosuximide oral solution 250 mg/5ml* | 1 | |
| *methsuximide oral capsule 300 mg* | 2 | |
| ZARONTIN ORAL CAPSULE 250 MG (*ethosuximide*) | 3 | |
| ZARONTIN ORAL SOLUTION 250 MG/5ML (*ethosuximide*) | 3 | |
| **THIOXANTHENES - Drugs for Depression & Psychosis** | | |
| *thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis** | | |
| *amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | 1 | |
| *amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg* | 1 | |
| *chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg* | 1 | |
| *clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg* | 3 | |
| *desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | 1 | |
| *doxepin hcl external cream 5 %* | 3 | PA; QL (45 grams per prescription.) |
| *doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | 1 | |
| *doxepin hcl oral concentrate 10 mg/ml* | 1 | |
| ENOVARX-AMITRIPTYLINE EXTERNAL KIT 2 % | 3 | PA |
| *imipramine hcl oral tablet 10 mg, 25 mg, 50 mg* | 1 | |
| *imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg* | 1 | |
| NORPRAMIN ORAL TABLET 10 MG, 25 MG (*desipramine hcl*) | 3 | |
| *nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg* | 1 | |
| *nortriptyline hcl oral solution 10 mg/5ml* | 1 | |
| *perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg* | 1 | |
| *protriptyline hcl oral tablet 10 mg, 5 mg* | 1 | |
| *trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg* | 3 | |
| **VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System** | | |
| AUSTEDO ORAL TABLET 12 MG, 9 MG (*deutetrabenazine*) | 2 | PA; QL (4 tablets per day.); SP |
| AUSTEDO ORAL TABLET 6 MG (*deutetrabenazine*) | 2 | PA; QL (2 tablets per day.); SP |
| AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (*deutetrabenazine*) | 2 | PA; QL (30 tablets per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (*deutetrabenazine*) | 2 | PA; QL (30 Tablets per month.); SP |
| AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (*deutetrabenazine*) | 2 | PA; QL (1 kit (28 tablets) per year.); SP |
| INGREZZA ORAL CAPSULE 40 MG, 80 MG (*valbenazine tosylate*) | 2 | PA; QL (1 capsule per day.); SP |
| INGREZZA ORAL CAPSULE 60 MG (*valbenazine tosylate*) | 2 | PA; QL (1 capsule per day.) |
| INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*) | 2 | PA; QL (30 capsules per month.); SP |
| INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (*valbenazine tosylate*) | 2 | PA; QL (1 kit (28 capsules) per year.); SP |
| *tetrabenazine oral tablet 12.5 mg* | 2 | PA |
| *tetrabenazine oral tablet 25 mg* | 2 | PA; SP |
| **WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System** | | |
| *armodafinil oral tablet 150 mg, 250 mg* | 2 | QL (1 tablet per day) |
| *armodafinil oral tablet 200 mg* | 2 | QL (1 tablet per day.) |
| *armodafinil oral tablet 50 mg* | 2 | QL (2 tablets per day.) |
| *diclofenac sodium oral tablet delayed release 75 mg* | 1 | |
| LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (*sodium oxybate*) | 4 | PA; QL (1 packet per day.); SP |
| LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (*sodium oxybate*) | 4 | PA; QL (1 box (28 packets) per year.); SP |
| *modafinil oral tablet 100 mg, 200 mg* | 2 | QL (3 tablets per day.) |
| *sodium oxybate oral solution 500 mg/ml* | 3 | PA; QL (18 ml per day.); SP |
| SUNOSI ORAL TABLET 150 MG, 75 MG (*solriamfetol hcl*) | 2 | PA; QL (1 tablet per day.) |
| WAKIX ORAL TABLET 17.8 MG, 4.45 MG (*pitolisant hcl*) | 3 | PA; QL (2 tablets per day.); SP |
| **DENTAL AGENTS** | | |
| **NUTRITIONAL SUPPLEMENTS** | | |
| DENTA 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |
| DENTAGEL DENTAL GEL 1.1 % | 3 | |
| EASYGEL DENTAL GEL 0.4 % (*stannous fluoride*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (*sodium fluoride-vitamin d*) | 3 | |
| FLOTREX ORAL TABLET CHEWABLE 1 MG (*pediatric multivitamins-fl*) | 3 | |
| FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (*stannous fluoride*) | 3 | |
| *multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (*sodium fluoride*) | 3 | |
| *sf 5000 plus dental cream 1.1 %* | 1 | |
| *sf dental gel 1.1 %* | 1 | |
| *sodium fluoride 5000 plus dental cream 1.1 %* | 1 | |
| *sodium fluoride 5000 ppm dental gel 1.1 %* | 1 | |
| *sodium fluoride dental cream 1.1 %* | 1 | |
| *sodium fluoride dental gel 1.1 %* | 1 | |
| *sodium fluoride mouth/throat solution 0.2 %* | 1 | |
| *sodium fluoride oral solution 1.1 (0.5 f) mg/ml* | 1 | H |
| *sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| *sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| **DENTAL AGENTS - Oral Care** | | |
| **DENTAL AGENTS - Oral Care** | | |
| CLINPRO 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| DENTA 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 % | 3 | |
| DENTAGEL DENTAL GEL 1.1 % | 3 | |
| EASYGEL DENTAL GEL 0.4 % (*stannous fluoride*) | 3 | |
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (*sodium fluoride-vitamin d*) | 3 | |
| FLOTREX ORAL TABLET CHEWABLE 1 MG (*pediatric multivitamins-fl*) | 3 | |
| FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (*stannous fluoride*) | 3 | |
| FLUORIDEX DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIMAX 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| JUST RIGHT 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| *multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| PREVIDENT DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (*sodium fluoride*) | 3 | |
| *sf 5000 plus dental cream 1.1 %* | 1 | |
| *sf dental gel 1.1 %* | 1 | |
| *sod fluoride-potassium nitrate dental gel 1.1-5 %* | 1 | |
| *sodium fluoride 5000 enamel dental gel 1.1-5 %* | 1 | |
| *sodium fluoride 5000 plus dental cream 1.1 %* | 1 | |
| *sodium fluoride 5000 ppm dental gel 1.1 %* | 1 | |
| *sodium fluoride 5000 ppm dental paste 1.1 %* | 1 | |
| *sodium fluoride 5000 sensitive dental gel 1.1-5 %* | 1 | |
| *sodium fluoride dental cream 1.1 %* | 1 | |
| *sodium fluoride dental gel 1.1 %* | 1 | |
| *sodium fluoride mouth/throat solution 0.2 %* | 1 | |
| *sodium fluoride oral solution 1.1 (0.5 f) mg/ml* | 1 | H |
| *sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| *sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| **DEVICES - Medical Supplies and Durable Medical Equipment** | | |
| **DEVICES - Medical Supplies and Durable Medical Equipment** | | |
| ACCU-CHEK AVIVA IN VITRO SOLUTION (*blood glucose calibration*) | 1 | |
| ACCU-CHEK FASTCLIX LANCET KIT KIT (*lancets misc.*) | 1 | |
| ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| ACCU-CHEK GUIDE KIT W/DEVICE (*blood glucose monitoring suppl*) | 2 | QL (1 meter or meter kit per year.) |
| ACCU-CHEK GUIDE ME KIT W/DEVICE (*blood glucose monitoring suppl*) | 2 | QL (1 meter or meter kit per year.) |
| ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (*blood glucose calibration*) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT (*lancets misc.*) | 1 | |
| ADVANTAGE SAFETY LANCETS 28G | 3 | |
| ADVOCATE SAFETY LANCETS 21G (*lancets*) | 3 | |
| ADVOCATE SAFETY LANCETS 23G (*lancets*) | 3 | |
| ADVOCATE SAFETY LANCETS 28G (*lancets*) | 3 | |
| AEROCHAMBER HOLDING CHAMBER DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER PLUS FLO-VU INTERM DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER PLUS FLO-VU LARGE DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER PLUS FLO-VU SMALL DEVICE (*spacer/aero-holding chambers*) | 3 | |
| AEROCHAMBER2GO ANTI-STATIC DEVICE (*spacer/aero-holding chambers*) | 3 | |
| ALCOHOL PREP PADS SHEET 70 % | 3 | |
| AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML | 2 | QL (10 syringes per day.) |
| AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM | 2 | QL (10 pen needles per day.) |
| ASSURE CONTROL SOLUTION 2/3 IN VITRO LIQUID (*blood glucose calibration*) | 2 | |
| ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| ASSURE ID PRO PEN NEEDLES 30G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM | 2 | QL (10 pen needles per day.) |
| AUM MINI INSULIN PEN NEEDLE 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM | 2 | QL (10 pen needles per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AUM PEN NEEDLE 32G X 5 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM | 2 | QL (10 pen needles per day.) |
| AUM READYGARD DUO PEN NEEDLE 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| AUTOKEEPER SAFETY PEN NEEDLE 30G X 5 MM , 30G X 8 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| AUTOLET LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| AUTOLET LITE LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD BLUNT FILL NEEDLE 18G X 1" (*needle (disp)*) | 2 | |
| BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (*needle (disp)*) | 2 | |
| BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (*needle (disp)*) | 2 | |
| BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD SAFETYGLIDE NEEDLE 23G X 1-1/2" (*needle (disp)*) | 2 | |
| BD SHARPS COLLECTOR (*sharps container*) | 3 | |
| BD ULTRA-FINE INSULIN SYRINGES 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*) | 2 | QL (10 syringes per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BD ULTRA-FINE PEN NEEDLES 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| BIGFOOT UNITY PROGRAM KIT (*blood glucose monitoring suppl*) | 3 | QL (1 meter or meter kit per year.) |
| BREATHE COMFORT CHAMBER/ADULT DEVICE | 3 | |
| BREATHE COMFORT CHAMBER/CHILD DEVICE | 3 | |
| CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8" | 2 | |
| CAREPOINT POLY HUB NEEDLE 21G X 1-1/2" | 2 | |
| CAREPOINT POLY HUB NEEDLE 22G X 1-1/2" | 2 | |
| CAREPOINT POLY HUB NEEDLE 27G X 1/2" | 2 | |
| CAREPOINT PRECISION POLY HUB 23G X 1" (*needle (disp)*) | 2 | |
| CAREPOINT PRECISION POLY HUB 25G X 5/8" | 2 | |
| CAREPOINT SAFETY 1ST NEEDLE 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8" | 2 | |
| CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION (*blood glucose calibration*) | 2 | |
| CARESENS LANCETS 30G (*lancets*) | 3 | |
| CARESENS S CONTROL SOLN A/B IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" (*needle (disp)*) | 2 | |
| CARETOUCH LANCING/EJECTOR (*lancet devices*) | 3 | QL (1 device per prescription.) |
| CEQUR SIMPLICITY 1U EXTND WEAR DEVICE (*injection device for insulin*) | 3 | ST |
| CEQUR SIMPLICITY 2U DEVICE (*injection device for insulin*) | 3 | ST |
| CEQUR SIMPLICITY 2U EXTND WEAR DEVICE (*injection device for insulin*) | 3 | ST |
| CHEMSTRIP BG LOG BOOK (*blood glucose monitoring suppl*) | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CHOSEN LANCETS 30G (*lancets*) | 3 | |
| CHOSEN LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| CHOSEN SAFETY LANCETS 28G (*lancets*) | 3 | |
| CLEVER CHOICE COMFORT EZ (*lancets*) | 3 | |
| COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| COMFORT TOUCH TWIST LANCET 30G (*lancets*) | 3 | |
| CONTOUR CONTROL IN VITRO LIQUID HIGH (*blood glucose calibration*) | 3 | |
| CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (*blood glucose calibration*) | 2 | |
| CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (*blood glucose calibration*) | 2 | |
| CONTOUR NEXT EZ KIT W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR NEXT EZ KIT W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR NEXT GEN MONITOR KIT W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR NEXT MONITOR KIT W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR NEXT ONE KIT , W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR PLUS BLUE KIT W/DEVICE (*blood glucose monitoring suppl*) | 1 | QL (1 meter or meter kit per year.) |
| CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (*blood glucose calibration*) | 2 | |
| DEXCOM G6 RECEIVER DEVICE (*continuous glucose receiver*) | 3 | PA; QL (1 kit per 999 days.) |
| DEXCOM G6 SENSOR (*continuous glucose sensor*) | 3 | PA; QL (3 sensors per month.) |
| DEXCOM G6 TRANSMITTER (*continuous glucose transmitter*) | 3 | PA; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DEXCOM G7 15 DAY SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per month.) |
| DEXCOM G7 RECEIVER DEVICE (*continuous glucose receiver*) | 3 | PA; QL (1 kit per 999 days.) |
| DEXCOM G7 SENSOR (*continuous glucose sensor*) | 3 | PA; QL (3 sensors per month.) |
| DIABETES MONITOR DIGIT ADD-ON KIT | 3 | QL (1 meter or meter kit per year.) |
| DIABETES MONITOR DIGIT SOLN KIT | 3 | QL (1 meter or meter kit per year.) |
| DROPLET MICRON 34G X 3.5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| DROPSAFE ACTI-LANCE 23G (*lancets*) | 3 | |
| DROPSAFE AUTOPROTECT DUO 31G X 4 MM , 31G X 5 MM , 31G X 8 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| DROPSAFE MEDLANCE LANCET 30G (*lancets*) | 3 | |
| DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| DROPSAFE SICURA 25G X 1" , 25G X 5/8" (*needle (disp)*) | 2 | |
| EASIVENT (*spacer/aero-holding chambers*) | 3 | |
| EASY COMFORT SHARPS CONTAINER | 3 | |
| EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| EASYMAX CONTROL IN VITRO SOLUTION NORMAL (*blood glucose calibration*) | 3 | |
| EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| EMBECTA AUTOSHIELD DUO 30G X 5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*) | 2 | QL (10 syringes per day.) |
| EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| EMBECTA PEN NEEDLE NANO 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| EMBRACE WAVE GLUCOSE CONTROL IN VITRO LIQUID HIGH (*blood glucose calibration*) | 2 | |
| ENLITE GLUCOSE SENSOR (*continuous glucose sensor*) | 3 | PA |
| FLEXICHAMBER ADULT MASK/SMALL (*spacer/aero-hold chamber mask*) | 2 | |
| FLEXICHAMBER CHILD MASK/LARGE (*spacer/aero-hold chamber mask*) | 2 | |
| FLEXICHAMBER CHILD MASK/SMALL (*spacer/aero-hold chamber mask*) | 2 | |
| FLEXICHAMBER DEVICE (*spacer/aero-holding chambers*) | 3 | |
| FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL | 2 | |
| FONDCIRCLE LANCING DEVICE | 3 | QL (1 device per prescription.) |
| FONDCIRCLE SINGLE USE LANCETS | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| FORA TEST N' GO ADVANCE DEVICE (*blood glucose/ketone monitor*) | 3 | |
| FREESTYLE LIBRE 14 DAY READER DEVICE (*continuous glucose receiver*) | 3 | PA; QL (1 receiver per 999 days.) |
| FREESTYLE LIBRE 14 DAY SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per 21 days.) |
| FREESTYLE LIBRE 2 PLUS SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per month.) |
| FREESTYLE LIBRE 2 READER DEVICE (*continuous glucose receiver*) | 3 | PA; QL (1 receiver per 999 days.) |
| FREESTYLE LIBRE 2 SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per 21 days.) |
| FREESTYLE LIBRE 3 PLUS SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per month.) |
| FREESTYLE LIBRE 3 READER DEVICE (*continuous glucose receiver*) | 3 | PA; QL (1 reader per 999 days.) |
| FREESTYLE LIBRE 3 SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per 21 days.) |
| GUARDIAN 4 GLUCOSE SENSOR (*continuous glucose sensor*) | 3 | PA; QL (5 sensors per month.) |
| GUARDIAN 4 TRANSMITTER (*continuous glucose transmitter*) | 3 | PA; QL (1 transmitter kit per year.) |
| GUARDIAN REAL-TIME CHARGER (*continuous glucose monitor sup*) | 3 | PA |
| GUARDIAN REAL-TIME TEST PLUG (*continuous glucose monitor sup*) | 3 | PA |
| GUARDIAN SENSOR 3 (*continuous glucose sensor*) | 3 | PA; QL (5 sensors per 24 days.) |
| HAN-EASE (*injection device*) | 3 | |
| IHEALTH CONTROL SOLUTION IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| IHEALTH LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| INPEN 100-BLUE-LILLY-HUMALOG DEVICE (*injection device for insulin*) | 3 | ST |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (*injection device for insulin*) | 3 | ST |
| INPEN 100-GREY-LILLY-HUMALOG DEVICE (*injection device for insulin*) | 3 | ST |
| INPEN 100-GREY-NOVOLOG-FIASP DEVICE (*injection device for insulin*) | 3 | ST |
| INPEN 100-PINK-LILLY-HUMALOG DEVICE (*injection device for insulin*) | 3 | ST |
| INPEN 100-PINK-NOVOLOG-FIASP DEVICE (*injection device for insulin*) | 3 | ST |
| INSPIREASE RESERVOIR BAGS (*spacer/aero-hold chamber bags*) | 2 | |
| INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 34G X 3.5 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| INSULIN PEN NEEDLES 29G X 4MM , 29G X 5MM , 30G X 5 MM , 30G X 8 MM , 31G X 6 MM | 2 | QL (10 pen needles per day.) |
| INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 32G X 5/16" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| INSULIN SYRINGES 28G X 1/2" 0.5 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 29G X 5/16" 0.5 ML, 29G X 5/16" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML | 2 | QL (10 syringes per day.) |
| INSUPEN32G EXTR3ME 32G X 6 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| KT TAPE CGM PATCH (*continuous glucose monitor sup*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LANCETS (*lancets*) | 1 | |
| LANCETS | 3 | |
| LANCETS 28G THIN | 3 | |
| LANCETS SUPER THIN (*lancets*) | 3 | |
| MICROLET NEXT LANCETS (*lancets*) | 3 | |
| MICROLET NEXT LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| MINIMED INSTINCT GLUC SENSOR (*continuous glucose sensor*) | 3 | PA; QL (2 sensors per month.) |
| MOBILE LANCETS 30G | 3 | |
| NORDIPEN 5 INJECTION DEVICE (*injection device*) | 3 | |
| NOVOFINE PEN NEEDLE 32G X 6 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| NOVOPEN ECHO DEVICE (*injection device for insulin*) | 3 | |
| OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (*insulin disposable pump*) | 2 | PA; QL (1 kit per 180 days.) |
| OMNIPOD 5 DEXG7G6 PODS GEN 5 (*insulin disposable pump*) | 2 | PA; QL (10 pods (2 boxes) per copay.) |
| OMNIPOD 5 DEXG7G6 PODS GEN 5 (*insulin disposable pump*) | 2 | PA; QL (10 pods per prescription.) |
| OMNIPOD 5 LIBRE INTRO KIT (*insulin disposable pump*) | 2 | PA; QL (1 kit per 2 years.) |
| OMNIPOD 5 LIBRE PODS (*insulin disposable pump*) | 2 | PA; QL (10 pods (2 boxes) per copay.) |
| ONETOUCH DELICA PLUS LANCING (*lancet devices*) | 1 | QL (1 device per prescription.) |
| ONETOUCH DELICA SAFETY LANCING (*lancets*) | 1 | |
| ONETOUCH ULTRA IN VITRO LIQUID (*blood glucose calibration*) | 1 | |
| ONETOUCH VERIO IN VITRO LIQUID HIGH (*blood glucose calibration*) | 1 | |
| PARI VORTEX ADULT MASK (*spacer/aero-hold chamber mask*) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PARI VORTEX PEDIATRIC MASK (*spacer/aero-hold chamber mask*) | 2 | |
| PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM | 2 | QL (10 pen needles per day.) |
| PEN NEEDLES 31G X 8 MM (OTC) | 2 | QL (10 pen needles per day.) |
| PEN NEEDLES 31G X 8 MM (RX) | 2 | QL (10 pen needles per day.) |
| PEN NEEDLES 32G X 4 MM (OTC) | 2 | QL (10 pen needles per day.) |
| PEN NEEDLES 32G X 4 MM (RX) | 2 | QL (10 pen needles per day.) |
| PERFECT POINT SAFETY LANCETS (*lancets*) | 3 | |
| PERFECT POINT SAFETY NEEDLE 25G X 1" (*needle (disp)*) | 2 | |
| PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (*blood glucose calibration*) | 3 | |
| PIVOT SUPPLY KIT KIT | 2 | PA; QL (1 kit per copay.) |
| PURE COMFORT SAFETY LANCET 30G | 3 | |
| PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM | 2 | QL (10 pen needles per day.) |
| QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 33G X 8 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| RAYA SURE PEN NEEDLE 29G X 12MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM | 2 | QL (10 pen needles per day.) |
| SAFETY PEN NEEDLES 30G X 5 MM , 30G X 8 MM | 2 | QL (10 pen needles per day.) |
| SENSILANCE SAFETY LANCETS 21G (*lancets*) | 3 | |
| SENSILANCE SAFETY LANCETS 26G (*lancets*) | 3 | |
| SENSILANCE SAFETY LANCETS 28G (*lancets*) | 3 | |
| SHARPS COLLECTOR | 3 | |
| SHARPS CONTAINER | 3 | |
| SIMPLERA SYNC SENSOR (*continuous glucose sensor*) | 3 | PA |
| SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC) | 2 | QL (10 pen needles per day.) |
| TECHLITE LANCETS 26G (*lancets*) | 3 | |
| TECHLITE PLUS PEN NEEDLES 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| TOPFINE INSULIN PEN NEEDLE 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TRUE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM | 2 | QL (10 pen needles per day.) |
| TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (*blood glucose calibration*) | 2 | |
| TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (*blood glucose calibration*) | 2 | |
| TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (*blood glucose calibration*) | 2 | |
| TWIIST REFILL KIT KIT (*insulin disposable pump*) | 2 | PA; QL (1 kit per copay.) |
| TWIIST REFILL KIT/INFUSION SET KIT (*insulin disposable pump*) | 2 | PA; QL (1 kit per copay.) |
| TWIIST STARTER KIT KIT (*insulin disposable pump*) | 2 | PA; QL (1 kit per 730 days.) |
| ULTRA-CARE SAFETY LANCETS 30G | 3 | |
| UNIFINE OTC PEN NEEDLES 31G X 5 MM , 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| UNISTRIP CONTROL IN VITRO SOLUTION LOW (*blood glucose calibration*) | 3 | |
| VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*) | 2 | QL (10 syringes per day.) |
| VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (*insulin pen needle*) | 2 | QL (10 pen needles per day.) |
| VERIFINE SAFE LANCET MINI 21G (*lancets*) | 3 | |
| VERIFINE SAFE LANCET MINI 23G (*lancets*) | 3 | |
| VERIFINE SAFE LANCET MINI 28G (*lancets*) | 3 | |
| VERIFINE SAFE LANCET MINI 30G (*lancets*) | 3 | |
| VERIFINE SHARPS CONTAINER (*sharps container*) | 3 | |
| VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (*needle (disp)*) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (*blood glucose calibration*) | 2 | |
| VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (*blood glucose calibration*) | 3 | |
| VIVAGUARD LANCETS 30G (*lancets*) | 3 | |
| VIVAGUARD LANCING DEVICE (*lancet devices*) | 3 | QL (1 device per prescription.) |
| VIVAGUARD SAFETY LANCETS 28G (*lancets*) | 3 | |
| VORTEX VALVE CHAMBER-PEDI MASK DEVICE (*spacer/aero-holding chambers*) | 3 | |
| VORTEX VALVED HOLDING CHAMBER DEVICE (*spacer/aero-holding chambers*) | 3 | |
| **DIAGNOSTIC AGENTS** | | |
| **ADRENOCORTICAL INSUFFICIENCY** | | |
| ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (*corticotropin*) | 4 | PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SP |
| ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (21 mL (21 injectors) per treatment course.); SP |
| ACTHAR INJECTION GEL 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (20 ml per 24 days.); SP |
| CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; SP |
| CORTROPHIN INJECTION GEL 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (20 ml per 24 days.); SP |
| CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (*cosyntropin*) | 3 | |
| *cosyntropin injection solution reconstituted 0.25 mg* | 1 | |
| **CARDIAC FUNCTION** | | |
| *aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg* | 3 | |
| *dipyridamole oral tablet 25 mg, 50 mg, 75 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **DIABETES MELLITUS** | | |
| ACCU-CHEK GUIDE TEST IN VITRO STRIP (*glucose blood*) | 2 | QL (51 strips per prescription without history 204 strips per prescription with history.) |
| CONTOUR NEXT TEST IN VITRO STRIP (*glucose blood*) | 1 | QL (51 strips per prescription without history 204 strips per prescription with history.) |
| CONTOUR PLUS TEST IN VITRO STRIP (*glucose blood*) | 1 | QL (51 strips per prescription without history 204 strips per prescription with history.) |
| FORA TEST N'GO ADV-VOICE-6 CON IN VITRO STRIP (*ketone blood test*) | 3 | |
| RELION GLUCOSE TEST STRIPS IN VITRO STRIP (*glucose blood*) | 3 | QL (51 strips per prescription without history 204 strips per prescription with history.) |
| **DIAGNOSTIC AGENTS** | | |
| BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| CARESTART COVID-19 HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| CLEARDETECT COVID-19 AG HOME IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| CLINITEST RAPID COVID-19 TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| COVID-19 AT HOME ANTIGEN TEST IN VITRO KIT | 3 | SM |
| COVID-19 AT-HOME TEST IN VITRO KIT | 3 | SM |
| DIATRUST COVID-19 HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| ELLUME COVID-19 HOME TEST IN VITRO KIT | 3 | SM |
| FASTEP COVID-19 ANTIGEN TEST IN VITRO KIT | 3 | SM |
| FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| IHEALTH COVID-19 RAPID TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| INDICAID COVID-19 RAPID TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| INTELISWAB COVID-19 RAPID TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| ON/GO COVID-19 ANTIGEN TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| ON/GO ONE COVID-19 HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| PILOT COVID-19 AT-HOME TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| SPEEDY SWAB COVID-19 ANTIGEN IN VITRO KIT (*covid-19 at home test*) | 3 | SM |
| **KETONES** | | |
| CHEMSTRIP K IN VITRO STRIP (*acetone (urine) test*) | 2 | |
| KETOSTIX IN VITRO STRIP (*acetone (urine) test*) | 2 | |
| **PHEOCHROMOCYTOMA** | | |
| *metyrosine oral capsule 250 mg* | 3 | PA |
| **PITUITARY FUNCTION** | | |
| METOPIRONE ORAL CAPSULE 250 MG (*metyrapone*) | 3 | |
| **SUGAR** | | |
| DIASTIX REAGENT IN VITRO STRIP (*glucose urine test-glucose ox*) | 3 | |
| **URINE AND FECES CONTENTS** | | |
| CHEMSTRIP UGK IN VITRO STRIP (*urine glucose-ketones test*) | 3 | |
| KETO-DIASTIX IN VITRO STRIP (*urine glucose-ketones test*) | 3 | |
| KETONE CARE IN VITRO STRIP (*urine glucose-ketones test*) | 2 | |
| **DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants** | | |
| **DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants** | | |
| *formaldehyde external solution 37 %* | 1 | |
| *glutaraldehyde external solution 25 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ELECTROLYTIC, CALORIC, AND WATER BALANCE** | | |
| **ACIDIFYING AGENTS** | | |
| K-PHOS NO 2 ORAL TABLET 305-700 MG (*pot & sod ac phosphates*) | 2 | |
| **ALKALINIZING AGENTS** | | |
| *cytra k crystals oral packet 3300-1002 mg* | 1 | |
| ORACIT ORAL SOLUTION 490-640 MG/5ML (*sod citrate-citric acid*) | 2 | |
| *potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)* | 1 | |
| *potassium citrate-citric acid oral solution 1100-334 mg/5ml* | 1 | |
| *sod citrate-citric acid oral solution 500-334 mg/5ml* | 1 | |
| *tricitrates oral solution 550-500-334 mg/5ml* | 1 | |
| UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (*potassium citrate*) | 3 | |
| UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (*potassium citrate*) | 3 | |
| **AMMONIA DETOXICANTS** | | |
| *carglumic acid oral tablet soluble 200 mg* | 2 | PA; SP |
| *constulose oral solution 10 gm/15ml* | 1 | |
| *enulose oral solution 10 gm/15ml* | 1 | |
| *generlac oral solution 10 gm/15ml* | 1 | |
| *glycerol phenylbutyrate oral liquid 1.1 gm/ml* | 3 | PA; QL (17.5 ml per day.); SP |
| KRISTALOSE ORAL PACKET 10 GM, 20 GM (*lactulose*) | 3 | |
| *lactulose encephalopathy oral solution 10 gm/15ml* | 1 | |
| *lactulose oral packet 20 gm* | 3 | |
| *lactulose oral solution 10 gm/15ml, 20 gm/30ml* | 1 | |
| LITHOSTAT ORAL TABLET 250 MG (*acetohydroxamic acid*) | 3 | |
| *sodium phenylbutyrate oral powder 3 gm/tsp* | 1 | PA |
| *sodium phenylbutyrate oral tablet 500 mg* | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **CALORIC AGENTS - Drugs for Nutrition** | | |
| CAMINO PRO COMPLETE/GLYTACTIN ORAL BAR (*nutritional supplements*) | 3 | |
| COMPLEX ESSENTIAL MSD ORAL POWDER (*nutritional supplements*) | 3 | |
| DOJOLVI ORAL LIQUID 100 % (*triheptanoin*) | 3 | PA; SP |
| EAA SUPPLEMENT ORAL PACKET (*nutritional supplements*) | 3 | |
| ENCALA ORAL POWDER (*nutritional supplements*) | 3 | |
| ENSURE ORIGINAL ORAL LIQUID (*nutritional supplements*) | 3 | |
| ENSURE PLUS ORAL LIQUID (*nutritional supplements*) | 3 | |
| GLYTACTIN BETTERMILK 15 ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN BETTERMILK DE-LITE ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN BUILD 10PE ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN BUILD 20/20 ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN BUILD 20/20 PKU ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN BURST ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN COMPLETE 10PE ORAL BAR (*nutritional supplements*) | 3 | |
| GLYTACTIN RESTORE 10 ORAL LIQUID (*nutritional supplements*) | 3 | |
| GLYTACTIN RESTORE 5 ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN RESTORE LITE 10 ORAL LIQUID (*nutritional supplements*) | 3 | |
| GLYTACTIN RESTORE LITE 10PE ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN RTD 10 ORAL LIQUID (*nutritional supplements*) | 3 | |
| GLYTACTIN RTD 15 ORAL LIQUID (*nutritional supplements*) | 3 | |
| GLYTACTIN RTD LITE 15 ORAL LIQUID (*nutritional supplements*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| GLYTACTIN SWIRL 15 ORAL PACKET (*nutritional supplements*) | 3 | |
| GLYTACTIN SWIRL 15PE ORAL PACKET (*nutritional supplements*) | 3 | |
| L-ISOLEUCINE POWDER | 3 | PA |
| MALTOCARB ORAL POWDER (*nutritional supplements*) | 3 | |
| NEOCATE SYNEO JUNIOR ORAL POWDER (*nutritional supplements*) | 3 | |
| PEPTICATE ORAL POWDER (*infant foods*) | 3 | |
| PHENYLADE ESSENTIAL DRINK MIX ORAL POWDER (*nutritional supplements*) | 3 | |
| PHENYLADE GMP MIX DHA/FIBER ORAL POWDER (*nutritional supplements*) | 3 | |
| PHENYLADE GMP MIX-IN ORAL POWDER (*nutritional supplements*) | 3 | |
| PHENYLADE GMP ULTRA ORAL PACKET (*nutritional supplements*) | 3 | |
| PHENYLADE60 DRINK MIX ORAL POWDER (*nutritional supplements*) | 3 | |
| PKU COOLER 10 ORAL LIQUID (*nutritional supplements*) | 3 | |
| PKU COOLER 15 ORAL LIQUID (*nutritional supplements*) | 3 | |
| PKU COOLER 20 ORAL LIQUID (*nutritional supplements*) | 3 | |
| PKU EASY MICROTABS ORAL TABLET DELAYED RELEASE (*nutritional supplements*) | 3 | |
| PKU EASY MICROTABS PLUS ORAL TABLET DELAYED RELEASE (*nutritional supplements*) | 3 | |
| PKU EASY SHAKE & GO ORAL POWDER (*nutritional supplements*) | 3 | |
| PKU GOLIKE 10G P.E. ORAL BAR (*amino acids*) | 3 | |
| PKU GOLIKE PLUS 16+ ORAL PACKET | 3 | |
| PKU GOLIKE PLUS 4-16 ORAL PACKET | 3 | |
| PKU PERIFLEX EARLY YEARS ORAL POWDER (*nutritional supplements*) | 3 | |
| PKU START ORAL POWDER (*nutritional supplements*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *pku trio oral powder* | 1 | |
| PREKUNIL ORAL TABLET (*nutritional supplements*) | 3 | |
| PRO-STAT/FIBER ORAL LIQUID (*amino acids-protein hydrolys*) | 3 | |
| REAL FOOD BLENDS ENTERAL LIQUID (*nutritional supplements*) | 3 | |
| REFRESH AA 15 PKU ORAL LIQUID (*amino acids*) | 3 | |
| RENASTART ORAL POWDER (*nutritional supplements*) | 3 | |
| **CARBONIC ANHYDRASE INHIBITORS (40:28) - Drugs for Water Balance** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | 1 | |
| *acetazolamide oral tablet 125 mg, 250 mg* | 1 | |
| **DIURETICS, MISCELLANEOUS - Drugs for Water Balance** | | |
| *elixophyllin oral elixir 80 mg/15ml* | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*) | 3 | |
| *theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg* | 1 | |
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | 1 | |
| *theophylline oral elixir 80 mg/15ml* | 1 | |
| *theophylline oral solution 80 mg/15ml* | 1 | |
| **LOOP DIURETICS (40:28) - Drugs for Water Balance** | | |
| *bumetanide oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| BUMEX ORAL TABLET 0.5 MG (*bumetanide*) | 3 | |
| ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (*bumetanide*) | 4 | PA; QL (12 nasal sprays per copay.) |
| *ethacrynic acid oral tablet 25 mg* | 3 | |
| *furosemide oral solution 10 mg/ml, 8 mg/ml* | 1 | |
| *furosemide oral tablet 20 mg, 40 mg, 80 mg* | 1 | |
| LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (*furosemide*) | 4 | PA |
| LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (*furosemide*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg* | 1 | |
| **OSMOTIC DIURETICS (40:28) - Drugs for Water Balance** | | |
| DERMACINRX UREA EXTERNAL CREAM 41 % (*urea*) | 3 | |
| DERMACURE EXTERNAL CREAM 41 % (*urea*) | 3 | |
| HYDRO 40 EXTERNAL FOAM 40 % (*urea*) | 3 | |
| *urea external cream 20 %, 40 %* | 1 | |
| *urea external cream 41 %* | 3 | |
| *urea external lotion 40 %* | 1 | |
| **OTHER ION-REMOVING AGENTS** | | |
| RADIOGARDASE ORAL CAPSULE 0.5 GM (*prussian blue insoluble*) | 3 | |
| **PHOSPHATE-REMOVING AGENTS** | | |
| *calcium acetate (phos binder) oral capsule 667 mg* | 1 | |
| *calcium acetate (phos binder) oral tablet 667 mg* | 1 | |
| *calcium acetate oral tablet 667 mg* | 1 | |
| FOSRENOL ORAL PACKET 1000 MG, 750 MG (*lanthanum carbonate*) | 3 | ST |
| *lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg* | 3 | ST |
| *sevelamer carbonate oral packet 0.8 gm, 2.4 gm* | 2 | PA |
| *sevelamer carbonate oral tablet 800 mg* | 2 | |
| VELPHORO ORAL TABLET CHEWABLE 500 MG (*sucroferric oxyhydroxide*) | 4 | ST |
| XPHOZAH ORAL TABLET 20 MG, 30 MG (*tenapanor hcl (ckd)*) | 4 | PA; QL (2 tablets per day.) |
| **POTASSIUM-REMOVING AGENTS** | | |
| LOKELMA ORAL PACKET 10 GM (*sodium zirconium cyclosilicate*) | 3 | PA; QL (1 packet per day.) |
| LOKELMA ORAL PACKET 5 GM (*sodium zirconium cyclosilicate*) | 3 | PA; QL (3 packets per day.) |
| *sodium polystyrene sulfonate combination suspension 15 gm/60ml* | 1 | |
| *sodium polystyrene sulfonate oral powder* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (*sodium polystyrene sulfonate*) | 3 | |
| SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (*sodium polystyrene sulfonate*) | 3 | |
| VELTASSA ORAL PACKET 1 GM (*patiromer sorbitex calcium*) | 3 | PA; QL (124 packets per month.) |
| VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (*patiromer sorbitex calcium*) | 3 | PA; QL (1 Packet per day.) |
| XPHOZAH ORAL TABLET 30 MG (*tenapanor hcl (ckd)*) | 4 | PA; QL (2 tablets per day.) |
| **POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance** | | |
| *amiloride hcl oral tablet 5 mg* | 1 | |
| *amiloride-hydrochlorothiazide oral tablet 5-50 mg* | 1 | |
| CAROSPIR ORAL SUSPENSION 25 MG/5ML (*spironolactone*) | 3 | PA |
| *eplerenone oral tablet 25 mg, 50 mg* | 2 | |
| *spironolactone oral suspension 25 mg/5ml* | 3 | PA |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *spironolactone-hctz oral tablet 25-25 mg* | 1 | |
| *triamterene oral capsule 100 mg, 50 mg* | 3 | |
| *triamterene-hctz oral capsule 37.5-25 mg* | 1 | |
| *triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg* | 1 | |
| **REPLACEMENT PREPARATIONS** | | |
| CALCIFOL ORAL WAFER 1342-1.6 MG (*ca carb-fa-d-b6-b12-boron-mg*) | 3 | |
| *calcium acetate (phos binder) oral capsule 667 mg* | 1 | |
| *calcium acetate (phos binder) oral tablet 667 mg* | 1 | |
| *calcium acetate oral tablet 667 mg* | 1 | |
| EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (*potassium bicarb-citric acid*) | 2 | |
| *effer-k oral tablet effervescent 25 meq* | 1 | |
| GALZIN ORAL CAPSULE 25 MG, 50 MG (*zinc acetate (oral)*) | 3 | |
| *klor-con 10 oral tablet extended release 10 meq* | 1 | |
| *klor-con m10 oral tablet extended release 10 meq* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *klor-con m15 oral tablet extended release 15 meq* | 1 | |
| *klor-con m20 oral tablet extended release 20 meq* | 1 | |
| *klor-con oral packet 20 meq* | 1 | |
| *klor-con oral tablet extended release 8 meq* | 1 | |
| K-PHOS ORAL TABLET 500 MG (*potassium phosphate monobasic*) | 2 | |
| K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (*k phos mono-sod phos di & mono*) | 2 | |
| MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (*insulin regular(human) in nacl*) | 3 | |
| ONENATAL RX ORAL TABLET 1 MG (*prenatal multivit-min-fe-fa*) | 3 | |
| PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (*k phos mono-sod phos di & mono*) | 2 | |
| *phosphorous oral tablet 155-852-130 mg* | 1 | |
| *phospho-trin 250 neutral oral tablet 155-852-130 mg* | 1 | |
| PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION 22-4-1 MEQ-MMOL/L | 3 | |
| PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5-1 MEQ-MMOL/L | 3 | |
| *potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq* | 1 | |
| *potassium chloride er oral capsule extended release 10 meq, 8 meq* | 1 | |
| *potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq* | 1 | |
| *potassium chloride oral packet 20 meq* | 1 | |
| *potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)* | 1 | |
| PREMESISRX ORAL TABLET 1 MG (*prenatal ca-b6-b12-fa-ginger*) | 3 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (*prenat-fecbn-feasp-meth-fa-dha*) | 3 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (*prenat mv-min-methylfolate-fa*) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION 22-4 MEQ/L (*bicarb-dextrose-k (crrt)*) | 3 | |
| PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION 32-2.5 MEQ/L (*bicarb-dextrose-ca (crrt)*) | 3 | |
| PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION 32-2 MEQ/L (*bicarb-dextrose-k (crrt)*) | 3 | |
| PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION 32-2-3.5 MEQ/L (*bicarb-dextrose-k-ca (crrt)*) | 3 | |
| PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION 32-4-1.2 MEQ/L (*bicarb-dextose-k-mg (crrt)*) | 3 | |
| PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5 MEQ/L (*bicarb-dextrose-k-ca (crrt)*) | 3 | |
| PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION 32-1.2 MEQ/L (*bicarb-mg (crrt)*) | 3 | |
| TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (*prenat-fe poly-methfol-fa-dha*) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (*prenatal mv-min-fe fum-fa-dha*) | 3 | |
| WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG | 3 | |
| WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (*copper histidinate*) | 4 | PA; QL (30 single-dose vials per month.); SP |
| **THIAZIDE DIURETICS (40:28) - Drugs for Water Balance** | | |
| *amiloride-hydrochlorothiazide oral tablet 5-50 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg* | 1 | |
| *bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg* | 1 | |
| *candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg* | 3 | |
| *captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg* | 1 | |
| *enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg* | 1 | |
| *fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg* | 1 | |
| *hydrochlorothiazide oral capsule 12.5 mg* | 1 | |
| *hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*hydrochlorothiazide*) | 3 | PA |
| *irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg* | 1 | |
| *lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | 1 | |
| *losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg* | 1 | |
| LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*benazepril-hydrochlorothiazide*) | 3 | |
| *metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg* | 1 | |
| *olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg* | 2 | |
| *quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | 2 | |
| *spironolactone-hctz oral tablet 25-25 mg* | 1 | |
| *telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg* | 2 | |
| *triamterene-hctz oral capsule 37.5-25 mg* | 1 | |
| *triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg* | 1 | |
| *valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **THIAZIDE-LIKE DIURETICS (40:28) - Drugs for Water Balance** | | |
| *atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg* | 1 | |
| *chlorthalidone oral tablet 25 mg, 50 mg* | 1 | |
| *indapamide oral tablet 1.25 mg, 2.5 mg* | 1 | |
| *metolazone oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| **URICOSURIC AGENTS** | | |
| *colchicine-probenecid oral tablet 0.5-500 mg* | 1 | |
| ORLYNVAH ORAL TABLET 500-500 MG (*sulopenem etzadrox-probenecid*) | 4 | QL (10 tablets per course of therapy.) |
| *probenecid oral tablet 500 mg* | 1 | |
| **VASOPRESSIN ANTAGONISTS - Drugs for Water Balance** | | |
| SAMSCA ORAL TABLET 15 MG (*tolvaptan (hyponatremia)*) | 4 | PA; QL (90 tablets per 365 days.); SP |
| SAMSCA ORAL TABLET 30 MG (*tolvaptan (hyponatremia)*) | 4 | PA; QL (60 tablets per 365 days.); SP |
| *tolvaptan (hyponatremia) oral tablet 15 mg* | 2 | PA; QL (90 tablets per 365 days.); SP |
| *tolvaptan (hyponatremia) oral tablet 30 mg* | 2 | PA; QL (60 tablets per 365 days.); SP |
| *tolvaptan oral tablet 15 mg, 30 mg* | 2 | PA; SP |
| *tolvaptan oral tablet therapy pack 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg* | 4 | PA; QL (2 tablets per day.); SP |
| *tolvaptan oral tablet therapy pack 30 & 15 mg* | 4 | PA; QL (2 tablets per day.) |
| **ENZYMES** | | |
| **ENZYME COFACTORS/CHAPERONES** | | |
| GALAFOLD ORAL CAPSULE 123 MG (*migalastat hcl*) | 3 | PA; QL (14 capsules per 21 days.); SP |
| MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (*arimoclomol citrate*) | 4 | PA; QL (90 capsules per month.); SP |
| *sapropterin dihydrochloride oral packet 100 mg* | 2 | PA; QL (16 packets per day.); SP |
| *sapropterin dihydrochloride oral packet 500 mg* | 2 | PA; QL (4 packets per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sapropterin dihydrochloride oral tablet 100 mg* | 2 | PA; QL (16 tablets per day); SP |
| SEPHIENCE ORAL PACKET 1000 MG (*sepiapterin*) | 4 | PA; ST; QL (186 packets per month.); SP |
| SEPHIENCE ORAL PACKET 250 MG (*sepiapterin*) | 4 | PA; ST; QL (682 packets per month.); SP |
| *zelvysia oral packet 100 mg* | 2 | PA; QL (589 packets per month.); SP |
| *zelvysia oral packet 500 mg* | 2 | PA; QL (4 packets per day.); SP |
| **ENZYME INHIBITORS** | | |
| CERDELGA ORAL CAPSULE 84 MG (*eliglustat tartrate*) | 2 | PA; SP |
| HARLIKU ORAL TABLET 2 MG (*nitisinone (aku)*) | 4 | PA; QL (31 tablets per month.); SP |
| *miglustat oral capsule 100 mg* | 2 | |
| OPFOLDA ORAL CAPSULE 65 MG (*miglustat (gaa deficiency)*) | 2 | PA; QL (8 capsules per 21 days.); SP |
| ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (*nitisinone*) | 4 | PA; SP |
| ORFADIN ORAL SUSPENSION 4 MG/ML (*nitisinone*) | 4 | PA; SP |
| ZOKINVY ORAL CAPSULE 50 MG (*lonafarnib*) | 2 | PA; QL (5 capsules per day.); SP |
| ZOKINVY ORAL CAPSULE 75 MG (*lonafarnib*) | 2 | PA; QL (1 tablet per day.); SP |
| **ENZYMES** | | |
| CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (*pancrelipase (lip-prot-amyl)*) | 2 | |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (*pegvaliase-pqpz*) | 3 | PA; ST; QL (7 mL per year.); SP |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (*pegvaliase-pqpz*) | 3 | PA; ST; QL (6 syringes per 365 days.); SP |
| PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*pegvaliase-pqpz*) | 3 | PA; ST; QL (1 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (*pancrelipase (lip-prot-amyl)*) | 3 | ST |
| PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (*pancrelipase (lip-prot-amyl)*) | 4 | ST |
| PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*) | 2 | PA; QL (5 ml per day.); SP |
| SANTYL EXTERNAL OINTMENT 250 UNIT/GM (*collagenase*) | 3 | QL (90 grams per prescription.) |
| STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML (*asfotase alfa*) | 2 | PA; QL (12 vials per month.); SP |
| SUCRAID ORAL SOLUTION 8500 UNIT/ML (*sacrosidase*) | 2 | PA; SP |
| VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*) | 3 | ST |
| ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (*pancrelipase (lip-prot-amyl)*) | 2 | |
| **EYE, EAR, NOSE AND THROAT (EENT) PREPS.** | | |
| **ALPHA-ADRENERGIC AGONISTS (52:40) - Drugs for the Eye** | | |
| ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (*brimonidine tartrate*) | 2 | QL (10 ml per prescription) |
| ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (*brimonidine tartrate*) | 3 | QL (10 ml per prescription) |
| *apraclonidine hcl ophthalmic solution 0.5 %* | 1 | |
| *brimonidine tartrate external gel 0.33 %* | 3 | PA; QL (30 grams per prescription.) |
| *brimonidine tartrate ophthalmic solution 0.15 %* | 2 | QL (10 ml per prescription) |
| *brimonidine tartrate ophthalmic solution 0.2 %* | 1 | |
| COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (*brimonidine tartrate-timolol*) | 2 | QL (5 ml per prescription) |
| IOPIDINE OPHTHALMIC SOLUTION 1 % (*apraclonidine hcl*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| MIRVASO EXTERNAL GEL 0.33 % (*brimonidine tartrate*) | 2 | PA; QL (30 grams per prescription.) |
| **ANTIALLERGIC AGENTS - Drugs for Allergy** | | |
| *azelastine hcl nasal solution 0.1 %, 137 mcg/spray* | 2 | |
| *azelastine hcl ophthalmic solution 0.05 %* | 1 | |
| *cromolyn sodium inhalation nebulization solution 20 mg/2ml* | 1 | |
| *cromolyn sodium ophthalmic solution 4 %* | 1 | |
| *cromolyn sodium oral concentrate 100 mg/5ml* | 1 | |
| *epinastine hcl ophthalmic solution 0.05 %* | 3 | QL (5 ml per prescription) |
| *olopatadine hcl nasal solution 0.6 %* | 3 | |
| **ANTIBACTERIALS (52:04) - Drugs for Infections** | | |
| AMZEEQ EXTERNAL FOAM 4 % (*minocycline hcl micronized*) | 3 | QL (30 grams per prescription.) |
| AZASITE OPHTHALMIC SOLUTION 1 % (*azithromycin*) | 3 | |
| *bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm* | 1 | |
| *bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %* | 1 | |
| BESIFLOXACIN HCL OPHTHALMIC SUSPENSION 0.6 % | 3 | |
| BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (*besifloxacin hcl*) | 3 | |
| CETRAXAL OTIC SOLUTION 0.2 % (*ciprofloxacin hcl*) | 3 | |
| CILOXAN OPHTHALMIC OINTMENT 0.3 % (*ciprofloxacin hcl*) | 3 | |
| CIPRO HC OTIC SUSPENSION 0.2-1 % (*ciprofloxacin-hydrocortisone*) | 3 | |
| *ciprofloxacin hcl ophthalmic solution 0.3 %* | 1 | |
| *ciprofloxacin hcl otic solution 0.2 %* | 1 | |
| *ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %* | 3 | |
| *ciprofloxacin-hydrocortisone otic suspension 0.2-1 %* | 3 | |
| CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (*neomycin-colist-hc-thonzonium*) | 3 | |
| DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 % | 3 | PA |
| ERY EXTERNAL PAD 2 % | 3 | |
| *erythromycin external gel 2 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *erythromycin external solution 2 %* | 1 | |
| *erythromycin ophthalmic ointment 5 mg/gm* | 1 | H-N |
| *gatifloxacin ophthalmic solution 0.5 %* | 3 | |
| *gentamicin sulfate external cream 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate external ointment 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate ophthalmic solution 0.3 %* | 1 | QL (15 ml per prescription.) |
| *levofloxacin ophthalmic solution 0.5 %, 1.5 %* | 1 | |
| *loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %* | 3 | |
| MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (*neomycin-polymyxin-dexameth*) | 3 | |
| MAXITROL OPHTHALMIC SUSPENSION 0.1 % (*neomycin-polymyxin-dexameth*) | 3 | |
| *minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg* | 2 | |
| *minocycline hcl oral capsule 100 mg, 50 mg, 75 mg* | 1 | |
| MITOSOL OPHTHALMIC KIT 0.2 MG (*mitomycin*) | 3 | |
| *moxifloxacin hcl (2x day) ophthalmic solution 0.5 %* | 3 | |
| *moxifloxacin hcl ophthalmic solution 0.5 %* | 3 | |
| *neomycin sulfate oral tablet 500 mg* | 1 | |
| *neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000* | 1 | |
| *neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1* | 1 | |
| *neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1* | 1 | |
| *neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025* | 1 | |
| *neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1* | 1 | |
| *neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1* | 1 | |
| *neomycin-polymyxin-hc otic suspension 3.5-10000-1* | 1 | |
| OCUFLOX OPHTHALMIC SOLUTION 0.3 % (*ofloxacin*) | 3 | |
| *ofloxacin ophthalmic solution 0.3 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ofloxacin otic solution 0.3 %* | 2 | |
| *polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%* | 1 | |
| *sulfacetamide sodium ophthalmic solution 10 %* | 1 | |
| *sulfacetamide-prednisolone ophthalmic solution 10-0.23 %* | 1 | |
| TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*) | 3 | PA; QL (280 ml (1 carton) per 56 days.); SP |
| TOBI PODHALER INHALATION CAPSULE 28 MG (*tobramycin*) | 3 | PA; QL (224 capsules per 56 days.); SP |
| TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*) | 3 | |
| *tobramycin inhalation nebulization solution 300 mg/4ml* | 2 | PA; QL (224 ml per 56 days.); SP |
| TOBRAMYCIN NEBULIZATION SOLUTION 300 MG/5ML INHALATION | 3 | PA; QL (280 ml (1 carton) per 56 days.); SP |
| *tobramycin ophthalmic solution 0.3 %* | 1 | QL (5 ml  per prescription.) |
| *tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %* | 2 | |
| TOBREX OPHTHALMIC OINTMENT 0.3 % (*tobramycin*) | 3 | QL (3.5 grams per prescription.) |
| TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 % | 3 | PA |
| TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 % | 3 | PA |
| ZILXI EXTERNAL FOAM 1.5 % (*minocycline hcl micronized*) | 3 | PA; ST; QL (30 grams per prescription.) |
| ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (*loteprednol-tobramycin*) | 3 | |
| **ANTIFUNGALS (EENT) - Drugs for Infections** | | |
| NATACYN OPHTHALMIC SUSPENSION 5 % (*natamycin*) | 3 | |
| **ANTI-INFECTIVES, MISCELLANEOUS (52:04) - Drugs for Infections** | | |
| ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % (*silver nitrate-pot nitrate*) | 3 | |
| BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (*povidone-iodine*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | 1 | |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (*chlorhexidine gluconate*) | 3 | |
| *periogard mouth/throat solution 0.12 %* | 1 | |
| PRAMOTIC OTIC LIQUID 1-0.1 % (*pramoxine-chloroxylenol*) | 3 | |
| *silver nitrate external solution 0.5 %* | 1 | |
| XDEMVY OPHTHALMIC SOLUTION 0.25 % (*lotilaner*) | 3 | PA; QL (10 ml per 63 days.) |
| **ANTI-INFLAMMATORY AGENTS (EENT) - Drugs for Inflammation** | | |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *cyclosporine modified oral solution 100 mg/ml* | 1 | |
| *cyclosporine oral capsule 100 mg, 25 mg* | 1 | |
| *gengraf oral capsule 100 mg, 25 mg* | 1 | |
| MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (*perfluorohexyloctane*) | 3 | PA; QL (1 bottle per month.) |
| OXERVATE OPHTHALMIC SOLUTION 0.002 % (*cenegermin-bkbj*) | 3 | PA; QL (1 ml per day and 56 ml per 365 days.); SP |
| RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*) | 3 | PA; QL (60 vials per month.) |
| VERKAZIA OPHTHALMIC EMULSION 0.1 % (*cyclosporine*) | 3 | PA; QL (4 vials per day.) |
| XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*) | 3 | PA; QL (60 vials per month.) |
| **ANTIVIRALS (EENT) - Drugs for Infections** | | |
| *trifluridine ophthalmic solution 1 %* | 1 | |
| ZIRGAN OPHTHALMIC GEL 0.15 % (*ganciclovir*) | 3 | |
| **ASTRINGENTS (52:04) - Drugs for Infections** | | |
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | 1 | |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (*chlorhexidine gluconate*) | 3 | |
| *periogard mouth/throat solution 0.12 %* | 1 | |
| **BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye** | | |
| *betaxolol hcl ophthalmic solution 0.5 %* | 1 | |
| BETIMOL OPHTHALMIC SOLUTION 0.5 % (*timolol hemihydrate*) | 3 | QL (5 ml per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *carteolol hcl ophthalmic solution 1 %* | 1 | |
| COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (*brimonidine tartrate-timolol*) | 2 | QL (5 ml per prescription) |
| COSOPT OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*) | 3 | |
| *dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %* | 2 | |
| ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*) | 3 | |
| *levobunolol hcl ophthalmic solution 0.5 %* | 1 | |
| *timolol hemihydrate ophthalmic solution 0.5 %* | 2 | QL (5 ml per prescription.) |
| *timolol maleate (once-daily) ophthalmic solution 0.5 %* | 3 | |
| *timolol maleate ocudose ophthalmic solution 0.5 %* | 2 | |
| *timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate ophthalmic solution 0.25 %, 0.5 %* | 1 | |
| *timolol maleate pf ophthalmic solution 0.25 %, 0.5 %* | 2 | |
| TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*) | 3 | |
| **CARBONIC ANHYDRASE INHIBITORS (52:40) - Drugs for the Eye** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | 1 | |
| *acetazolamide oral tablet 125 mg, 250 mg* | 1 | |
| *brinzolamide ophthalmic suspension 1 %* | 2 | QL (10 ml per prescription) |
| COSOPT OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*) | 3 | |
| DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC | 3 | |
| *dorzolamide hcl solution 2 % ophthalmic* | 1 | |
| *dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %* | 2 | |
| *methazolamide oral tablet 25 mg, 50 mg* | 1 | |
| **CORTICOSTEROIDS (EENT) - Drugs for Inflammation** | | |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*) | 3 | QL (0.4 grams per day.) |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ALREX OPHTHALMIC SUSPENSION 0.2 % (*loteprednol etabonate*) | 3 | QL (5 ml per prescription) |
| ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANALPRAM HC EXTERNAL LOTION 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANUCORT-HC RECTAL SUPPOSITORY 25 MG | 2 | |
| ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 blister per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 packet per day.) |
| *bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %* | 1 | |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*) | 3 | QL (2 blisters per day.) |
| CIPRO HC OTIC SUSPENSION 0.2-1 % (*ciprofloxacin-hydrocortisone*) | 3 | |
| *ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %* | 3 | |
| *ciprofloxacin-hydrocortisone otic suspension 0.2-1 %* | 3 | |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (*hc-pramoxine-chloroxylenol*) | 3 | |
| CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (*hydrocortisone*) | 3 | |
| CORTENEMA RECTAL ENEMA 100 MG/60ML (*hydrocortisone*) | 3 | |
| CORTIFOAM EXTERNAL FOAM 10 % (*hydrocortisone acetate*) | 2 | |
| CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (*neomycin-colist-hc-thonzonium*) | 3 | |
| DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*) | 3 | QL (118.28 ml per prescription.) |
| DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*) | 3 | |
| DERMOTIC OTIC OIL 0.01 % (*fluocinolone acetonide*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dexamethasone intensol oral concentrate 1 mg/ml* | 1 | |
| *dexamethasone oral elixir 0.5 mg/5ml* | 1 | |
| *dexamethasone oral solution 0.5 mg/5ml* | 1 | |
| *dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg* | 1 | |
| *dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)* | 3 | |
| *dexamethasone sodium phosphate ophthalmic solution 0.1 %* | 1 | |
| *difluprednate ophthalmic emulsion 0.05 %* | 3 | |
| DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 % | 3 | PA |
| EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (*loteprednol etabonate*) | 3 | QL (8.3 mL per prescription) |
| FLAREX OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone acetate*) | 2 | |
| *flunisolide nasal solution 25 mcg/act (0.025%)* | 3 | |
| *fluocinolone acetonide body external oil 0.01 %* | 3 | QL (118.28 ml per prescription.) |
| *fluocinolone acetonide external cream 0.01 %* | 3 | QL (15 grams per prescription.) |
| *fluocinolone acetonide external cream 0.025 %* | 3 | QL (120 grams per copay.) |
| *fluocinolone acetonide external ointment 0.025 %* | 2 | QL (120 grams per copay.) |
| *fluocinolone acetonide external solution 0.01 %* | 1 | |
| *fluocinolone acetonide otic oil 0.01 %* | 1 | |
| *fluocinolone acetonide scalp external oil 0.01 %* | 3 | |
| *fluorometholone ophthalmic suspension 0.1 %* | 1 | |
| *fluticasone propionate nasal suspension 50 mcg/act* | 2 | |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | QL (0.04 mcg per day.) |
| FML FORTE OPHTHALMIC SUSPENSION 0.25 % (*fluorometholone*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone*) | 3 | |
| HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (*hydrocortisone acetate*) | 3 | |
| *hydrocortisone (perianal) external cream 2.5 %* | 1 | |
| *hydrocortisone ace-pramoxine external cream 1-1 %* | 1 | |
| *hydrocortisone acetate rectal suppository 25 mg, 30 mg* | 2 | |
| *hydrocortisone butyrate external cream 0.1 %* | 1 | |
| *hydrocortisone butyrate external ointment 0.1 %* | 1 | |
| *hydrocortisone butyrate external solution 0.1 %* | 1 | |
| *hydrocortisone external cream 2.5 %* | 1 | |
| *hydrocortisone external lotion 2.5 %* | 1 | |
| *hydrocortisone external ointment 1 %, 2.5 %* | 1 | |
| *hydrocortisone oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *hydrocortisone rectal enema 100 mg/60ml* | 1 | |
| *hydrocortisone valerate external cream 0.2 %* | 2 | QL (15 grams per prescription.) |
| *hydrocortisone valerate external ointment 0.2 %* | 3 | QL (15 grams per prescription.) |
| *hydrocortisone-acetic acid otic solution 1-2 %* | 1 | |
| *hydrocort-pramoxine (perianal) external cream 2.5-1 %* | 1 | |
| INVELTYS OPHTHALMIC SUSPENSION 1 % (*loteprednol etabonate*) | 3 | |
| KHINDIVI ORAL SOLUTION 1 MG/ML (*hydrocortisone*) | 3 | PA |
| LOTEMAX OPHTHALMIC OINTMENT 0.5 % (*loteprednol etabonate*) | 3 | |
| LOTEMAX SM OPHTHALMIC GEL 0.38 % (*loteprednol etabonate*) | 3 | QL (5 grams per prescription.) |
| *loteprednol etabonate ophthalmic suspension 0.2 %* | 3 | QL (5 ml per prescription) |
| *loteprednol etabonate ophthalmic suspension 0.5 %* | 3 | QL (5 ml per prescription.) |
| *loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %* | 3 | |
| MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (*dexamethasone*) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (*neomycin-polymyxin-dexameth*) | 3 | |
| MAXITROL OPHTHALMIC SUSPENSION 0.1 % (*neomycin-polymyxin-dexameth*) | 3 | |
| *mometasone furoate external cream 0.1 %* | 1 | |
| *mometasone furoate external ointment 0.1 %* | 1 | |
| *mometasone furoate external solution 0.1 %* | 1 | |
| *mometasone furoate nasal suspension 50 mcg/act* | 3 | QL (34 grams (2 bottles) per copay.) |
| *neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1* | 1 | |
| *neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1* | 1 | |
| *neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1* | 1 | |
| *neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1* | 1 | |
| *neomycin-polymyxin-hc otic suspension 3.5-10000-1* | 1 | |
| NUCORT EXTERNAL LOTION 2 % (*hydrocortisone acetate*) | 3 | |
| ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (*prednisolone sodium phosphate*) | 3 | |
| PRED MILD OPHTHALMIC SUSPENSION 0.12 % (*prednisolone acetate*) | 3 | |
| *prednisolone acetate ophthalmic suspension 1 %* | 1 | |
| *prednisolone oral solution 15 mg/5ml* | 1 | |
| *prednisolone oral tablet 5 mg* | 3 | |
| *prednisolone sodium phosphate ophthalmic solution 1 %* | 1 | |
| *prednisolone sodium phosphate oral solution 15 mg/5ml* | 1 | |
| *prednisolone sodium phosphate oral tablet dispersible 30 mg* | 3 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*) | 2 | |
| *procto-med hc external cream 2.5 %* | 1 | |
| PROCTOSOL HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| PROCTOZONE-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| *sulfacetamide-prednisolone ophthalmic solution 10-0.23 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*) | 3 | |
| TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21) (*dexamethasone*) | 3 | |
| TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (*dexamethasone*) | 3 | |
| TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*) | 2 | |
| TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*) | 3 | |
| *tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %* | 2 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*) | 3 | QL (2 blisters per day.) |
| TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 % | 3 | PA |
| TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 % | 3 | PA |
| *wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (*loteprednol-tobramycin*) | 3 | |
| **EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation** | | |
| RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*) | 3 | PA; QL (60 vials per month.) |
| VERKAZIA OPHTHALMIC EMULSION 0.1 % (*cyclosporine*) | 3 | PA; QL (4 vials per day.) |
| XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*) | 3 | PA; QL (60 vials per month.) |
| **EENT DRUGS, MISCELLANEOUS** | | |
| *acetic acid otic solution 2 %* | 1 | |
| *apraclonidine hcl ophthalmic solution 0.5 %* | 1 | |
| AQUORAL MOUTH/THROAT SOLUTION (*artificial saliva*) | 3 | |
| *cromolyn sodium inhalation nebulization solution 20 mg/2ml* | 1 | |
| *cromolyn sodium ophthalmic solution 4 %* | 1 | |
| *cromolyn sodium oral concentrate 100 mg/5ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (*cysteamine hcl*) | 3 | PA; QL (20 mL per 21 days) |
| CYSTARAN OPHTHALMIC SOLUTION 0.44 % (*cysteamine hcl*) | 2 | PA; QL (60 ml (4 bottles) per month.); SP |
| DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (*sulfuric acid-sulf phenolics*) | 2 | |
| *hydrocortisone-acetic acid otic solution 1-2 %* | 1 | |
| IOPIDINE OPHTHALMIC SOLUTION 1 % (*apraclonidine hcl*) | 3 | |
| MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (*perfluorohexyloctane*) | 3 | PA; QL (1 bottle per month.) |
| MUCOSITISRX MOUTH/THROAT PACKET (*artificial saliva*) | 3 | |
| OXERVATE OPHTHALMIC SOLUTION 0.002 % (*cenegermin-bkbj*) | 3 | PA; QL (1 ml per day and 56 ml per 365 days.); SP |
| TRYPTYR OPHTHALMIC SOLUTION 0.003 % (*acoltremon*) | 4 | PA; QL (60 vials per month.) |
| TYRVAYA NASAL SOLUTION 0.03 MG/ACT (*varenicline tartrate*) | 3 | PA; QL (0.28 ml per day.) |
| **EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation** | | |
| ACULAR LS OPHTHALMIC SOLUTION 0.4 % (*ketorolac tromethamine*) | 3 | |
| ACULAR OPHTHALMIC SOLUTION 0.5 % (*ketorolac tromethamine*) | 3 | |
| *diclofenac sodium ophthalmic solution 0.1 %* | 1 | |
| *flurbiprofen oral tablet 100 mg, 50 mg* | 1 | |
| *flurbiprofen sodium ophthalmic solution 0.03 %* | 1 | |
| *ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %* | 1 | |
| *ketorolac tromethamine oral tablet 10 mg* | 1 | |
| LURBIRO ORAL TABLET 100 MG (*flurbiprofen*) | 3 | |
| NEVANAC OPHTHALMIC SUSPENSION 0.1 % (*nepafenac*) | 3 | |
| SPRIX NASAL SOLUTION 15.75 MG/SPRAY (*ketorolac tromethamine*) | 3 | ST; QL (5 bottles per prescription.) |
| TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 % | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 % | 3 | PA |
| **LOCAL ANESTHETICS (EENT) - Drugs for Numbing** | | |
| AKTEN OPHTHALMIC GEL 3.5 % (*lidocaine hcl*) | 3 | |
| ALCAINE OPHTHALMIC SOLUTION 0.5 % (*proparacaine hcl*) | 3 | |
| ALTACAINE OPHTHALMIC SOLUTION 0.5 % (*tetracaine hcl*) | 3 | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| *lidocaine hcl mouth/throat solution 4 %* | 1 | |
| *lidocaine viscous hcl mouth/throat solution 2 %* | 1 | |
| PRAMOTIC OTIC LIQUID 1-0.1 % (*pramoxine-chloroxylenol*) | 3 | |
| *proparacaine hcl ophthalmic solution 0.5 %* | 1 | |
| *tetracaine hcl ophthalmic solution 0.5 %* | 1 | |
| **MACULAR DEGENERATION AGENTS** | | |
| CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (*cysteamine hcl*) | 3 | PA; QL (20 mL per 21 days) |
| CYSTARAN OPHTHALMIC SOLUTION 0.44 % (*cysteamine hcl*) | 2 | PA; QL (60 ml (4 bottles) per month.); SP |
| **MIOTICS - Drugs for the Eye** | | |
| PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (*echothiophate iodide*) | 2 | |
| *pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %* | 1 | |
| *pilocarpine hcl oral tablet 5 mg, 7.5 mg* | 1 | |
| SALAGEN ORAL TABLET 5 MG, 7.5 MG (*pilocarpine hcl*) | 3 | |
| **MYDRIATICS - Drugs for the Eye** | | |
| *atropine sulfate ophthalmic solution 1 %* | 1 | |
| CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (*cyclopentolate hcl*) | 3 | |
| CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (*cyclopentolate-phenylephrine*) | 3 | |
| *cyclopentolate hcl ophthalmic solution 1 %* | 1 | |
| *phenylephrine hcl ophthalmic solution 10 %, 2.5 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **OSMOTIC AGENTS - Drugs for the Eye** | | |
| DERMACINRX UREA EXTERNAL CREAM 41 % (*urea*) | 3 | |
| DERMACURE EXTERNAL CREAM 41 % (*urea*) | 3 | |
| HYDRO 40 EXTERNAL FOAM 40 % (*urea*) | 3 | |
| *urea external cream 20 %, 40 %* | 1 | |
| *urea external cream 41 %* | 3 | |
| *urea external lotion 40 %* | 1 | |
| **PROSTAGLANDIN ANALOGS - Drugs for the Eye** | | |
| *bimatoprost ophthalmic solution 0.03 %* | 2 | QL (2.5 ml per prescription.) |
| *bimatoprost solution 0.01 % ophthalmic* | 2 | QL (2.5 mL per copay.) |
| LATANOPROST OIL | 3 | PA |
| *latanoprost ophthalmic solution 0.005 %* | 1 | |
| LUMIGAN OPHTHALMIC SOLUTION 0.01 % (*bimatoprost*) | 2 | QL (2.5 mL per copay.) |
| ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (*netarsudil-latanoprost*) | 3 | QL (2.5 mL per prescription.) |
| *tafluprost (pf) ophthalmic solution 0.0015 %* | 3 | ST; QL (30 unit of use droppers per prescription.) |
| *travoprost (bak free) ophthalmic solution 0.004 %* | 3 | QL (2.5 ml per prescription) |
| XELPROS OPHTHALMIC EMULSION 0.005 % (*latanoprost*) | 3 | QL (2.5 ml per prescription.) |
| ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (*tafluprost*) | 3 | ST; QL (30 unit of use droppers per prescription.) |
| **RHO KINASE INHIBITORS - Drugs for the Eye** | | |
| RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (*netarsudil dimesylate*) | 3 | QL (2.5 ml per prescription.) |
| ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (*netarsudil-latanoprost*) | 3 | QL (2.5 mL per prescription.) |
| **VASOCONSTRICTORS** | | |
| ADRENALIN NASAL SOLUTION 0.1 % (*epinephrine hcl (nasal)*) | 2 | |
| CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (*cyclopentolate-phenylephrine*) | 3 | |
| *oxymetazoline hcl external cream 1 %* | 3 | PA; QL (30 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *phenylephrine hcl ophthalmic solution 10 %, 2.5 %* | 1 | |
| RHOFADE EXTERNAL CREAM 1 % (*oxymetazoline hcl*) | 3 | PA; QL (30 grams per prescription.) |
| UPNEEQ OPHTHALMIC SOLUTION 0.1 % (*oxymetazoline hcl*) | 3 | PA; QL (30 single-use vials per prescription.) |
| **GASTROINTESTINAL DRUGS** | | |
| **ANTACIDS AND ADSORBENTS** | | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| **CHLORIDE CHANNEL ACTIVATORS** | | |
| *lubiprostone oral capsule 24 mcg, 8 mcg* | 2 | PA; QL (2 capsules per day.) |
| **GUANYLATE CYCLASE C (GCC) RECEPT AGONIST** | | |
| LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (*linaclotide*) | 2 | PA; QL (1 capsule per day.) |
| **IMMUNOMODULATORY AGENTS (56:44)** | | |
| ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (*vedolizumab*) | 2 | PA; QL (0.05 ml per day.); SP |
| OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (*mirikizumab-mrkz*) | 2 | PA; QL (3 ml (2 syringes/1 box) per month.); SP |
| OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (*mirikizumab-mrkz*) | 2 | PA; QL (3 ml (2 syringes/1 box) per month.); SP |
| OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*mirikizumab-mrkz*) | 4 | PA; QL (2 ml (1 auto-injector) per month.); SP |
| OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*mirikizumab-mrkz*) | 4 | PA; QL (2 ml (1 prefilled syringe) per month.); SP |
| **OPIOID ANTAGONISTS (56:18)** | | |
| *alvimopan oral capsule 12 mg* | 3 | |
| RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.4 ml per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*) | 2 | PA; QL (1 tablet per day.) |
| **GASTROINTESTINAL DRUGS - Drugs for the Stomach** | | |
| **5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea** | | |
| AKYNZEO ORAL CAPSULE 300-0.5 MG (*netupitant-palonosetron*) | 3 | QL (1 capsule per prescription.) |
| *granisetron hcl oral tablet 1 mg* | 2 | |
| GRANISOL ORAL SOLUTION 2 MG/10ML (*granisetron hcl*) | 3 | |
| *ondansetron hcl oral solution 4 mg/5ml* | 1 | |
| *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg* | 1 | |
| *ondansetron odt oral tablet dispersible 4 mg, 8 mg* | 1 | |
| **ANTIDIARRHEA AGENTS - Drugs for Diarrhea** | | |
| *bis subcit-metronid-tetracyc oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml* | 1 | |
| *diphenoxylate-atropine oral tablet 2.5-0.025 mg* | 1 | |
| LOMOTIL ORAL TABLET 2.5-0.025 MG (*diphenoxylate-atropine*) | 3 | |
| MYTESI ORAL TABLET DELAYED RELEASE 125 MG (*crofelemer*) | 3 | PA; QL (2 tablets per day.) |
| *opium oral tincture 10 mg/ml (1%)* | 1 | |
| PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*) | 3 | QL (120 capsules per 180 days.) |
| VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*) | 4 | PA; QL (2 tablets per day.) |
| XERMELO ORAL TABLET 250 MG (*telotristat etiprate*) | 3 | PA; QL (3 tablets per day.); SP |
| **ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea** | | |
| *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg* | 1 | |
| *olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg* | 1 | |
| *olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg* | 2 | QL (1 capsule per day) |
| *promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml* | 1 | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |
| *scopolamine transdermal patch 72 hour 1 mg/3days* | 3 | |
| SYNDROS ORAL SOLUTION 5 MG/ML (*dronabinol*) | 3 | PA; QL (4 ml per day.) |
| **ANTIFLATULENTS - Drugs for Gas** | | |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| **ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea** | | |
| COMPRO RECTAL SUPPOSITORY 25 MG (*prochlorperazine*) | 3 | |
| *prochlorperazine maleate oral tablet 10 mg, 5 mg* | 1 | |
| *prochlorperazine rectal suppository 25 mg* | 1 | |
| *trimethobenzamide hcl oral capsule 300 mg* | 1 | |
| **ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation** | | |
| *alosetron hcl oral tablet 0.5 mg, 1 mg* | 2 | PA; QL (2 tablets per day) |
| APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (*mesalamine*) | 1 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*) | 3 | |
| *balsalazide disodium oral capsule 750 mg* | 1 | |
| DIPENTUM ORAL CAPSULE 250 MG (*olsalazine sodium*) | 3 | |
| *mesalamine oral capsule delayed release 400 mg* | 2 | |
| *mesalamine oral tablet delayed release 1.2 gm* | 2 | |
| *mesalamine rectal enema 4 gm* | 1 | QL (28 bottles per month.) |
| *mesalamine rectal suppository 1000 mg* | 2 | QL (1 suppository per day.) |
| *mesalamine-cleanser rectal kit 4 gm* | 1 | QL (4 kits per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ROWASA RECTAL KIT 4 GM (*mesalamine-cleanser*) | 4 | QL (4 kits per month.) |
| *sulfasalazine oral tablet 500 mg* | 1 | |
| *sulfasalazine oral tablet delayed release 500 mg* | 1 | |
| **ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid** | | |
| *bis subcit-metronid-tetracyc oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| *bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg* | 3 | QL (120 capsules per 180 days.) |
| PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*) | 3 | QL (120 capsules per 180 days.) |
| **ANTIULCER AGENTS AND ACID SUPPRESSANTS - Drugs for Ulcers and Stomach Acid** | | |
| *amoxicillin oral capsule 250 mg, 500 mg* | 1 | |
| *amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml* | 1 | |
| *amoxicillin oral tablet 500 mg, 875 mg* | 1 | |
| *amoxicillin oral tablet chewable 125 mg, 250 mg* | 1 | |
| *amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml* | 1 | |
| *clarithromycin er oral tablet extended release 24 hour 500 mg* | 2 | |
| *clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | 2 | |
| *clarithromycin oral tablet 250 mg, 500 mg* | 1 | |
| LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*) | 3 | |
| *metronidazole oral capsule 375 mg* | 1 | |
| *metronidazole oral tablet 250 mg, 500 mg* | 1 | |
| *tetracycline hcl oral capsule 250 mg, 500 mg* | 3 | |
| **CATHARTICS AND LAXATIVES - Drugs for Constipation** | | |
| *bisacodyl ec oral tablet delayed release 5 mg* | E | H |
| *clearlax oral powder 17 gm/scoop* | E | H |
| CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (*sod picosulfate-mag ox-cit acd*) | 3 | QL (350 ml per prescription.) |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ft clearlax oral powder 17 gm/scoop* | E | H |
| *ft laxative oral tablet delayed release 5 mg* | E | H |
| *ft magnesium citrate oral solution 1.745 gm/30ml* | E | H |
| *gavilax oral powder 17 gm/scoop* | E | H |
| *gavilyte-c oral solution reconstituted 240 gm* | 1 | H |
| *gavilyte-g oral solution reconstituted 236 gm* | 1 | QL (4000 mL per prescription.); H |
| *gavilyte-n with flavor pack oral solution reconstituted 420 gm* | 1 | QL (4000 ml per prescription.); H |
| *gentle laxative oral tablet delayed release 5 mg* | E | H |
| *glycolax oral powder 17 gm/scoop* | E | H |
| GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (*peg 3350-kcl-nabcb-nacl-nasulf*) | 1 | QL (4000 mL per prescription.); H |
| *goodsense clearlax oral powder 17 gm/scoop* | E | H |
| *laxative osmotic oral powder 17 gm/scoop* | E | H |
| *magnesium citrate oral solution 1.745 gm/30ml* | E | H |
| *mm clearlax oral powder 17 gm/scoop* | E | H |
| MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (*peg-kcl-nacl-nasulf-na asc-c*) | 3 | QL (1 kit per prescription.) |
| *na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml* | 3 | QL (354 ml per prescription.) |
| *peg 3350 oral powder 17 gm/scoop* | E | H |
| *peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm* | 1 | QL (4000 ml per prescription.); H |
| *peg-3350/electrolytes oral solution reconstituted 236 gm* | 1 | QL (4000 mL per prescription.); H |
| *peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm* | 3 | QL (1 kit per prescription.) |
| *peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm* | 3 | QL (1 kit per prescription.) |
| PEG-PREP ORAL KIT 5-210 MG-GM (*bisacodyl-peg-kcl-nabicar-nacl*) | 3 | |
| *polyethylene glycol 3350 oral powder 17 gm/scoop* | E | H |
| *smooth lax oral powder 17 gm/scoop* | E | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (*peg 3350-kcl-nacl-nasulf-mgsul*) | 3 | QL (2 doses (1 box) per prescription.) |
| SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (*na sulfate-k sulfate-mg sulf*) | 3 | QL (354 ml per prescription.) |
| SUTAB ORAL TABLET 1479-225-188 MG (*sodium sulfate-mag sulfate-kcl*) | 3 | QL (2 doses (24 tablets) per copay.); H |
| **CHOLELITHOLYTIC AGENTS - Drugs for the Stomach** | | |
| BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (*odevixibat*) | 3 | PA; QL (2 capsules per day.); SP |
| BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (*odevixibat*) | 3 | PA; QL (1 capsule per day.); SP |
| BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (*odevixibat*) | 3 | PA; QL (2 capsules per day.); SP |
| CHOLBAM ORAL CAPSULE 250 MG, 50 MG (*cholic acid*) | 2 | PA; QL (4 capsules per day.); SP |
| CTEXLI ORAL TABLET 250 MG (*chenodiol (basds)*) | 4 | PA; ST; QL (93 tablets per month.); SP |
| IQIRVO ORAL TABLET 80 MG (*elafibranor*) | 4 | PA; ST; QL (31 tablets per month.); SP |
| LIVDELZI ORAL CAPSULE 10 MG (*seladelpar lysine*) | 4 | PA; ST; QL (30 capsules per month.); SP |
| LIVMARLI ORAL SOLUTION 19 MG/ML (*maralixibat chloride*) | 3 | PA; QL (60 mL (1140 mg) per month.); SP |
| LIVMARLI ORAL SOLUTION 9.5 MG/ML (*maralixibat chloride*) | 3 | PA; QL (4 mL per day.); SP |
| LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (*maralixibat chloride*) | 4 | PA; QL (60 tablets per month.); SP |
| LIVMARLI ORAL TABLET 30 MG (*maralixibat chloride*) | 4 | PA; QL (30 tablets per month.); SP |
| *ursodiol oral capsule 300 mg* | 1 | |
| *ursodiol oral tablet 250 mg, 500 mg* | 1 | |
| URSODIOL+SYRSPEND SF ORAL SUSPENSION 30 MG/ML (*ursodiol*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **DIGESTANTS - Drugs for the Stomach** | | |
| CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (*pancrelipase (lip-prot-amyl)*) | 2 | |
| GATTEX SUBCUTANEOUS KIT 5 MG (*teduglutide (rdna)*) | 2 | PA; QL (1 vial per day.); SP |
| PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (*pancrelipase (lip-prot-amyl)*) | 3 | ST |
| PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (*pancrelipase (lip-prot-amyl)*) | 4 | ST |
| VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*) | 3 | ST |
| ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (*pancrelipase (lip-prot-amyl)*) | 2 | |
| **DOPAMINE RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea** | | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |
| **GI DRUGS, MISCELLANEOUS - Drugs for the Stomach** | | |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML | 4 | PA; QL (0.036 kits per day (1 kit per month).); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML | 4 | PA; QL (0.08 syringe per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML | 4 | PA; QL (1.6 mL (2 auto-injectors) per month.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML | 2 | PA; QL (0.01 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML | 4 | PA; QL (0.02 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| *alvimopan oral capsule 12 mg* | 3 | |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; SP |
| BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (*odevixibat*) | 3 | PA; QL (2 capsules per day.); SP |
| BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (*odevixibat*) | 3 | PA; QL (1 capsule per day.); SP |
| BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (*odevixibat*) | 3 | PA; QL (2 capsules per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CHOLBAM ORAL CAPSULE 250 MG, 50 MG (*cholic acid*) | 2 | PA; QL (4 capsules per day.); SP |
| CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (1 syringe per month.); SP |
| CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (2 syringes (1 carton) per month.); SP |
| CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (Maximum quantity 1 kit per 365 days.); SP |
| *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg* | 1 | |
| ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (*vedolizumab*) | 2 | PA; QL (0.05 ml per day.); SP |
| GATTEX SUBCUTANEOUS KIT 5 MG (*teduglutide (rdna)*) | 2 | PA; QL (1 vial per day.); SP |
| IQIRVO ORAL TABLET 80 MG (*elafibranor*) | 4 | PA; ST; QL (31 tablets per month.); SP |
| LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (*linaclotide*) | 2 | PA; QL (1 capsule per day.) |
| LIVMARLI ORAL SOLUTION 9.5 MG/ML (*maralixibat chloride*) | 3 | PA; QL (4 mL per day.); SP |
| *lubiprostone oral capsule 24 mcg, 8 mcg* | 2 | PA; QL (2 capsules per day.) |
| *octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml* | 1 | PA |
| *octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml* | 1 | PA |
| *octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml* | 1 | PA |
| ORLISTAT ORAL CAPSULE 120 MG | 3 | PA |
| *prucalopride succinate oral tablet 1 mg, 2 mg* | 3 | PA; QL (1 tablet per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.6 ml per day.) |
| RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (*methylnaltrexone bromide*) | 4 | PA; QL (0.4 ml per day.) |
| REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (*resmetirom*) | 4 | PA; QL (1 Tablet per day.) |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 auto-injector per month.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 syringe per month.); SP |
| SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled cartridge (180 mg) every 8 weeks after induction.); SP |
| SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled cartridge (360 mg) every 8 weeks after induction.); SP |
| SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*) | 2 | PA; QL (1 tablet per day.) |
| SYNDROS ORAL SOLUTION 5 MG/ML (*dronabinol*) | 3 | PA; QL (4 ml per day.) |
| VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*) | 4 | PA; QL (2 tablets per day.) |
| VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*) | 3 | PA; QL (12 capsules per 365 days.); SP |
| XENICAL ORAL CAPSULE 120 MG (*orlistat*) | 3 | PA |
| XPHOZAH ORAL TABLET 30 MG (*tenapanor hcl (ckd)*) | 4 | PA; QL (2 tablets per day.) |
| **HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid** | | |
| *cimetidine hcl oral solution 300 mg/5ml* | 1 | |
| *cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg* | 1 | |
| *famotidine oral suspension reconstituted 40 mg/5ml* | 1 | |
| **LIPOTROPIC AGENTS - Drugs for the Stomach** | | |
| *scopolamine transdermal patch 72 hour 1 mg/3days* | 3 | |
| **NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea** | | |
| AKYNZEO ORAL CAPSULE 300-0.5 MG (*netupitant-palonosetron*) | 3 | QL (1 capsule per prescription.) |
| *aprepitant oral capsule 125 mg, 40 mg* | 2 | QL (1 capsule per prescription) |
| *aprepitant oral capsule 80 mg* | 2 | QL (2 capsules per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *aprepitant oral capsule therapy pack 80 & 125 mg* | 2 | QL (3 capsules per prescription) |
| EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (*aprepitant*) | 2 | QL (3 pouches per prescription.) |
| **POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid** | | |
| VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (*amoxicillin-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| VOQUEZNA ORAL TABLET 10 MG (*vonoprazan fumarate*) | 3 | PA; QL (1 tablet per day and 186 tablets per 365 days.) |
| VOQUEZNA ORAL TABLET 20 MG (*vonoprazan fumarate*) | 3 | PA; QL (60 tablets per month and 60 tablets per year.) |
| VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (*amoxicill-clarithro-vonoprazan*) | 3 | ST; QL (112 tablets per 180 days.) |
| **PROKINETIC AGENTS - Drugs for the Stomach** | | |
| *metoclopramide hcl oral solution 5 mg/5ml* | 1 | |
| *metoclopramide hcl oral tablet 10 mg, 5 mg* | 1 | |
| REGLAN ORAL TABLET 10 MG, 5 MG (*metoclopramide hcl*) | 3 | |
| **PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid** | | |
| CYTOTEC ORAL TABLET 100 MCG, 200 MCG (*misoprostol*) | 3 | SM |
| *diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg* | 3 | |
| *misoprostol oral tablet 100 mcg, 200 mcg* | 1 | SM |
| **PROTECTANTS - Drugs for Ulcers and Stomach Acid** | | |
| *sucralfate oral suspension 1 gm/10ml* | 3 | |
| *sucralfate oral tablet 1 gm* | 1 | |
| **PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid** | | |
| *esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg* | 3 | PA; ST; QL (1 packet per day.) |
| *esomeprazole magnesium oral packet 40 mg* | 3 | PA; ST; QL (1 packet per day) |
| FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (*lansoprazole*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg* | 3 | PA; ST; QL (1 tablet per day.) |
| *omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg* | 1 | |
| *pantoprazole sodium oral tablet delayed release 20 mg, 40 mg* | 1 | |
| *rabeprazole sodium oral tablet delayed release 20 mg* | 2 | QL (1 tablet per day) |
| VOQUEZNA ORAL TABLET 10 MG (*vonoprazan fumarate*) | 3 | PA; QL (1 tablet per day and 186 tablets per 365 days.) |
| VOQUEZNA ORAL TABLET 20 MG (*vonoprazan fumarate*) | 3 | PA; QL (60 tablets per month and 60 tablets per year.) |
| **GOLD COMPOUNDS** | | |
| **GOLD COMPOUNDS** | | |
| AURANOFIN ORAL CAPSULE 3 MG | 3 | SP |
| RIDAURA ORAL CAPSULE 3 MG (*auranofin*) | 3 | SP |
| **HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron** | | |
| **HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron** | | |
| CHEMET ORAL CAPSULE 100 MG (*succimer*) | 2 | |
| *deferasirox granules oral packet 180 mg, 360 mg, 90 mg* | 2 | PA; SP |
| *deferasirox oral packet 180 mg, 360 mg, 90 mg* | 2 | PA; SP |
| *deferasirox oral tablet 180 mg, 360 mg, 90 mg* | 2 | PA; SP |
| *deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg* | 2 | PA; SP |
| *deferiprone oral tablet 1000 mg, 500 mg* | 3 | PA; SP |
| DEPEN TITRATABS ORAL TABLET 250 MG (*penicillamine*) | 2 | SP |
| FERRIPROX ORAL SOLUTION 100 MG/ML (*deferiprone*) | 2 | PA; SP |
| FERRIPROX ORAL TABLET 1000 MG (*deferiprone*) | 4 | PA; SP |
| *penicillamine oral tablet 250 mg* | 2 | SP |
| *trientine hcl oral capsule 250 mg* | 3 | PA; SP |
| *trientine hcl oral capsule 500 mg* | 3 | PA |
| **HORMONES AND SYNTHETIC SUBSTITUTES** | | |
| **MELANOCORTIN RECEPTOR AGONISTS** | | |
| VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (*bremelanotide acetate*) | 3 | PA; QL (4 autoinjector pens (1.2mls) per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **HORMONES AND SYNTHETIC SUBSTITUTES - Hormones** | | |
| **ADRENALS - Hormones** | | |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*) | 3 | QL (0.4 grams per day.) |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |
| ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANALPRAM HC EXTERNAL LOTION 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANUCORT-HC RECTAL SUPPOSITORY 25 MG | 2 | |
| ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 blister per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 packet per day.) |
| *betamethasone dipropionate aug external cream 0.05 %* | 1 | |
| *betamethasone dipropionate aug external gel 0.05 %* | 1 | |
| *betamethasone dipropionate aug external lotion 0.05 %* | 3 | |
| *betamethasone dipropionate aug external ointment 0.05 %* | 3 | |
| *betamethasone dipropionate external cream 0.05 %* | 2 | |
| *betamethasone dipropionate external lotion 0.05 %* | 1 | |
| *betamethasone dipropionate external ointment 0.05 %* | 2 | |
| *betamethasone valerate external cream 0.1 %* | 1 | |
| *betamethasone valerate external lotion 0.1 %* | 1 | |
| *betamethasone valerate external ointment 0.1 %* | 1 | |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*) | 3 | QL (2 blisters per day.) |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | |
| BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*) | 3 | QL (0.36 grams per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml* | 2 | QL (120 ml (2 boxes) per 30 days.) |
| *budesonide inhalation suspension 1 mg/2ml* | 2 | QL (60 ml (1 box) per 30 days.) |
| *budesonide oral capsule delayed release particles 3 mg* | 2 | |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (*hc-pramoxine-chloroxylenol*) | 3 | |
| CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (*hydrocortisone*) | 3 | |
| CORTENEMA RECTAL ENEMA 100 MG/60ML (*hydrocortisone*) | 3 | |
| CORTIFOAM EXTERNAL FOAM 10 % (*hydrocortisone acetate*) | 2 | |
| *dexamethasone intensol oral concentrate 1 mg/ml* | 1 | |
| *dexamethasone oral elixir 0.5 mg/5ml* | 1 | |
| *dexamethasone oral solution 0.5 mg/5ml* | 1 | |
| *dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg* | 1 | |
| *dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)* | 3 | |
| DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*) | 3 | |
| EOHILIA ORAL SUSPENSION 2 MG/10ML (*budesonide*) | 4 | PA; QL (20 grams per day.) |
| *fludrocortisone acetate oral tablet 0.1 mg* | 1 | |
| *flunisolide nasal solution 25 mcg/act (0.025%)* | 3 | |
| *fluticasone propionate external cream 0.05 %* | 1 | |
| *fluticasone propionate external lotion 0.05 %* | 3 | ST; QL (60 ml per prescription.) |
| *fluticasone propionate external ointment 0.005 %* | 1 | |
| *fluticasone propionate nasal suspension 50 mcg/act* | 2 | |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | QL (0.04 mcg per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (*hydrocortisone acetate*) | 3 | |
| *hydrocortisone (perianal) external cream 2.5 %* | 1 | |
| *hydrocortisone ace-pramoxine external cream 1-1 %* | 1 | |
| *hydrocortisone acetate rectal suppository 25 mg, 30 mg* | 2 | |
| *hydrocortisone butyrate external cream 0.1 %* | 1 | |
| *hydrocortisone butyrate external ointment 0.1 %* | 1 | |
| *hydrocortisone butyrate external solution 0.1 %* | 1 | |
| *hydrocortisone external cream 2.5 %* | 1 | |
| *hydrocortisone external lotion 2.5 %* | 1 | |
| *hydrocortisone external ointment 1 %, 2.5 %* | 1 | |
| *hydrocortisone oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *hydrocortisone rectal enema 100 mg/60ml* | 1 | |
| *hydrocortisone valerate external cream 0.2 %* | 2 | QL (15 grams per prescription.) |
| *hydrocortisone valerate external ointment 0.2 %* | 3 | QL (15 grams per prescription.) |
| *hydrocortisone-acetic acid otic solution 1-2 %* | 1 | |
| *hydrocort-pramoxine (perianal) external cream 2.5-1 %* | 1 | |
| INTRAROSA VAGINAL INSERT 6.5 MG (*prasterone*) | 3 | PA; QL (1 insert per day.) |
| ISTURISA ORAL TABLET 1 MG (*osilodrostat phosphate*) | 4 | PA; QL (8 tablets per day.); SP |
| ISTURISA ORAL TABLET 5 MG (*osilodrostat phosphate*) | 4 | PA; QL (372 tablets per month.); SP |
| KHINDIVI ORAL SOLUTION 1 MG/ML (*hydrocortisone*) | 3 | PA |
| MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (*methylprednisolone*) | 3 | |
| MEDROL ORAL TABLET 2 MG (*methylprednisolone*) | 2 | |
| MEDROL ORAL TABLET THERAPY PACK 4 MG (*methylprednisolone*) | 3 | |
| *methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg* | 1 | |
| *methylprednisolone oral tablet therapy pack 4 mg* | 1 | |
| *mometasone furoate external cream 0.1 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *mometasone furoate external ointment 0.1 %* | 1 | |
| *mometasone furoate external solution 0.1 %* | 1 | |
| *mometasone furoate nasal suspension 50 mcg/act* | 3 | QL (34 grams (2 bottles) per copay.) |
| NUCORT EXTERNAL LOTION 2 % (*hydrocortisone acetate*) | 3 | |
| ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (*prednisolone sodium phosphate*) | 3 | |
| PRED MILD OPHTHALMIC SUSPENSION 0.12 % (*prednisolone acetate*) | 3 | |
| *prednisolone acetate ophthalmic suspension 1 %* | 1 | |
| *prednisolone oral solution 15 mg/5ml* | 1 | |
| *prednisolone oral tablet 5 mg* | 3 | |
| *prednisolone sodium phosphate ophthalmic solution 1 %* | 1 | |
| *prednisolone sodium phosphate oral solution 15 mg/5ml* | 1 | |
| *prednisolone sodium phosphate oral tablet dispersible 30 mg* | 3 | |
| *prednisone intensol oral concentrate 5 mg/ml* | 1 | |
| *prednisone oral solution 5 mg/5ml* | 1 | |
| *prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg* | 1 | |
| *prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)* | 1 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*) | 2 | |
| *procto-med hc external cream 2.5 %* | 1 | |
| PROCTOSOL HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| PROCTOZONE-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (10.6 grams per month.) |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (42.4 grams per month.) |
| SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (*budesonide-formoterol fumarate*) | 3 | QL (0.35 grams per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*) | 3 | |
| TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21) (*dexamethasone*) | 3 | |
| TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (*dexamethasone*) | 3 | |
| TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (*budesonide*) | 3 | PA; QL (4 capsules per day.); SP |
| TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*) | 2 | |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*) | 3 | QL (2 blisters per day.) |
| *triamcinolone acetonide external aerosol solution 0.147 mg/gm* | 2 | QL (63 grams per prescription.) |
| *triamcinolone acetonide external cream 0.025 %, 0.1 %* | 1 | |
| *triamcinolone acetonide external cream 0.5 %* | 1 | QL (15 grams per prescription.) |
| *triamcinolone acetonide external lotion 0.025 %, 0.1 %* | 1 | |
| *triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %* | 1 | |
| *triderm external cream 0.5 %* | 1 | QL (15 grams per prescription.) |
| TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*olezarsen sodium*) | 3 | PA; QL (1 Auto-injector (0.8 mL) per month.); SP |
| UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (*budesonide*) | 3 | |
| *wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| **ALPHA-GLUCOSIDASE INHIBITORS - Drugs for Diabetes** | | |
| *acarbose oral tablet 100 mg, 25 mg, 50 mg* | 1 | |
| *miglitol oral tablet 100 mg, 25 mg, 50 mg* | 2 | |
| **ANDROGENS - Hormones** | | |
| COVARYX HS ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| COVARYX ORAL TABLET 1.25-2.5 MG (*est estrogens-methyltest*) | 2 | |
| *danazol oral capsule 100 mg, 200 mg, 50 mg* | 1 | |
| DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML, 200 MG/ML (*testosterone cypionate*) | 3 | |
| EC-RX TESTOSTERONE TRANSDERMAL CREAM 0.2 %, 0.4 %, 10 %, 20 % | 3 | PA |
| EEMT HS ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |
| EEMT ORAL TABLET 1.25-2.5 MG (*est estrogens-methyltest*) | 2 | |
| *est estrogens-methyltest ds oral tablet 1.25-2.5 mg* | 1 | |
| *est estrogens-methyltest hs oral tablet 0.625-1.25 mg* | 1 | |
| *est estrogens-methyltest oral tablet 1.25-2.5 mg* | 1 | |
| ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |
| KYZATREX ORAL CAPSULE 150 MG, 200 MG (*testosterone undecanoate*) | 3 | PA; QL (4 capsules per day.) |
| METHITEST ORAL TABLET 10 MG | 2 | |
| *methyltestosterone oral capsule 10 mg* | 2 | |
| TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*) | 2 | PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day) |
| *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml* | 1 | |
| TESTOSTERONE CYPIONATE SOLUTION 200 MG/ML INTRAMUSCULAR | 3 | |
| *testosterone enanthate intramuscular solution 200 mg/ml* | 1 | |
| *testosterone gel 20.25 mg/act (1.62%) transdermal* | 2 | PA; QL (150 grams (2 pumps) per month.) |
| *testosterone gel 25 mg/2.5gm (1%) transdermal* | 3 | PA; QL (7.5 grams per day.) |
| *testosterone transdermal gel 1.62 %* | 2 | PA; QL (150 grams (2 pumps) per month.) |
| **ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes** | | |
| *colesevelam hcl oral packet 3.75 gm* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *colesevelam hcl oral tablet 625 mg* | 2 | |
| CYCLOSET ORAL TABLET 0.8 MG (*bromocriptine mesylate*) | 3 | |
| *mifepristone oral tablet 300 mg* | 4 | PA; QL (4 tablets per day.); SP |
| **ANTIESTROGENS - Drugs for Women** | | |
| *anastrozole oral tablet 1 mg* | 1 | H-N |
| *exemestane oral tablet 25 mg* | 2 | H-N |
| *letrozole oral tablet 2.5 mg* | 1 | H-N |
| **ANTIGONADTROPINS - Hormones** | | |
| *aftera oral tablet 1.5 mg* | 1 | H |
| DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML, 200 MG/ML (*testosterone cypionate*) | 3 | |
| *econtra one-step oral tablet 1.5 mg* | 1 | H |
| FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (*degarelix acetate*) | 3 | SP |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (*degarelix acetate*) | 3 | SP |
| *her style oral tablet 1.5 mg* | 1 | H |
| KYZATREX ORAL CAPSULE 150 MG, 200 MG (*testosterone undecanoate*) | 3 | PA; QL (4 capsules per day.) |
| *levonorgestrel oral tablet 1.5 mg* | 1 | H |
| *my choice oral tablet 1.5 mg* | 1 | H |
| *my way oral tablet 1.5 mg* | 1 | H |
| MYFEMBREE ORAL TABLET 40-1-0.5 MG (*relugolix-estradiol-norethind*) | 2 | PA; QL (1 tablet day.) |
| *new day oral tablet 1.5 mg* | 1 | H |
| *opcicon one-step oral tablet 1.5 mg* | 1 | H |
| *option 2 oral tablet 1.5 mg* | 1 | H |
| ORGOVYX ORAL TABLET 120 MG (*relugolix*) | 3 | PA; QL (1 tablet per day); SP; CM |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (*elagolix-estradiol-norethind*) | 2 | PA; QL (2 capsules per day.) |
| ORILISSA ORAL TABLET 150 MG (*elagolix sodium*) | 2 | PA; QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ORILISSA ORAL TABLET 200 MG (*elagolix sodium*) | 2 | PA; QL (2 tablets per day.) |
| PLAN B ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*) | 1 | H |
| *shewise oral tablet 1.5 mg* | 1 | H |
| SLYND ORAL TABLET 4 MG (*drospirenone*) | 3 | H |
| *take action oral tablet 1.5 mg* | 1 | H |
| TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*) | 2 | PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day) |
| *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml* | 1 | |
| TESTOSTERONE CYPIONATE SOLUTION 200 MG/ML INTRAMUSCULAR | 3 | |
| *testosterone enanthate intramuscular solution 200 mg/ml* | 1 | |
| *testosterone gel 20.25 mg/act (1.62%) transdermal* | 2 | PA; QL (150 grams (2 pumps) per month.) |
| *testosterone gel 25 mg/2.5gm (1%) transdermal* | 3 | PA; QL (7.5 grams per day.) |
| *testosterone transdermal gel 1.62 %* | 2 | PA; QL (150 grams (2 pumps) per month.) |
| *your choice oral tablet 1.5 mg* | 1 | H |
| **ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones** | | |
| *diazoxide oral suspension 50 mg/ml* | 3 | |
| PROGLYCEM ORAL SUSPENSION 50 MG/ML (*diazoxide*) | 4 | |
| **ANTIPARATHYROID AGENTS - Drugs for Bones** | | |
| *calcitonin (salmon) injection solution 200 unit/ml* | 3 | |
| *calcitonin (salmon) nasal solution 200 unit/act* | 2 | |
| *cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg* | 1 | |
| MIACALCIN INJECTION SOLUTION 200 UNIT/ML (*calcitonin (salmon)*) | 3 | |
| **ANTITHYROID AGENTS - Drugs for the Thyroid** | | |
| *iodine strong oral solution 5 %* | 1 | |
| *methimazole oral tablet 10 mg, 5 mg* | 1 | |
| *propylthiouracil oral tablet 50 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **BIGUANIDES - Drugs for Diabetes** | | |
| ACTOPLUS MET ORAL TABLET 15-850 MG (*pioglitazone hcl-metformin hcl*) | 3 | QL (3 tablets per day) |
| ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG | 2 | QL (2 tablets per day.) |
| *glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg* | 2 | |
| *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg* | 1 | |
| JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (*linagliptin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (*linagliptin-metformin hcl*) | 2 | QL (1 tablet per day.) |
| *metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg* | 1 | |
| *metformin hcl oral solution 500 mg/5ml* | 3 | |
| *metformin hcl oral tablet 1000 mg, 500 mg* | 1 | |
| *metformin hcl oral tablet 850 mg* | 1 | H-N |
| *pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg* | 2 | QL (3 tablets per day) |
| *saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg* | 2 | QL (62 tablets per month.) |
| *saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg* | 2 | QL (31 tablets per month.) |
| SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (*empagliflozin-metformin hcl*) | 2 | QL (1 tablet per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (2 tablets per day.) |
| **CONTRACEPTIVES - Drugs for Women** | | |
| *afirmelle oral tablet 0.1-20 mg-mcg* | 1 | H |
| *aftera oral tablet 1.5 mg* | 1 | H |
| *altavera oral tablet 0.15-30 mg-mcg* | 1 | H |
| *alyacen 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *amethyst oral tablet 90-20 mcg* | 1 | H |
| ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (*segesterone-ethinyl estradiol*) | 3 | QL (1 vaginal ring per 327 days); H |
| *apri oral tablet 0.15-30 mg-mcg* | 1 | H |
| *aranelle oral tablet 0.5/1/0.5-35 mg-mcg* | 1 | H |
| *ashlyna oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *aubra eq oral tablet 0.1-20 mg-mcg* | 1 | H |
| *aurovela 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aurovela 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aviane oral tablet 0.1-20 mg-mcg* | 1 | H |
| *ayuna oral tablet 0.15-30 mg-mcg* | 1 | H |
| *azurette oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *balziva oral tablet 0.4-35 mg-mcg* | 1 | H |
| *blisovi 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *blisovi fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *briellyn oral tablet 0.4-35 mg-mcg* | 1 | H |
| *camila oral tablet 0.35 mg* | 1 | H |
| *camrese lo oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *camrese oral tablet 0.15-0.03 &0.01 mg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *chateal eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| *cryselle oral tablet 0.3-30 mg-mcg* | 1 | H |
| *cyred eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| *dasetta 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *daysee oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *deblitane oral tablet 0.35 mg* | 1 | H |
| *delyla oral tablet 0.1-20 mg-mcg* | 1 | H |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (*medroxyprogesterone acetate*) | 3 | QL (5 ml per year.) |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*) | 3 | QL (5 mL per 365 days.) |
| DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (*medroxyprogesterone acetate*) | 1 | QL (3.25 ml per year.); H |
| *dolishale oral tablet 90-20 mcg* | 1 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg* | 3 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg* | 1 | H |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg* | 3 | |
| *econtra one-step oral tablet 1.5 mg* | 1 | H |
| *elinest oral tablet 0.3-30 mg-mcg* | 1 | H |
| ELLA ORAL TABLET 30 MG (*ulipristal acetate*) | 1 | QL (1 tablet per 21 days.); H |
| *eluryng vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *emzahh oral tablet 0.35 mg* | 1 | H |
| *enilloring vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *enskyce oral tablet 0.15-30 mg-mcg* | 1 | H |
| *errin oral tablet 0.35 mg* | 1 | H |
| *estarylla oral tablet 0.25-35 mg-mcg* | 1 | H |
| *etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *falmina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *feirza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *feirza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (*norethindrone acet-ethinyl est*) | 4 | H |
| *finzala oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *galbriela oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *gemmily oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *hailey 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *heather oral tablet 0.35 mg* | 1 | H |
| *her style oral tablet 1.5 mg* | 1 | H |
| *iclevia oral tablet 0.15-0.03 mg* | 2 | H |
| *incassia oral tablet 0.35 mg* | 1 | H |
| *introvale oral tablet 0.15-0.03 mg* | 2 | H |
| *isibloom oral tablet 0.15-30 mg-mcg* | 1 | H |
| *jaimiess oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *jasmiel oral tablet 3-0.02 mg* | 3 | |
| *jencycla oral tablet 0.35 mg* | 1 | H |
| *jolessa oral tablet 0.15-0.03 mg* | 2 | H |
| *joyeaux oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *juleber oral tablet 0.15-30 mg-mcg* | 1 | H |
| *junel 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 24 oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *kaitlib fe oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *kalliga oral tablet 0.15-30 mg-mcg* | 1 | H |
| *kariva oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *kelnor 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *kurvelo oral tablet 0.15-30 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *larin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *larin 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *larin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lessina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *levonest oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |
| *levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg* | 2 | H |
| *levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *levonorgestrel oral tablet 1.5 mg* | 1 | H |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg* | 1 | H |
| *levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |
| LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (*norethin-eth estrad-fe biphas*) | 1 | H |
| *lojaimiess oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *loryna oral tablet 3-0.02 mg* | 3 | |
| *low-ogestrel oral tablet 0.3-30 mg-mcg* | 1 | H |
| *lo-zumandimine oral tablet 3-0.02 mg* | 3 | |
| *luizza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *luizza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lutera oral tablet 0.1-20 mg-mcg* | 1 | H |
| *lyleq oral tablet 0.35 mg* | 1 | H |
| *lyza oral tablet 0.35 mg* | 1 | H |
| *marlissa oral tablet 0.15-30 mg-mcg* | 1 | H |
| *medroxyprogesterone acetate intramuscular suspension 150 mg/ml* | 1 | QL (5 ml per year.); H |
| *medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml* | 1 | QL (5 mL per 365 days.); H |
| *meleya oral tablet 0.35 mg* | 1 | H |
| *mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *microgestin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *microgestin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *microgestin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *mili oral tablet 0.25-35 mg-mcg* | 1 | H |
| *minzoya oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *mono-linyah oral tablet 0.25-35 mg-mcg* | 1 | H |
| *my choice oral tablet 1.5 mg* | 1 | H |
| *my way oral tablet 1.5 mg* | 1 | H |
| NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (*estradiol valerate-dienogest*) | 1 | H |
| *necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| *new day oral tablet 1.5 mg* | 1 | H |
| NEXTSTELLIS ORAL TABLET 3-14.2 MG (*drospirenone-estetrol*) | 3 | H |
| *nikki oral tablet 3-0.02 mg* | 3 | |
| *nora-be oral tablet 0.35 mg* | 1 | H |
| *norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| *norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg* | 1 | H |
| *norethindrone oral tablet 0.35 mg* | 1 | H |
| *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg* | 1 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *norlyroc oral tablet 0.35 mg* | 1 | H |
| *nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (21) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *nylia 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *opcicon one-step oral tablet 1.5 mg* | 1 | H |
| OPILL ORAL TABLET 0.075 MG (*norgestrel*) | 1 | H |
| *option 2 oral tablet 1.5 mg* | 1 | H |
| *orquidea oral tablet 0.35 mg* | 1 | H |
| *philith oral tablet 0.4-35 mg-mcg* | 1 | H |
| *pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| PLAN B ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*) | 1 | H |
| *portia-28 oral tablet 0.15-30 mg-mcg* | 1 | H |
| *reclipsen oral tablet 0.15-30 mg-mcg* | 1 | H |
| *rivelsa oral tablet 42-21-21-7 days* | 1 | H |
| *rosyrah oral tablet 42-21-21-7 days* | 1 | H |
| *setlakin oral tablet 0.15-0.03 mg* | 2 | H |
| *sharobel oral tablet 0.35 mg* | 1 | H |
| *shewise oral tablet 1.5 mg* | 1 | H |
| *simliya oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *simpesse oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| SLYND ORAL TABLET 4 MG (*drospirenone*) | 3 | H |
| *sprintec 28 oral tablet 0.25-35 mg-mcg* | 1 | H |
| *syeda oral tablet 3-0.03 mg* | 3 | |
| *take action oral tablet 1.5 mg* | 1 | H |
| *tarina 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *tarina fe 1/20 eq oral tablet 1-20 mg-mcg* | 1 | H |
| *taysofy oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *tilia fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *turqoz oral tablet 0.3-30 mg-mcg* | 1 | H |
| TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (*levonorgestrel-eth estradiol*) | 3 | H |
| TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (*levonorgestrel-ethinyl estrad*) | 1 | H |
| *tydemy oral tablet 3-0.03-0.451 mg* | 1 | H |
| *valtya 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *valtya 1/50 oral tablet 1-50 mg-mcg* | 1 | H |
| *velivet oral tablet 0.1/0.125/0.15 -0.025 mg* | 1 | H |
| *vestura oral tablet 3-0.02 mg* | 3 | |
| *vienva oral tablet 0.1-20 mg-mcg* | 1 | H |
| *viorele oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *volnea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *vyfemla oral tablet 0.4-35 mg-mcg* | 1 | H |
| *vylibra oral tablet 0.25-35 mg-mcg* | 1 | H |
| *wera oral tablet 0.5-35 mg-mcg* | 1 | H |
| *wymzya fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xarah fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *xelria fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xulane transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| YASMIN 28 ORAL TABLET 3-0.03 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| YAZ ORAL TABLET 3-0.02 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| *your choice oral tablet 1.5 mg* | 1 | H |
| *zafemy transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| *zovia 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *zumandimine oral tablet 3-0.03 mg* | 3 | |
| **DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes** | | |
| ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG | 2 | QL (1 tablet per day.) |
| ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG | 2 | QL (2 tablets per day.) |
| ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG | 2 | QL (1 tablet per day.) |
| BRYNOVIN ORAL SOLUTION 25 MG/ML (*sitagliptin hydrochloride*) | 3 | PA |
| GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*) | 2 | QL (1 tablet per day.) |
| JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (*linagliptin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (*linagliptin-metformin hcl*) | 2 | QL (1 tablet per day.) |
| *saxagliptin hcl oral tablet 2.5 mg, 5 mg* | 2 | QL (1 tablet per day) |
| *saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg* | 2 | QL (62 tablets per month.) |
| *saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg* | 2 | QL (31 tablets per month.) |
| TRADJENTA ORAL TABLET 5 MG (*linagliptin*) | 2 | QL (1 tablet per day) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (1 tablet per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (2 tablets per day.) |
| **ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women** | | |
| DUAVEE ORAL TABLET 0.45-20 MG (*conj estrogens-bazedoxifene*) | 3 | QL (1 tablet per day.) |
| OSPHENA ORAL TABLET 60 MG (*ospemifene*) | 3 | PA; QL (1 tablet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *raloxifene hcl oral tablet 60 mg* | 2 | H-N |
| *tamoxifen citrate oral tablet 10 mg* | 1 | |
| *tamoxifen citrate oral tablet 20 mg* | 1 | H-N |
| *toremifene citrate oral tablet 60 mg* | 2 | CM |
| **ESTROGENS - Drugs for Women** | | |
| *abigale lo oral tablet 0.5-0.1 mg* | 2 | |
| *abigale oral tablet 1-0.5 mg* | 1 | |
| ACTIVELLA ORAL TABLET 1-0.5 MG (*estradiol-norethindrone acet*) | 3 | |
| *afirmelle oral tablet 0.1-20 mg-mcg* | 1 | H |
| ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (*estradiol*) | 3 | QL (8 patches (1 box) per 28 days.) |
| *altavera oral tablet 0.15-30 mg-mcg* | 1 | H |
| *alyacen 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *amethyst oral tablet 90-20 mcg* | 1 | H |
| ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (*drospirenone-estradiol*) | 3 | |
| ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (*segesterone-ethinyl estradiol*) | 3 | QL (1 vaginal ring per 327 days); H |
| *apri oral tablet 0.15-30 mg-mcg* | 1 | H |
| *aranelle oral tablet 0.5/1/0.5-35 mg-mcg* | 1 | H |
| *ashlyna oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *aubra eq oral tablet 0.1-20 mg-mcg* | 1 | H |
| *aurovela 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aurovela 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aviane oral tablet 0.1-20 mg-mcg* | 1 | H |
| *ayuna oral tablet 0.15-30 mg-mcg* | 1 | H |
| *azurette oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *balziva oral tablet 0.4-35 mg-mcg* | 1 | H |
| BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (*estradiol-progesterone*) | 3 | |
| *blisovi 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *blisovi fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *briellyn oral tablet 0.4-35 mg-mcg* | 1 | H |
| *camrese lo oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *camrese oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *chateal eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (*estradiol-levonorgestrel*) | 3 | QL (4 patches per month.) |
| COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (*estradiol-norethindrone acet*) | 3 | QL (8 patches per 28 days.) |
| COVARYX HS ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |
| COVARYX ORAL TABLET 1.25-2.5 MG (*est estrogens-methyltest*) | 2 | |
| *cryselle oral tablet 0.3-30 mg-mcg* | 1 | H |
| *cyred eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| *dasetta 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *daysee oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (*estradiol valerate*) | 3 | |
| *delyla oral tablet 0.1-20 mg-mcg* | 1 | H |
| DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (*estradiol cypionate*) | 3 | |
| DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (*estradiol*) | 3 | |
| *dolishale oral tablet 90-20 mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| *drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg* | 3 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg* | 1 | H |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg* | 3 | |
| DUAVEE ORAL TABLET 0.45-20 MG (*conj estrogens-bazedoxifene*) | 3 | QL (1 tablet per day.) |
| EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 % | 3 | PA |
| EEMT HS ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |
| EEMT ORAL TABLET 1.25-2.5 MG (*est estrogens-methyltest*) | 2 | |
| ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (*estradiol*) | 3 | |
| *elinest oral tablet 0.3-30 mg-mcg* | 1 | H |
| *eluryng vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *enilloring vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *enskyce oral tablet 0.15-30 mg-mcg* | 1 | H |
| *est estrogens-methyltest ds oral tablet 1.25-2.5 mg* | 1 | |
| *est estrogens-methyltest hs oral tablet 0.625-1.25 mg* | 1 | |
| *est estrogens-methyltest oral tablet 1.25-2.5 mg* | 1 | |
| *estarylla oral tablet 0.25-35 mg-mcg* | 1 | H |
| *estradiol oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| *estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm* | 3 | |
| *estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)* | 3 | QL (37.5 grams (1 box) per month.) |
| *estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| *estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 1 | QL (4 patches (1 carton) per 28 days.) |
| *estradiol vaginal cream 0.01 %* | 3 | |
| *estradiol vaginal tablet 10 mcg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml* | 1 | |
| *estradiol-norethindrone acet oral tablet 0.5-0.1 mg* | 2 | |
| *estradiol-norethindrone acet oral tablet 1-0.5 mg* | 1 | |
| ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (*est estrogens-methyltest*) | 3 | |
| ESTRING VAGINAL RING 7.5 MCG/24HR (*estradiol*) | 2 | QL (1 ring per 90 days.) |
| *estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg* | 3 | |
| *etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (*estradiol*) | 2 | |
| *falmina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *feirza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *feirza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (*norethindrone acet-ethinyl est*) | 4 | H |
| FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (*estradiol acetate*) | 3 | QL (1 ring per 3 months.) |
| *finzala oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg* | 1 | |
| *galbriela oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *gemmily oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *hailey 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *iclevia oral tablet 0.15-0.03 mg* | 2 | H |
| IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG (*estradiol*) | 2 | QL (0.29 vaginal insert per day.) |
| IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (*estradiol*) | 2 | QL (0.29 insert per day.) |
| IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*) | 2 | QL (18 inserts per year.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *introvale oral tablet 0.15-0.03 mg* | 2 | H |
| *isibloom oral tablet 0.15-30 mg-mcg* | 1 | H |
| *jaimiess oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *jasmiel oral tablet 3-0.02 mg* | 3 | |
| *jinteli oral tablet 1-5 mg-mcg* | 1 | |
| *jolessa oral tablet 0.15-0.03 mg* | 2 | H |
| *joyeaux oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *juleber oral tablet 0.15-30 mg-mcg* | 1 | H |
| *junel 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 24 oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *kaitlib fe oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *kalliga oral tablet 0.15-30 mg-mcg* | 1 | H |
| *kariva oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *kelnor 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *kurvelo oral tablet 0.15-30 mg-mcg* | 1 | H |
| *larin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *larin 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *larin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lessina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *levonest oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |
| *levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg* | 2 | H |
| *levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg* | 1 | H |
| *levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (*norethin-eth estrad-fe biphas*) | 1 | H |
| *lojaimiess oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *loryna oral tablet 3-0.02 mg* | 3 | |
| *low-ogestrel oral tablet 0.3-30 mg-mcg* | 1 | H |
| *lo-zumandimine oral tablet 3-0.02 mg* | 3 | |
| *luizza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *luizza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lutera oral tablet 0.1-20 mg-mcg* | 1 | H |
| *lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| *marlissa oral tablet 0.15-30 mg-mcg* | 1 | H |
| MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (*estradiol*) | 3 | QL (4 patches (1 carton) per 28 days.) |
| *mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *microgestin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *microgestin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *microgestin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *mili oral tablet 0.25-35 mg-mcg* | 1 | H |
| *mimvey oral tablet 1-0.5 mg* | 1 | |
| *minzoya oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *mono-linyah oral tablet 0.25-35 mg-mcg* | 1 | H |
| MYFEMBREE ORAL TABLET 40-1-0.5 MG (*relugolix-estradiol-norethind*) | 2 | PA; QL (1 tablet day.) |
| NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (*estradiol valerate-dienogest*) | 1 | H |
| *necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| NEXTSTELLIS ORAL TABLET 3-14.2 MG (*drospirenone-estetrol*) | 3 | H |
| *nikki oral tablet 3-0.02 mg* | 3 | |
| *norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr* | 3 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg* | 1 | H |
| *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg* | 1 | |
| *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg* | 1 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (21) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *nylia 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (*elagolix-estradiol-norethind*) | 2 | PA; QL (2 capsules per day.) |
| *philith oral tablet 0.4-35 mg-mcg* | 1 | H |
| *pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *portia-28 oral tablet 0.15-30 mg-mcg* | 1 | H |
| PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (*estrogens conjugated*) | 3 | |
| PREMARIN VAGINAL CREAM 0.625 MG/GM (*estrogens, conjugated*) | 3 | |
| PREMPHASE ORAL TABLET 0.625-5 MG (*conj estrog-medroxyprogest ace*) | 3 | |
| PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (*conj estrog-medroxyprogest ace*) | 3 | |
| *reclipsen oral tablet 0.15-30 mg-mcg* | 1 | H |
| *rivelsa oral tablet 42-21-21-7 days* | 1 | H |
| *rosyrah oral tablet 42-21-21-7 days* | 1 | H |
| *setlakin oral tablet 0.15-0.03 mg* | 2 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *simliya oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *simpesse oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *sprintec 28 oral tablet 0.25-35 mg-mcg* | 1 | H |
| *syeda oral tablet 3-0.03 mg* | 3 | |
| *tarina 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *tarina fe 1/20 eq oral tablet 1-20 mg-mcg* | 1 | H |
| *taysofy oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *tilia fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *turqoz oral tablet 0.3-30 mg-mcg* | 1 | H |
| TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (*levonorgestrel-eth estradiol*) | 3 | H |
| TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (*levonorgestrel-ethinyl estrad*) | 1 | H |
| *tydemy oral tablet 3-0.03-0.451 mg* | 1 | H |
| *valtya 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *valtya 1/50 oral tablet 1-50 mg-mcg* | 1 | H |
| *velivet oral tablet 0.1/0.125/0.15 -0.025 mg* | 1 | H |
| *vestura oral tablet 3-0.02 mg* | 3 | |
| *vienva oral tablet 0.1-20 mg-mcg* | 1 | H |
| *viorele oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *volnea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *vyfemla oral tablet 0.4-35 mg-mcg* | 1 | H |
| *vylibra oral tablet 0.25-35 mg-mcg* | 1 | H |
| *wera oral tablet 0.5-35 mg-mcg* | 1 | H |
| *wymzya fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xarah fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *xelria fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xulane transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| YASMIN 28 ORAL TABLET 3-0.03 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| YAZ ORAL TABLET 3-0.02 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| *yuvafem vaginal tablet 10 mcg* | 2 | |
| *zafemy transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| *zovia 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *zumandimine oral tablet 3-0.03 mg* | 3 | |
| **GLYCOGENOLYTIC AGENTS - Hormones** | | |
| BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |
| BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |
| *glucagon emergency kit injection solution reconstituted 1 mg* | 2 | |
| GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML | 2 | |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*) | 2 | QL (2 vials per copay.) |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*) | 2 | QL (2 prefilled syringes per copay.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **GONADOTROPINS - Hormones** | | |
| *leuprolide acetate injection kit 1 mg/0.2ml* | 1 | PA |
| SYNAREL NASAL SOLUTION 2 MG/ML (*nafarelin acetate*) | 2 | |
| **INCRETIN MIMETICS - Drugs for Diabetes** | | |
| *liraglutide solution pen-injector 18 mg/3ml subcutaneous* | 2 | PA; QL (2 pens (6 mL) per month.) |
| *liraglutide solution pen-injector 18 mg/3ml subcutaneous* | 3 | PA; QL (3 pens (9 mL) per month.) |
| *liraglutide -weight management subcutaneous solution pen-injector 18 mg/3ml* | 3 | PA; QL (0.6 ml per day.) |
| MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide*) | 2 | PA; QL (0.08 ml per day.) |
| OZEMPIC ORAL TABLET 1.5 MG, 9 MG (*semaglutide*) | 2 | PA; QL (30 tablets per month.) |
| OZEMPIC ORAL TABLET 4 MG (*semaglutide*) | 2 | PA; QL (30 Tablets per month.) |
| OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (*semaglutide*) | 2 | PA; QL (1 Pen-injector per month.) |
| OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (*semaglutide*) | 2 | PA; QL (3 ml per month.) |
| RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (*semaglutide*) | 2 | PA; QL (1 tablet per day.) |
| SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide -weight management*) | 3 | PA; QL (0.6 ml per day.) |
| SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*) | 2 | QL (18 ml per month.) |
| TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (*dulaglutide*) | 2 | PA; QL (2 ml per month.) |
| TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (*dulaglutide*) | 2 | PA; QL (2 mL per month.) |
| WEGOVY HD SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.2 MG/0.75ML (*semaglutide-weight management*) | 3 | PA |
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (*semaglutide-weight management*) | 3 | PA; QL (0.08 ml per day and 4 ml per 365 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (*semaglutide-weight management*) | 3 | PA; QL (0.11 ml per day.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (2 mL (4 vials) per month.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (2 mL (4 vials) per month. 4 mL (8 vials) per 365 days.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (4 pens per month.) |
| ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (*tirzepatide-weight management*) | 3 | PA; QL (4 pens per month and 8 pens per year.) |
| **INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*) | 2 | QL (75 ml per prescription.) |
| HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*) | 1 | QL (70 ml per prescription.) |
| HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*) | 2 | QL (75 ml per prescription.) |
| HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*) | 1 | QL (70 ml per prescription.) |
| **LEPTINS - Hormones** | | |
| MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (*metreleptin*) | 3 | PA; QL (0.9 vial per day.); SP |
| **LONG-ACTING INSULINS - Drugs for Diabetes** | | |
| LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*) | 1 | QL (75 ml per prescription.) |
| LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine*) | 1 | QL (70 ml per prescription.) |
| SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*) | 2 | QL (18 ml per month.) |
| TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*) | 2 | QL (75 ml per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*) | 2 | QL (37.5 ml per prescription.) |
| **MEGLITINIDES - Drugs for Diabetes** | | |
| *nateglinide oral tablet 120 mg, 60 mg* | 2 | |
| *repaglinide oral tablet 0.5 mg, 1 mg* | 2 | QL (4 tablets per day) |
| *repaglinide oral tablet 2 mg* | 2 | QL (8 tablets per day) |
| **PARATHYROID AGENTS - Drugs for Bones** | | |
| BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (*teriparatide*) | 4 | PA; SP |
| TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML | 4 | PA; SP |
| TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*) | 3 | PA; SP |
| YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (*palopegteriparatide*) | 4 | PA; QL (2 pens (1.12 mL) per 28 days.); SP |
| YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (*palopegteriparatide*) | 4 | PA; QL (2 pens (1.96 mL) per 28 days.); SP |
| YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (*palopegteriparatide*) | 4 | PA; QL (2 pens (2.8 mL) per 28 days.); SP |
| **PITUITARY - Hormones** | | |
| ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (*corticotropin*) | 4 | PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SP |
| ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (21 mL (21 injectors) per treatment course.); SP |
| ACTHAR INJECTION GEL 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (20 ml per 24 days.); SP |
| CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; SP |
| CORTROPHIN INJECTION GEL 80 UNIT/ML (*corticotropin*) | 4 | PA; ST; QL (20 ml per 24 days.); SP |
| CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (*crinecerfont*) | 4 | PA; QL (62 capsules per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CRENESSITY ORAL SOLUTION 50 MG/ML (*crinecerfont*) | 4 | PA; QL (120 mL (4 bottles) per month.); SP |
| DESMODA ORAL SOLUTION 0.05 MG/ML (*desmopressin acetate*) | 4 | PA |
| *desmopressin ace spray refrig nasal solution 0.01 %* | 1 | |
| *desmopressin acetate injection solution 4 mcg/ml* | 1 | |
| DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML | 3 | |
| *desmopressin acetate oral tablet 0.1 mg, 0.2 mg* | 1 | |
| *desmopressin acetate pf injection solution 4 mcg/ml* | 1 | |
| *desmopressin acetate spray nasal solution 0.01 %* | 1 | |
| NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML (*somatrogon-ghla*) | 4 | PA; QL (0.172 ml per day.); SP |
| NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 60 MG/1.2ML (*somatrogon-ghla*) | 4 | PA; QL (4.8 mL (4 Prefilled Pens) per month.); SP |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (*somatropin*) | 2 | PA; QL (13.5 mL (9 Pens) per month.) |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (*somatropin*) | 2 | PA; QL (9 mL (6 Pens) per month.); SP |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (*somatropin*) | 2 | PA; QL (27 mL (18 Pens) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (*somatropin*) | 2 | PA; QL (13.5 ml (9 cartridges) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (*somatropin*) | 2 | PA; QL (27 ml (18 cartridges) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (*somatropin*) | 2 | PA; QL (16 vials per month.); SP |
| SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (*somatropin (non-refrigerated)*) | 4 | PA; QL (1 vial per day.); SP |
| SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (*lonapegsomatropin-tcgd*) | 4 | PA; QL (4 single-dose prefilled cartridges per month.); SP |
| SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (*lonapegsomatropin-tcgd*) | 4 | PA; QL (0.143 cartridge per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (*somapacitan-beco*) | 4 | PA; QL (0.215 ml per day.); SP |
| **PROGESTINS - Drugs for Women** | | |
| *abigale lo oral tablet 0.5-0.1 mg* | 2 | |
| *abigale oral tablet 1-0.5 mg* | 1 | |
| ACTIVELLA ORAL TABLET 1-0.5 MG (*estradiol-norethindrone acet*) | 3 | |
| *afirmelle oral tablet 0.1-20 mg-mcg* | 1 | H |
| *aftera oral tablet 1.5 mg* | 1 | H |
| *altavera oral tablet 0.15-30 mg-mcg* | 1 | H |
| *alyacen 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *amethyst oral tablet 90-20 mcg* | 1 | H |
| ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (*drospirenone-estradiol*) | 3 | |
| ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (*segesterone-ethinyl estradiol*) | 3 | QL (1 vaginal ring per 327 days); H |
| *apri oral tablet 0.15-30 mg-mcg* | 1 | H |
| *aranelle oral tablet 0.5/1/0.5-35 mg-mcg* | 1 | H |
| *ashlyna oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *aubra eq oral tablet 0.1-20 mg-mcg* | 1 | H |
| *aurovela 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aurovela 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *aurovela fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *aviane oral tablet 0.1-20 mg-mcg* | 1 | H |
| *ayuna oral tablet 0.15-30 mg-mcg* | 1 | H |
| *azurette oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *balziva oral tablet 0.4-35 mg-mcg* | 1 | H |
| BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (*estradiol-progesterone*) | 3 | |
| *blisovi 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *blisovi fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *briellyn oral tablet 0.4-35 mg-mcg* | 1 | H |
| *camila oral tablet 0.35 mg* | 1 | H |
| *camrese lo oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *camrese oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *chateal eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (*estradiol-levonorgestrel*) | 3 | QL (4 patches per month.) |
| COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (*estradiol-norethindrone acet*) | 3 | QL (8 patches per 28 days.) |
| CRINONE VAGINAL GEL 4 %, 8 % (*progesterone*) | 3 | ST |
| *cryselle oral tablet 0.3-30 mg-mcg* | 1 | H |
| *cyred eq oral tablet 0.15-30 mg-mcg* | 1 | H |
| *dasetta 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *daysee oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *deblitane oral tablet 0.35 mg* | 1 | H |
| *delyla oral tablet 0.1-20 mg-mcg* | 1 | H |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (*medroxyprogesterone acetate*) | 3 | QL (5 ml per year.) |
| DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*) | 3 | QL (5 mL per 365 days.) |
| DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (*medroxyprogesterone acetate*) | 1 | QL (3.25 ml per year.); H |
| *dolishale oral tablet 90-20 mcg* | 1 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg* | 3 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg* | 1 | H |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *econtra one-step oral tablet 1.5 mg* | 1 | H |
| EC-RX PROGESTERONE TRANSDERMAL CREAM 10 %, 20 % | 3 | PA |
| *elinest oral tablet 0.3-30 mg-mcg* | 1 | H |
| ELLA ORAL TABLET 30 MG (*ulipristal acetate*) | 1 | QL (1 tablet per 21 days.); H |
| *eluryng vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *emzahh oral tablet 0.35 mg* | 1 | H |
| ENDOMETRIN VAGINAL INSERT 100 MG (*progesterone*) | 2 | |
| *enilloring vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *enskyce oral tablet 0.15-30 mg-mcg* | 1 | H |
| *errin oral tablet 0.35 mg* | 1 | H |
| *estarylla oral tablet 0.25-35 mg-mcg* | 1 | H |
| *estradiol-norethindrone acet oral tablet 0.5-0.1 mg* | 2 | |
| *estradiol-norethindrone acet oral tablet 1-0.5 mg* | 1 | |
| *etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr* | 1 | H |
| *falmina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *feirza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *feirza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (*norethindrone acet-ethinyl est*) | 4 | H |
| *finzala oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg* | 1 | |
| *galbriela oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *gallifrey oral tablet 5 mg* | 1 | |
| *gemmily oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *hailey 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *hailey fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *heather oral tablet 0.35 mg* | 1 | H |
| *her style oral tablet 1.5 mg* | 1 | H |
| *iclevia oral tablet 0.15-0.03 mg* | 2 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *incassia oral tablet 0.35 mg* | 1 | H |
| *introvale oral tablet 0.15-0.03 mg* | 2 | H |
| *isibloom oral tablet 0.15-30 mg-mcg* | 1 | H |
| *jaimiess oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| *jasmiel oral tablet 3-0.02 mg* | 3 | |
| *jencycla oral tablet 0.35 mg* | 1 | H |
| *jinteli oral tablet 1-5 mg-mcg* | 1 | |
| *jolessa oral tablet 0.15-0.03 mg* | 2 | H |
| *joyeaux oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *juleber oral tablet 0.15-30 mg-mcg* | 1 | H |
| *junel 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *junel fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *junel fe 24 oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *kaitlib fe oral tablet chewable 0.8-25 mg-mcg* | 1 | H |
| *kalliga oral tablet 0.15-30 mg-mcg* | 1 | H |
| *kariva oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *kelnor 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *kurvelo oral tablet 0.15-30 mg-mcg* | 1 | H |
| *larin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *larin 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *larin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *larin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lessina oral tablet 0.1-20 mg-mcg* | 1 | H |
| *levonest oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |
| *levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg* | 2 | H |
| *levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *levonorgestrel oral tablet 1.5 mg* | 1 | H |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg* | 1 | H |
| LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (*norethin-eth estrad-fe biphas*) | 1 | H |
| *lojaimiess oral tablet 0.1-0.02 & 0.01 mg* | 1 | H |
| *loryna oral tablet 3-0.02 mg* | 3 | |
| *low-ogestrel oral tablet 0.3-30 mg-mcg* | 1 | H |
| *lo-zumandimine oral tablet 3-0.02 mg* | 3 | |
| *luizza 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *luizza 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *lutera oral tablet 0.1-20 mg-mcg* | 1 | H |
| *lyleq oral tablet 0.35 mg* | 1 | H |
| *lyza oral tablet 0.35 mg* | 1 | H |
| *marlissa oral tablet 0.15-30 mg-mcg* | 1 | H |
| *medroxyprogesterone acetate intramuscular suspension 150 mg/ml* | 1 | QL (5 ml per year.); H |
| *medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml* | 1 | QL (5 mL per 365 days.); H |
| *medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg* | 1 | |
| *megestrol acetate oral suspension 40 mg/ml* | 1 | |
| *megestrol acetate oral suspension 625 mg/5ml* | 3 | |
| *megestrol acetate oral tablet 20 mg, 40 mg* | 1 | |
| *meleya oral tablet 0.35 mg* | 1 | H |
| *mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *microgestin 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *microgestin 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg* | 1 | H |
| *microgestin fe 1/20 oral tablet 1-20 mg-mcg* | 1 | H |
| *mili oral tablet 0.25-35 mg-mcg* | 1 | H |
| *mimvey oral tablet 1-0.5 mg* | 1 | |
| *minzoya oral tablet 0.1-20 mg-mcg(21)* | 1 | H |
| *mono-linyah oral tablet 0.25-35 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *my choice oral tablet 1.5 mg* | 1 | H |
| *my way oral tablet 1.5 mg* | 1 | H |
| MYFEMBREE ORAL TABLET 40-1-0.5 MG (*relugolix-estradiol-norethind*) | 2 | PA; QL (1 tablet day.) |
| NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (*estradiol valerate-dienogest*) | 1 | H |
| *necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| *new day oral tablet 1.5 mg* | 1 | H |
| NEXTSTELLIS ORAL TABLET 3-14.2 MG (*drospirenone-estetrol*) | 3 | H |
| *nikki oral tablet 3-0.02 mg* | 3 | |
| *nora-be oral tablet 0.35 mg* | 1 | H |
| *norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| *norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)* | 1 | H |
| *norethindrone acetate oral tablet 5 mg* | 1 | |
| *norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg* | 1 | H |
| *norethindrone oral tablet 0.35 mg* | 1 | H |
| *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg* | 1 | |
| *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg* | 1 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *norlyroc oral tablet 0.35 mg* | 1 | H |
| *nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (21) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *nylia 1/35 oral tablet 1-35 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | 1 | H |
| *opcicon one-step oral tablet 1.5 mg* | 1 | H |
| OPILL ORAL TABLET 0.075 MG (*norgestrel*) | 1 | H |
| *option 2 oral tablet 1.5 mg* | 1 | H |
| ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (*elagolix-estradiol-norethind*) | 2 | PA; QL (2 capsules per day.) |
| *orquidea oral tablet 0.35 mg* | 1 | H |
| *philith oral tablet 0.4-35 mg-mcg* | 1 | H |
| *pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| PLAN B ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*) | 1 | H |
| *portia-28 oral tablet 0.15-30 mg-mcg* | 1 | H |
| PREMPHASE ORAL TABLET 0.625-5 MG (*conj estrog-medroxyprogest ace*) | 3 | |
| PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (*conj estrog-medroxyprogest ace*) | 3 | |
| *progesterone intramuscular oil 50 mg/ml* | 1 | |
| PROGESTERONE MICRONIZED TRANSDERMAL CREAM 10 % | 3 | PA |
| *progesterone oral capsule 100 mg, 200 mg* | 2 | |
| *progesterone vaginal insert 100 mg* | 2 | |
| PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (*medroxyprogesterone acetate*) | 3 | |
| *reclipsen oral tablet 0.15-30 mg-mcg* | 1 | H |
| *rivelsa oral tablet 42-21-21-7 days* | 1 | H |
| *rosyrah oral tablet 42-21-21-7 days* | 1 | H |
| *setlakin oral tablet 0.15-0.03 mg* | 2 | H |
| *sharobel oral tablet 0.35 mg* | 1 | H |
| *shewise oral tablet 1.5 mg* | 1 | H |
| *simliya oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *simpesse oral tablet 0.15-0.03 &0.01 mg* | 1 | H |
| SLYND ORAL TABLET 4 MG (*drospirenone*) | 3 | H |
| *sprintec 28 oral tablet 0.25-35 mg-mcg* | 1 | H |
| *syeda oral tablet 3-0.03 mg* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *take action oral tablet 1.5 mg* | 1 | H |
| *tarina 24 fe oral tablet 1-20 mg-mcg(24)* | 1 | H |
| *tarina fe 1/20 eq oral tablet 1-20 mg-mcg* | 1 | H |
| *taysofy oral capsule 1-20 mg-mcg(24)* | 3 | H |
| *tilia fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg* | 2 | H |
| *tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg* | 1 | H |
| *turqoz oral tablet 0.3-30 mg-mcg* | 1 | H |
| TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (*levonorgestrel-eth estradiol*) | 3 | H |
| TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (*levonorgestrel-ethinyl estrad*) | 1 | H |
| *tydemy oral tablet 3-0.03-0.451 mg* | 1 | H |
| *valtya 1/35 oral tablet 1-35 mg-mcg* | 1 | H |
| *valtya 1/50 oral tablet 1-50 mg-mcg* | 1 | H |
| *velivet oral tablet 0.1/0.125/0.15 -0.025 mg* | 1 | H |
| *vestura oral tablet 3-0.02 mg* | 3 | |
| *vienva oral tablet 0.1-20 mg-mcg* | 1 | H |
| *viorele oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *volnea oral tablet 0.15-0.02/0.01 mg (21/5)* | 1 | H |
| *vyfemla oral tablet 0.4-35 mg-mcg* | 1 | H |
| *vylibra oral tablet 0.25-35 mg-mcg* | 1 | H |
| *wera oral tablet 0.5-35 mg-mcg* | 1 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *wymzya fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xarah fe oral tablet 1-20/1-30/1-35 mg-mcg* | 1 | H |
| *xelria fe oral tablet chewable 0.4-35 mg-mcg* | 1 | H |
| *xulane transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| YASMIN 28 ORAL TABLET 3-0.03 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| YAZ ORAL TABLET 3-0.02 MG (*drospirenone-ethinyl estradiol*) | 2 | H |
| *your choice oral tablet 1.5 mg* | 1 | H |
| *zafemy transdermal patch weekly 150-35 mcg/24hr* | 3 | H |
| *zovia 1/35 (28) oral tablet 1-35 mg-mcg* | 1 | H |
| *zumandimine oral tablet 3-0.03 mg* | 3 | |
| **RAPID-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*) | 2 | QL (75 ml per prescription.) |
| HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (*insulin lispro*) | 2 | QL (75 ml (25 pens) per prescription.) |
| HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*) | 2 | QL (75 ml per prescription.) |
| HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*) | 2 | QL (75 ml per prescription.) |
| HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*) | 1 | QL (70 ml per prescription.) |
| HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin lispro*) | 2 | QL (75 ml per prescription.) |
| HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*) | 2 | QL (75 ml per prescription.) |
| INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML | 2 | QL (75 ml per prescription.) |
| INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML | 1 | QL (70 ml per prescription.) |
| INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML | 2 | QL (75 ml per prescription.) |
| INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML | 2 | QL (75 ml per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro-aabc*) | 2 | QL (75 ml per prescription.) |
| LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (*insulin lispro-aabc*) | 1 | QL (70 ml per prescription.) |
| **SHORT-ACTING INSULINS - Drugs for Diabetes** | | |
| HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*) | 2 | QL (75 ml per prescription.) |
| HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*) | 1 | QL (70 ml per prescription.) |
| HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (*insulin regular human*) | 2 | QL (75 mL per prescription.) |
| HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*) | 1 | QL (70 ml per prescription.) |
| MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (*insulin regular(human) in nacl*) | 3 | |
| **SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes** | | |
| BRENZAVVY ORAL TABLET 20 MG (*bexagliflozin*) | 3 | ST; QL (1 tablet per day.) |
| GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*) | 2 | QL (1 tablet per day.) |
| JARDIANCE ORAL TABLET 10 MG, 25 MG (*empagliflozin*) | 2 | QL (30 tablets per month.) |
| SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (*empagliflozin-metformin hcl*) | 2 | QL (1 tablet per day.) |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*) | 2 | QL (2 tablets per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (1 tablet per day.) |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*) | 2 | QL (2 tablets per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **SOMATOSTATIN AGONISTS - Hormones** | | |
| *octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml* | 1 | PA |
| *octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml* | 1 | PA |
| *octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml* | 1 | PA |
| SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (*pasireotide diaspartate*) | 4 | PA; QL (2 ampules per day.); SP |
| **SOMATOTROPIN AGONISTS - Hormones** | | |
| EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (*tesamorelin acetate*) | 4 | PA; QL (1 vial per day.) |
| EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (*tesamorelin acetate*) | 4 | PA; QL (4 vials per month.); SP |
| INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (*mecasermin*) | 2 | PA; QL (13 vials per month.); SP |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (*somatropin*) | 2 | PA; QL (13.5 mL (9 Pens) per month.) |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (*somatropin*) | 2 | PA; QL (9 mL (6 Pens) per month.); SP |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (*somatropin*) | 2 | PA; QL (27 mL (18 Pens) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (*somatropin*) | 2 | PA; QL (13.5 ml (9 cartridges) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (*somatropin*) | 2 | PA; QL (27 ml (18 cartridges) per month.) |
| OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (*somatropin*) | 2 | PA; QL (16 vials per month.); SP |
| SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (*somatropin (non-refrigerated)*) | 4 | PA; QL (1 vial per day.); SP |
| **SOMATOTROPIN ANTAGONISTS - Hormones** | | |
| SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (*pegvisomant*) | 4 | PA; QL (1 vial per day.); SP |
| **SULFONYLUREAS - Drugs for Diabetes** | | |
| DUETACT ORAL TABLET 30-2 MG, 30-4 MG (*pioglitazone hcl-glimepiride*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *glimepiride oral tablet 1 mg, 2 mg, 4 mg* | 1 | |
| *glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg* | 1 | |
| *glipizide oral tablet 10 mg, 5 mg* | 1 | |
| *glipizide oral tablet 15 mg* | 3 | |
| *glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg* | 2 | |
| GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (*glipizide*) | 3 | |
| *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg* | 1 | |
| *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg* | 1 | |
| *pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg* | 1 | |
| **THIAZOLIDINEDIONES - Drugs for Diabetes** | | |
| ACTOPLUS MET ORAL TABLET 15-850 MG (*pioglitazone hcl-metformin hcl*) | 3 | QL (3 tablets per day) |
| ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG | 2 | QL (1 tablet per day.) |
| DUETACT ORAL TABLET 30-2 MG, 30-4 MG (*pioglitazone hcl-glimepiride*) | 3 | |
| *pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg* | 1 | |
| *pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg* | 1 | |
| *pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg* | 2 | QL (3 tablets per day) |
| **THYROID AGENTS - Drugs for the Thyroid** | | |
| ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (*thyroid*) | 3 | |
| EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (*thyroid*) | 3 | |
| *levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg* | 1 | |
| *levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg* | 2 | |
| *liomny oral tablet 25 mcg, 5 mcg, 50 mcg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg* | 2 | |
| NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG | 3 | |
| *np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (*thyroid*) | 3 | |
| REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (*resmetirom*) | 4 | PA; QL (1 Tablet per day.) |
| *thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg* | 1 | |
| TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (*levothyroxine sodium*) | 2 | PA |
| *unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg* | 1 | |
| **IMMUNOMODULATORY AGENTS (90:00)** | | |
| **AMINO ACID POLYMERS** | | |
| *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml* | 2 | PA; QL (30 ml per month.) |
| *glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml* | 2 | PA; QL (12 ml per 21 days.) |
| *glatopa subcutaneous solution prefilled syringe 20 mg/ml* | 2 | PA; QL (30 ml per month.) |
| *glatopa subcutaneous solution prefilled syringe 40 mg/ml* | 2 | PA; QL (12 ml per 21 days.) |
| **ANTIMETABOLITES** | | |
| *cladribine (10 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (4 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (5 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (6 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *cladribine (7 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (8 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (9 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (*cladribine*) | 4 | PA; ST; QL (40 tablets per 720 days.) |
| *teriflunomide oral tablet 14 mg* | 2 | PA; QL (1 tablet per day.) |
| *teriflunomide oral tablet 7 mg* | 2 | PA; QL (31 tablets per month.) |
| **ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC** | | |
| AZASAN ORAL TABLET 100 MG, 75 MG (*azathioprine*) | 3 | |
| *azathioprine oral tablet 100 mg, 75 mg* | 3 | |
| *azathioprine oral tablet 50 mg* | 1 | |
| *mycophenolate mofetil oral capsule 250 mg* | 1 | |
| **APRIL OR BAFF INHIBITOR AGENTS** | | |
| VOYXACT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 400 MG/2ML (*sibeprenlimab-szsi*) | 4 | PA; QL (1 prefilled syringe per month.); SP |
| **CALCINEURIN INHIBITORS, MISC (90:28)** | | |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *cyclosporine modified oral solution 100 mg/ml* | 1 | |
| *cyclosporine oral capsule 100 mg, 25 mg* | 1 | |
| *gengraf oral capsule 100 mg, 25 mg* | 1 | |
| PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (*tacrolimus*) | 3 | |
| PROGRAF ORAL PACKET 0.2 MG, 1 MG (*tacrolimus*) | 3 | PA |
| RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*) | 3 | PA; QL (60 vials per month.) |
| *tacrolimus external ointment 0.03 %, 0.1 %* | 2 | QL (30 grams per prescription.) |
| *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg* | 1 | |
| VERKAZIA OPHTHALMIC EMULSION 0.1 % (*cyclosporine*) | 3 | PA; QL (4 vials per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **COMPLEMENT INHIBITOR AGENTS (90:20)** | | |
| FABHALTA ORAL CAPSULE 200 MG (*iptacopan hcl*) | 2 | PA; QL (2 capsules per day.); SP |
| TAVNEOS ORAL CAPSULE 10 MG (*avacopan*) | 3 | PA; QL (6 capsules per day.); SP |
| **COMPLEMENT INHIBITORS (90:08)** | | |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (*zilucoplan sodium*) | 4 | PA; QL (0.416 ml per day.); SP |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (*zilucoplan sodium*) | 4 | PA; QL (0.574 ml per day.); SP |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (*zilucoplan sodium*) | 4 | PA; QL (0.81 ml per day.); SP |
| **DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC** | | |
| ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (*vedolizumab*) | 2 | PA; QL (0.05 ml per day.); SP |
| ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 autoinjectors per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 syringes per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (*abatacept*) | 3 | PA; ST; QL (0.06 ml per day.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (*abatacept*) | 3 | PA; ST; QL (0.1 ml per day.); SP |
| **DISEASE-MODIFYING ANTIRHEUMATIC DRUGS** | | |
| AURANOFIN ORAL CAPSULE 3 MG | 3 | SP |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*) | 3 | |
| CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (1 syringe per month.); SP |
| CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (2 syringes (1 carton) per month.); SP |
| CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (Maximum quantity 1 kit per 365 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*) | 3 | PA; CM |
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution reconstituted 1 gm* | 1 | |
| *methotrexate sodium oral tablet 2.5 mg* | 1 | CM |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (*methotrexate (anti-rheumatic)*) | 2 | QL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (*methotrexate (anti-rheumatic)*) | 2 | QL (0.6 ml (4 auto-injectors) per month.) |
| RIDAURA ORAL CAPSULE 3 MG (*auranofin*) | 3 | SP |
| *sulfasalazine oral tablet 500 mg* | 1 | |
| *sulfasalazine oral tablet delayed release 500 mg* | 1 | |
| TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 device) every 8 weeks.); SP |
| TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 device) every 8 weeks.); SP |
| TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*) | 2 | PA; QL (2 ml (1 auto-injector) per month.) |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 syringe) every 8 weeks.); SP |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*guselkumab*) | 2 | PA; QL (2 ml (1 syringe) per month.) |
| TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*) | 2 | PA; QL (4 ml (2 pens/1 box) per month.) |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*) | 2 | CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*) | 3 | PA; CM |
| **FUMARATES** | | |
| BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*) | 2 | PA; QL (4 capsules per day.); SP |
| *dimethyl fumarate oral capsule delayed release 120 mg* | 1 | PA; QL (56 capsules per year.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *dimethyl fumarate oral capsule delayed release 240 mg* | 1 | PA; QL (2 capsules per day.) |
| *dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg* | 1 | PA; QL (60 capsules (1 starter pack) per 365 days.) |
| **IGG1 MONOCLONAL ANTIBODIES** | | |
| BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (*belimumab*) | 2 | PA; QL (4 ml per month.); SP |
| BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (*belimumab*) | 2 | PA; QL (4 ml per month.); SP |
| **IMMUNOMODULATORY AGENTS (90:00)** | | |
| *cyclophosphamide oral capsule 25 mg, 50 mg* | 2 | CM |
| CYCLOPHOSPHAMIDE ORAL TABLET 50 MG | 2 | CM |
| *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg* | 3 | |
| *everolimus oral tablet 10 mg, 7.5 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *everolimus oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *everolimus oral tablet soluble 2 mg, 3 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *mercaptopurine oral suspension 2000 mg/100ml* | 1 | SP; CM |
| *mercaptopurine oral tablet 50 mg* | 1 | CM |
| PURIXAN ORAL SUSPENSION 2000 MG/100ML (*mercaptopurine*) | 3 | SP; CM |
| *torpenz oral tablet 10 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *torpenz oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| *torpenz tablet 7.5 mg oral* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *yulithira oral tablet 10 mg, 7.5 mg* | 2 | PA; QL (2 tablets per day.); SP; CM |
| *yulithira oral tablet 2.5 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP; CM |
| **INTERFERONS** | | |
| AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (*interferon beta-1a*) | 2 | PA; QL (4 pens (1 box) per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*) | 2 | PA; QL (4 syringes (1 box) per month.); SP |
| BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*) | 2 | PA; QL (15 vials per month.) |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*) | 2 | SP |
| PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*) | 2 | SP |
| **INTERLEUKIN INHIBITOR AGENTS, MISC** | | |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*omalizumab*) | 2 | PA; QL (2 auto injectors per month.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*omalizumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (*omalizumab*) | 2 | PA; QL (0.04 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*omalizumab*) | 2 | PA; QL (0.08 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*omalizumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*omalizumab*) | 2 | PA; QL (0.04 ml per day.); SP |
| **INTERLEUKIN-MEDIATED AGENTS, MISC** | | |
| ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 auto injector per month.); SP |
| ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 prefilled syringes per month.); SP |
| AVTOZMA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab-anoh*) | 3 | PA; ST; QL (4 autoinjectors per month.); SP |
| AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab-anoh*) | 3 | PA; ST; QL (4 syringes per month.); SP |
| COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*secukinumab*) | 2 | PA; QL (0.018 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*) | 3 | PA; ST; QL (2.28 ml per month.); SP |
| KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*sarilumab*) | 3 | PA; ST; QL (2.28 ml per month.); SP |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*) | 3 | PA; ST; QL (0.67 ml (1 syringe) per day.); SP |
| STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-hmny*) | 2 | PA; QL (1 single-dose vial every 3 months.) |
| STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-hmny*) | 2 | PA; QL (1 prefilled syringe every 3 months.) |
| STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-stba*) | 2 | SP |
| STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-stba*) | 2 | PA; QL (1 syringe every 3 months.); SP |
| WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-auub*) | 2 | PA; QL (1 single-dose vial every 3 months.); SP |
| WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-auub*) | 2 | PA; QL (1 syringe per 3 months.); SP |
| YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-kfce*) | 2 | PA; QL (1 single-dose vial every 3 months.); SP |
| YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-kfce*) | 2 | PA; QL (1 syringe every 3 months.); SP |
| **JANUS KINASE INHIBITORS, MISCELLANEOUS** | | |
| CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*) | 4 | PA; ST; QL (1 tablet per day.); SP |
| RINVOQ LQ ORAL SOLUTION 1 MG/ML (*upadacitinib*) | 2 | PA; QL (360 mL (2 bottles) per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (*upadacitinib*) | 2 | PA; QL (1 tablet per day.); SP |
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (*upadacitinib*) | 2 | PA; QL (84 tablets per 365 days.); SP |
| *tofacitinib citrate er oral tablet extended release 24 hour 22 mg* | 2 | PA; QL (1 tablet per day.) |
| *tofacitinib citrate er tablet extended release 24 hour 11 mg oral* | 2 | PA; QL (1 tablet per day.); SP |
| *tofacitinib citrate oral solution 1 mg/ml* | 2 | PA; QL (8 mL per day.); SP |
| *tofacitinib citrate oral tablet 10 mg, 5 mg* | 2 | PA; QL (2 tablets per day.); SP |
| **MONOCARBOXYLIC ACID AMIDE AGENTS** | | |
| *leflunomide oral tablet 10 mg, 20 mg* | 1 | |
| **MONOCLONAL ANTIBODIES (90:04)** | | |
| KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*) | 2 | PA; QL (0.02 ml per day.); SP |
| **MONOCLONAL ANTIBODIES (90:10)** | | |
| LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (*lecanemab-irmb*) | 4 | PA; QL (7.2 mL (4 autoinjectors) per month.); SP |
| **MONOCLONAL ANTIBODIES (90:12)** | | |
| ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*) | 3 | PA; QL (0.04 ml per day.); SP |
| **MTOR INHIBITORS, MISCELLANEOUS** | | |
| HYFTOR EXTERNAL GEL 0.2 % (*sirolimus*) | 3 | PA; QL (10 g per 23 days.) |
| *sirolimus oral solution 1 mg/ml* | 2 | |
| *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| **NEONATAL FC RECEPTOR BLOCKERS** | | |
| VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (*efgartigimod alfa-hyalur-qvfc*) | 4 | PA; QL (4 syringes every 50 days.); SP |
| **PHOSPHODIESTERASE-4 INHIBITORS, MISC** | | |
| OTEZLA ORAL TABLET 20 MG (*apremilast*) | 2 | PA; QL (60 tablets per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| OTEZLA ORAL TABLET 30 MG (*apremilast*) | 4 | PA; QL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*) | 2 | PA; QL (55 tablets (one starter pack) per year.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (*apremilast*) | 2 | PA; QL (1 starter pack per year.) |
| OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (*apremilast*) | 2 | PA; QL (30 tablets per month.); SP |
| OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (*apremilast*) | 2 | PA; QL (1 starter pack (41 tablets) per 365 days.) |
| **SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS** | | |
| *fingolimod hcl oral capsule 0.5 mg* | 1 | PA; QL (1 capsule per day.) |
| GILENYA ORAL CAPSULE 0.25 MG (*fingolimod hcl*) | 3 | PA; QL (1 capsule per day.) |
| MAYZENT ORAL TABLET 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (4 tablets per day.) |
| MAYZENT ORAL TABLET 1 MG (*siponimod fumarate*) | 3 | PA; QL (1 tablet per day.) |
| MAYZENT ORAL TABLET 2 MG (*siponimod fumarate*) | 3 | PA; QL (1 tablet per day.) |
| MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (12 tablets per 365 days.) |
| MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (7 tablets per 365 days.) |
| **T-CELL BLOCKERS (90:24)** | | |
| LUPKYNIS ORAL CAPSULE 7.9 MG (*voclosporin*) | 4 | PA; QL (6 capsules per day.); SP |
| **TUMOR NECROSIS FACTOR INHIBITORS, MISC** | | |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML | 4 | PA; QL (0.036 kits per day (1 kit per month).); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML | 4 | PA; QL (0.08 syringe per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML | 4 | PA; QL (1.6 mL (2 auto-injectors) per month.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML | 2 | PA; QL (0.01 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML | 4 | PA; QL (0.02 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; SP |
| CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (1 syringe per month.); SP |
| CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (2 syringes (1 carton) per month.); SP |
| CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (Maximum quantity 1 kit per 365 days.); SP |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 auto-injector per month.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 syringe per month.); SP |
| **LOCAL ANESTHETICS - Drugs for Numbing** | | |
| **LOCAL ANESTHETICS - Drugs for Numbing** | | |
| ALTACAINE OPHTHALMIC SOLUTION 0.5 % (*tetracaine hcl*) | 3 | |
| LETS KIT | 3 | PA |
| *tetracaine hcl ophthalmic solution 0.5 %* | 1 | |
| ZTLIDO EXTERNAL PATCH 1.8 % (*lidocaine*) | 3 | PA; QL (3 patches per day.) |
| **MISCELLANEOUS THERAPEUTIC AGENTS** | | |
| **5-ALPHA-REDUCTASE INHIBITORS** | | |
| *dutasteride oral capsule 0.5 mg* | 2 | |
| *finasteride oral tablet 5 mg* | 1 | |
| **5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence** | | |
| *disulfiram oral tablet 250 mg, 500 mg* | 1 | |
| *dutasteride oral capsule 0.5 mg* | 2 | |
| *finasteride oral tablet 5 mg* | 1 | |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| **ANTIDOTES (92:12) - Drugs for Overdose or Poisoning** | | |
| *acetylcysteine inhalation solution 10 %, 20 %* | 1 | |
| BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*) | 2 | QL (2 intranasal devices per prescription.) |
| CHEMET ORAL CAPSULE 100 MG (*succimer*) | 2 | |
| FOSRENOL ORAL PACKET 1000 MG, 750 MG (*lanthanum carbonate*) | 3 | ST |
| *glucagon emergency kit injection solution reconstituted 1 mg* | 2 | |
| GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML | 2 | |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*) | 2 | QL (0.2 ml per prescription.) |
| GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*) | 2 | QL (0.4 ml per prescription.) |
| GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*) | 2 | QL (2 vials per copay.) |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*) | 2 | QL (2 prefilled syringes per copay.) |
| *lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg* | 3 | ST |
| *lederle leucovorin oral tablet 5 mg* | 1 | |
| *leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg* | 1 | |
| *naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml* | 1 | |
| *naloxone hcl injection solution cartridge 0.4 mg/ml* | 1 | |
| *naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml* | 1 | |
| *naltrexone hcl oral tablet 50 mg* | 1 | |
| *phytonadione oral tablet 5 mg* | 3 | QL (5 tablets per prescription.) |
| RADIOGARDASE ORAL CAPSULE 0.5 GM (*prussian blue insoluble*) | 3 | |
| *sevelamer carbonate oral packet 0.8 gm, 2.4 gm* | 2 | PA |
| *sevelamer carbonate oral tablet 800 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sodium polystyrene sulfonate combination suspension 15 gm/60ml* | 1 | |
| *sodium polystyrene sulfonate oral powder* | 1 | |
| SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (*sodium polystyrene sulfonate*) | 3 | |
| SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (*sodium polystyrene sulfonate*) | 3 | |
| VISTOGARD ORAL PACKET 10 GM (*uridine triacetate*) | 2 | QL (20 packets per prescription.) |
| **ANTIGOUT AGENTS - Drugs for Gout** | | |
| *allopurinol oral tablet 100 mg, 300 mg* | 1 | |
| *colchicine oral capsule 0.6 mg* | 2 | |
| *colchicine oral tablet 0.6 mg* | 2 | |
| *colchicine-probenecid oral tablet 0.5-500 mg* | 1 | |
| *febuxostat oral tablet 40 mg, 80 mg* | 3 | |
| GLOPERBA ORAL SOLUTION 0.6 MG/5ML (*colchicine*) | 3 | PA |
| *indomethacin er oral capsule extended release 75 mg* | 2 | |
| *indomethacin oral capsule 25 mg, 50 mg* | 1 | |
| *indomethacin oral suspension 25 mg/5ml* | 3 | PA |
| *indomethacin rectal suppository 50 mg* | 3 | PA |
| MITIGARE ORAL CAPSULE 0.6 MG (*colchicine*) | 2 | |
| *naproxen dr oral tablet delayed release 500 mg* | 1 | |
| *naproxen oral tablet 250 mg, 375 mg, 500 mg* | 1 | |
| *naproxen oral tablet delayed release 375 mg, 500 mg* | 1 | |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 2 | |
| ORLYNVAH ORAL TABLET 500-500 MG (*sulopenem etzadrox-probenecid*) | 4 | QL (10 tablets per course of therapy.) |
| *probenecid oral tablet 500 mg* | 1 | |
| **ANTISENSE OLIGONUCLEOTIDES** | | |
| LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (*sodium oxybate*) | 4 | PA; QL (1 packet per day.); SP |
| LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (*sodium oxybate*) | 4 | PA; QL (1 box (28 packets) per year.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sodium oxybate oral solution 500 mg/ml* | 3 | PA; QL (18 ml per day.); SP |
| TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*olezarsen sodium*) | 3 | PA; QL (1 Auto-injector (0.8 mL) per month.); SP |
| WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (*eplontersen sodium*) | 2 | PA; QL (0.029 ml per day.); SP |
| **BONE ANABOLIC AGENTS** | | |
| BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (*teriparatide*) | 4 | PA; SP |
| TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML | 4 | PA; SP |
| TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*) | 3 | PA; SP |
| **BONE RESORPTION INHIBITORS - Drugs for Bone Loss** | | |
| *alendronate sodium oral solution 70 mg/75ml* | 1 | |
| *alendronate sodium oral tablet 10 mg, 35 mg, 70 mg* | 1 | |
| ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (*estradiol*) | 3 | QL (8 patches (1 box) per 28 days.) |
| *calcitonin (salmon) injection solution 200 unit/ml* | 3 | |
| *calcitonin (salmon) nasal solution 200 unit/act* | 2 | |
| DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (*estradiol valerate*) | 3 | |
| DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (*estradiol cypionate*) | 3 | |
| DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (*estradiol*) | 3 | |
| *dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 % | 3 | PA |
| ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (*estradiol*) | 3 | |
| *estradiol oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| *estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm* | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)* | 3 | QL (37.5 grams (1 box) per month.) |
| *estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| *estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 1 | QL (4 patches (1 carton) per 28 days.) |
| *estradiol vaginal cream 0.01 %* | 3 | |
| *estradiol vaginal tablet 10 mcg* | 2 | |
| *estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml* | 1 | |
| ESTRING VAGINAL RING 7.5 MCG/24HR (*estradiol*) | 2 | QL (1 ring per 90 days.) |
| *estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg* | 3 | |
| EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (*estradiol*) | 2 | |
| FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (*estradiol acetate*) | 3 | QL (1 ring per 3 months.) |
| FOSAMAX ORAL TABLET 70 MG (*alendronate sodium*) | 3 | |
| FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (*alendronate-cholecalciferol*) | 3 | |
| *ibandronate sodium oral tablet 150 mg* | 2 | |
| *lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr* | 2 | QL (8 patches (1 box) per 28 days.) |
| MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (*estradiol*) | 3 | QL (4 patches (1 carton) per 28 days.) |
| MIACALCIN INJECTION SOLUTION 200 UNIT/ML (*calcitonin (salmon)*) | 3 | |
| PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (*estrogens conjugated*) | 3 | |
| PREMARIN VAGINAL CREAM 0.625 MG/GM (*estrogens, conjugated*) | 3 | |
| *raloxifene hcl oral tablet 60 mg* | 2 | H-N |
| *risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg* | 3 | |
| *yuvafem vaginal tablet 10 mcg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **BRADYKININ RECEPTOR ANTAGONISTS** | | |
| *icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml* | 2 | PA; QL (0.6 ml per day.); SP |
| **CARBONIC ANHYDRASE INHIBITORS (92:26)** | | |
| *dichlorphenamide oral tablet 50 mg* | 2 | PA; QL (4 tablets per day.); SP |
| **CARIOSTATIC AGENTS - Vitamins and Fluoride** | | |
| CLINPRO 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| DENTA 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |
| DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 % | 3 | |
| DENTAGEL DENTAL GEL 1.1 % | 3 | |
| EASYGEL DENTAL GEL 0.4 % (*stannous fluoride*) | 3 | |
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (*sodium fluoride-vitamin d*) | 3 | |
| FLOTREX ORAL TABLET CHEWABLE 1 MG (*pediatric multivitamins-fl*) | 3 | |
| FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (*stannous fluoride*) | 3 | |
| FLUORIDEX DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIMAX 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| JUST RIGHT 5000 DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| *multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml* | 1 | |
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (*ped multivitamins-fl-iron*) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (*ped multivitamins-fl-iron*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (*sod fluoride-potassium nitrate*) | 3 | |
| PREVIDENT DENTAL GEL 1.1 % (*sodium fluoride*) | 3 | |
| PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (*sodium fluoride*) | 3 | |
| *sf 5000 plus dental cream 1.1 %* | 1 | |
| *sf dental gel 1.1 %* | 1 | |
| *sod fluoride-potassium nitrate dental gel 1.1-5 %* | 1 | |
| *sodium fluoride 5000 enamel dental gel 1.1-5 %* | 1 | |
| *sodium fluoride 5000 plus dental cream 1.1 %* | 1 | |
| *sodium fluoride 5000 ppm dental gel 1.1 %* | 1 | |
| *sodium fluoride 5000 ppm dental paste 1.1 %* | 1 | |
| *sodium fluoride 5000 sensitive dental gel 1.1-5 %* | 1 | |
| *sodium fluoride dental cream 1.1 %* | 1 | |
| *sodium fluoride dental gel 1.1 %* | 1 | |
| *sodium fluoride mouth/throat solution 0.2 %* | 1 | |
| *sodium fluoride oral solution 1.1 (0.5 f) mg/ml* | 1 | H |
| *sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| *sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg* | 1 | H |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **COMPLEMENT INHIBITORS** | | |
| BERINERT INTRAVENOUS KIT 500 UNIT (*c1 esterase inhibitor (human)*) | 4 | PA; ST; QL (0.4 boxes per day.); SP |
| EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (*pegcetacoplan*) | 2 | PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP |
| FABHALTA ORAL CAPSULE 200 MG (*iptacopan hcl*) | 2 | PA; QL (2 capsules per day.); SP |
| HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (*c1 esterase inhibitor (human)*) | 2 | PA; QL (24 vials per month.); SP |
| HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (*c1 esterase inhibitor (human)*) | 2 | PA; QL (16 vials per month.); SP |
| RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (*c1 esterase inhibitor (recomb)*) | 3 | PA; QL (0.27 vials per day.); SP |
| TAVNEOS ORAL CAPSULE 10 MG (*avacopan*) | 3 | PA; QL (6 capsules per day.); SP |
| VOYDEYA ORAL TABLET 100 MG (*danicopan*) | 2 | PA; QL (6 tablets per day.); SP |
| VOYDEYA ORAL TABLET THERAPY PACK 50 & 100 MG (*danicopan*) | 2 | PA; QL (180 tablets per month.); SP |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (*zilucoplan sodium*) | 4 | PA; QL (0.416 ml per day.); SP |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (*zilucoplan sodium*) | 4 | PA; QL (0.574 ml per day.); SP |
| ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (*zilucoplan sodium*) | 4 | PA; QL (0.81 ml per day.); SP |
| **COMPLEMENT INHIBITORS (92:32)** | | |
| BERINERT INTRAVENOUS KIT 500 UNIT (*c1 esterase inhibitor (human)*) | 4 | PA; ST; QL (0.4 boxes per day.); SP |
| EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (*pegcetacoplan*) | 2 | PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP |
| HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (*c1 esterase inhibitor (human)*) | 2 | PA; QL (24 vials per month.); SP |
| HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (*c1 esterase inhibitor (human)*) | 2 | PA; QL (16 vials per month.); SP |
| *icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml* | 2 | PA; QL (0.6 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (*c1 esterase inhibitor (recomb)*) | 3 | PA; QL (0.27 vials per day.); SP |
| TAVNEOS ORAL CAPSULE 10 MG (*avacopan*) | 3 | PA; QL (6 capsules per day.); SP |
| **DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis** | | |
| ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 auto injector per month.); SP |
| ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 prefilled syringes per month.); SP |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML | 4 | PA; QL (0.036 kits per day (1 kit per month).); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML | 4 | PA; QL (0.08 syringe per day.); SP |
| ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML | 4 | PA; QL (1.6 mL (2 auto-injectors) per month.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML | 2 | PA; QL (0.01 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML | 4 | PA; QL (0.02 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; SP |
| AURANOFIN ORAL CAPSULE 3 MG | 3 | SP |
| AZASAN ORAL TABLET 100 MG, 75 MG (*azathioprine*) | 3 | |
| *azathioprine oral tablet 100 mg, 75 mg* | 3 | |
| *azathioprine oral tablet 50 mg* | 1 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*) | 3 | |
| CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (1 syringe per month.); SP |
| CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (2 syringes (1 carton) per month.); SP |
| CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (Maximum quantity 1 kit per 365 days.); SP |
| COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*secukinumab*) | 2 | PA; QL (0.018 ml per day.); SP |
| COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *cyclosporine modified oral solution 100 mg/ml* | 1 | |
| *cyclosporine oral capsule 100 mg, 25 mg* | 1 | |
| DEPEN TITRATABS ORAL TABLET 250 MG (*penicillamine*) | 2 | SP |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| *gengraf oral capsule 100 mg, 25 mg* | 1 | |
| *hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*) | 3 | PA; CM |
| KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*) | 3 | PA; ST; QL (2.28 ml per month.); SP |
| KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*sarilumab*) | 3 | PA; ST; QL (2.28 ml per month.); SP |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*) | 3 | PA; ST; QL (0.67 ml (1 syringe) per day.); SP |
| *leflunomide oral tablet 10 mg, 20 mg* | 1 | |
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution reconstituted 1 gm* | 1 | |
| *methotrexate sodium oral tablet 2.5 mg* | 1 | CM |
| OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*) | 4 | PA; ST; QL (1 tablet per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 autoinjectors per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 syringes per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (*abatacept*) | 3 | PA; ST; QL (0.06 ml per day.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (*abatacept*) | 3 | PA; ST; QL (0.1 ml per day.); SP |
| OTEZLA ORAL TABLET 30 MG (*apremilast*) | 4 | PA; QL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*) | 2 | PA; QL (55 tablets (one starter pack) per year.); SP |
| *penicillamine oral tablet 250 mg* | 2 | SP |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (*methotrexate (anti-rheumatic)*) | 2 | QL (0.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (*methotrexate (anti-rheumatic)*) | 2 | QL (1 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (*methotrexate (anti-rheumatic)*) | 2 | QL (1.2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (*methotrexate (anti-rheumatic)*) | 2 | QL (1.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*methotrexate (anti-rheumatic)*) | 2 | QL (1.6 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (*methotrexate (anti-rheumatic)*) | 2 | QL (1.8 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (*methotrexate (anti-rheumatic)*) | 2 | QL (2 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (*methotrexate (anti-rheumatic)*) | 2 | QL (2.4 ml (4 auto-injectors) per month.) |
| RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (*methotrexate (anti-rheumatic)*) | 2 | QL (0.6 ml (4 auto-injectors) per month.) |
| RIDAURA ORAL CAPSULE 3 MG (*auranofin*) | 3 | SP |
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (*upadacitinib*) | 2 | PA; QL (1 tablet per day.); SP |
| RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (*upadacitinib*) | 2 | PA; QL (84 tablets per 365 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 auto-injector per month.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 syringe per month.); SP |
| *sulfasalazine oral tablet 500 mg* | 1 | |
| *sulfasalazine oral tablet delayed release 500 mg* | 1 | |
| *tofacitinib citrate er oral tablet extended release 24 hour 22 mg* | 2 | PA; QL (1 tablet per day.) |
| *tofacitinib citrate er tablet extended release 24 hour 11 mg oral* | 2 | PA; QL (1 tablet per day.); SP |
| *tofacitinib citrate oral solution 1 mg/ml* | 2 | PA; QL (8 mL per day.); SP |
| *tofacitinib citrate oral tablet 10 mg, 5 mg* | 2 | PA; QL (2 tablets per day.); SP |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*) | 2 | CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*) | 3 | PA; CM |
| **ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)** | | |
| FILSPARI ORAL TABLET 200 MG, 400 MG (*sparsentan*) | 4 | PA; QL (60 tablets per month.); SP |
| VANRAFIA ORAL TABLET 0.75 MG (*atrasentan hcl*) | 4 | PA; QL (30 tablets per month.); SP |
| **IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM** | | |
| ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 auto injector per month.); SP |
| ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*) | 3 | PA; ST; QL (4 prefilled syringes per month.); SP |
| ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (*interferon gamma-1b*) | 2 | PA; QL (8.5 mls per month.); SP |
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML | 4 | PA; QL (2 auto injector pens per month.); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML | 4 | PA; QL (0.036 kits per day (1 kit per month).); SP |
| ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML | 4 | PA; QL (0.08 syringe per day.); SP |
| ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 4 | PA; SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML | 4 | PA; QL (1.6 mL (2 auto-injectors) per month.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML | 2 | PA; QL (0.01 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML | 4 | PA; QL (0.02 ml per day.); SP |
| ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 2 | PA; QL (0.03 ml per day.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 auto-injectors (1 carton) per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; QL (2 syringes per month per month.); SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 2 | PA; SP |
| AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-atto*) | 4 | PA; SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| AURANOFIN ORAL CAPSULE 3 MG | 3 | SP |
| AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (*interferon beta-1a*) | 2 | PA; QL (4 pens (1 box) per month.); SP |
| AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*) | 2 | PA; QL (4 syringes (1 box) per month.); SP |
| AZASAN ORAL TABLET 100 MG, 75 MG (*azathioprine*) | 3 | |
| *azathioprine oral tablet 100 mg, 75 mg* | 3 | |
| *azathioprine oral tablet 50 mg* | 1 | |
| AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*) | 3 | |
| AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*) | 3 | |
| BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*) | 2 | PA; QL (4 capsules per day.); SP |
| BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; SP; CM |
| BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (*ropeginterferon alfa-2b-njft*) | 4 | PA; QL (0.08 ml per day.); SP; CM |
| BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*) | 2 | PA; QL (15 vials per month.) |
| CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (1 syringe per month.); SP |
| CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (2 syringes (1 carton) per month.); SP |
| CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*) | 2 | PA; QL (Maximum quantity 1 kit per 365 days.); SP |
| *cladribine (10 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (4 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (5 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (6 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (7 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *cladribine (8 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (9 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *cyclosporine modified oral solution 100 mg/ml* | 1 | |
| *cyclosporine oral capsule 100 mg, 25 mg* | 1 | |
| *dimethyl fumarate oral capsule delayed release 120 mg* | 1 | PA; QL (56 capsules per year.) |
| *dimethyl fumarate oral capsule delayed release 240 mg* | 1 | PA; QL (2 capsules per day.) |
| *dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg* | 1 | PA; QL (60 capsules (1 starter pack) per 365 days.) |
| ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*) | 3 | PA; QL (0.04 ml per day.); SP |
| *fingolimod hcl oral capsule 0.5 mg* | 1 | PA; QL (1 capsule per day.) |
| *gengraf oral capsule 100 mg, 25 mg* | 1 | |
| GILENYA ORAL CAPSULE 0.25 MG (*fingolimod hcl*) | 3 | PA; QL (1 capsule per day.) |
| *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml* | 2 | PA; QL (30 ml per month.) |
| *glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml* | 2 | PA; QL (12 ml per 21 days.) |
| *glatopa subcutaneous solution prefilled syringe 20 mg/ml* | 2 | PA; QL (30 ml per month.) |
| *glatopa subcutaneous solution prefilled syringe 40 mg/ml* | 2 | PA; QL (12 ml per 21 days.) |
| *hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg* | 1 | |
| JOENJA ORAL TABLET 70 MG (*leniolisib phosphate*) | 4 | PA; QL (2 tablets per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*) | 3 | PA; CM |
| KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*) | 2 | PA; QL (0.02 ml per day.); SP |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*) | 3 | PA; ST; QL (0.67 ml (1 syringe) per day.); SP |
| *leflunomide oral tablet 10 mg, 20 mg* | 1 | |
| *lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg* | 2 | PA; QL (28 capsules per 21 days.); SP; CM |
| *lenalidomide oral capsule 20 mg, 25 mg* | 2 | PA; QL (21 capsules per 21 days.); SP; CM |
| MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (*cladribine*) | 4 | PA; ST; QL (40 tablets per 720 days.) |
| MAYZENT ORAL TABLET 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (4 tablets per day.) |
| MAYZENT ORAL TABLET 1 MG (*siponimod fumarate*) | 3 | PA; QL (1 tablet per day.) |
| MAYZENT ORAL TABLET 2 MG (*siponimod fumarate*) | 3 | PA; QL (1 tablet  per day.) |
| MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (12 tablets per 365 days.) |
| MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*) | 3 | PA; QL (7 tablets per 365 days.) |
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution reconstituted 1 gm* | 1 | |
| *methotrexate sodium oral tablet 2.5 mg* | 1 | CM |
| ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 autoinjectors per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (*abatacept*) | 3 | PA; ST; QL (4 syringes per month.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (*abatacept*) | 3 | PA; ST; QL (0.06 ml per day.); SP |
| ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (*abatacept*) | 3 | PA; ST; QL (0.1 ml per day.); SP |
| OTEZLA ORAL TABLET 20 MG (*apremilast*) | 2 | PA; QL (60 tablets per month.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| OTEZLA ORAL TABLET 30 MG (*apremilast*) | 4 | PA; QL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*) | 2 | PA; QL (55 tablets (one starter pack) per year.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (*apremilast*) | 2 | PA; QL (1 starter pack per year.) |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*) | 2 | SP |
| PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*) | 2 | SP |
| PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*) | 3 | PA; QL (1 ml per month.); SP |
| PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (*peginterferon beta-1a*) | 3 | PA; QL (2 ml per year without additional quantity notification.); SP |
| PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (*peginterferon beta-1a*) | 3 | PA; QL (2 ml per year without additional quantity notification.); SP |
| PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (*peginterferon beta-1a*) | 3 | PA; QL (1 ml per month.); SP |
| PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*) | 3 | PA; QL (1 ml per month.); SP |
| *pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg* | 4 | PA; QL (21 capsules per 21 days.); SP; CM |
| RHAPSIDO ORAL TABLET 25 MG (*remibrutinib*) | 2 | PA; QL (60 tablets per month.); SP |
| RIDAURA ORAL CAPSULE 3 MG (*auranofin*) | 3 | SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 auto-injector per month.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*golimumab*) | 2 | PA; QL (1 syringe per 21 days.); SP |
| SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (*golimumab*) | 2 | PA; QL (1 syringe per month.); SP |
| *sulfasalazine oral tablet 500 mg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sulfasalazine oral tablet delayed release 500 mg* | 1 | |
| *teriflunomide oral tablet 14 mg* | 2 | PA; QL (1 tablet per day.) |
| *teriflunomide oral tablet 7 mg* | 2 | PA; QL (31 tablets per month.) |
| THALOMID ORAL CAPSULE 100 MG, 50 MG (*thalidomide*) | 2 | PA; QL (28 capsules per prescription.); SP; CM |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*) | 2 | CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*) | 3 | PA; CM |
| ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (*ozanimod hcl*) | 3 | PA; ST; QL (7 capsules per year.) |
| ZEPOSIA ORAL CAPSULE 0.92 MG (*ozanimod hcl*) | 3 | PA; ST; QL (1 capsule per day.) |
| ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (*ozanimod hcl*) | 3 | PA; ST |
| **IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant** | | |
| AZASAN ORAL TABLET 100 MG, 75 MG (*azathioprine*) | 3 | |
| *azathioprine oral tablet 100 mg, 75 mg* | 3 | |
| *azathioprine oral tablet 50 mg* | 1 | |
| BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (*belimumab*) | 2 | PA; QL (4 ml per month.); SP |
| BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (*belimumab*) | 2 | PA; QL (4 ml per month.); SP |
| *cladribine (10 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (4 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (5 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (6 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (7 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cladribine (8 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *cladribine (9 tabs) oral tablet therapy pack 10 mg* | 3 | PA; ST; QL (40 tablets per 720 days.) |
| *cyclophosphamide oral capsule 25 mg, 50 mg* | 2 | CM |
| CYCLOPHOSPHAMIDE ORAL TABLET 50 MG | 2 | CM |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | 1 | |
| *cyclosporine modified oral solution 100 mg/ml* | 1 | |
| *cyclosporine oral capsule 100 mg, 25 mg* | 1 | |
| *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg* | 3 | |
| *gengraf oral capsule 100 mg, 25 mg* | 1 | |
| HYFTOR EXTERNAL GEL 0.2 % (*sirolimus*) | 3 | PA; QL (10 g per 23 days.) |
| JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*) | 3 | PA; CM |
| *leflunomide oral tablet 10 mg, 20 mg* | 1 | |
| LUPKYNIS ORAL CAPSULE 7.9 MG (*voclosporin*) | 4 | PA; QL (6 capsules per day.); SP |
| MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (*cladribine*) | 4 | PA; ST; QL (40 tablets per 720 days.) |
| *mercaptopurine oral suspension 2000 mg/100ml* | 1 | SP; CM |
| *mercaptopurine oral tablet 50 mg* | 1 | CM |
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution reconstituted 1 gm* | 1 | |
| *methotrexate sodium oral tablet 2.5 mg* | 1 | CM |
| *mycophenolate mofetil oral capsule 250 mg* | 1 | |
| *mycophenolate mofetil oral suspension reconstituted 200 mg/ml* | 1 | |
| *mycophenolate mofetil oral tablet 500 mg* | 1 | |
| *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg* | 2 | |
| *mycophenolic acid oral tablet delayed release 180 mg, 360 mg* | 2 | |
| MYHIBBIN ORAL SUSPENSION 200 MG/ML (*mycophenolate mofetil*) | 1 | |
| *pimecrolimus external cream 1 %* | 3 | QL (30 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (*tacrolimus*) | 3 | |
| PROGRAF ORAL PACKET 0.2 MG, 1 MG (*tacrolimus*) | 3 | PA |
| PURIXAN ORAL SUSPENSION 2000 MG/100ML (*mercaptopurine*) | 3 | SP; CM |
| *sirolimus oral solution 1 mg/ml* | 2 | |
| *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| *tacrolimus external ointment 0.03 %, 0.1 %* | 2 | QL (30 grams per prescription.) |
| *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg* | 1 | |
| TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*) | 2 | CM |
| XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*) | 3 | PA; CM |
| **KALLIKREIN INHIBITORS** | | |
| TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*lanadelumab-flyo*) | 2 | PA; QL (0.0375 ml per day.); SP |
| TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*lanadelumab-flyo*) | 2 | PA; QL (0.072 ml per day.); SP |
| **OTHER MISCELLANEOUS THERAPEUTIC AGENTS** | | |
| AQNEURSA ORAL PACKET 1 GM (*levacetylleucine*) | 4 | PA; QL (112 packets per month.); SP |
| ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (*rilonacept*) | 2 | PA; QL (4 vials per 21 days.); SP |
| *betaine oral powder* | 2 | SP |
| CARNITOR ORAL SOLUTION 1 GM/10ML (*levocarnitine*) | 3 | |
| CARNITOR ORAL TABLET 330 MG (*levocarnitine*) | 3 | |
| CARNITOR SF ORAL SOLUTION 1 GM/10ML (*levocarnitine*) | 3 | |
| CERDELGA ORAL CAPSULE 84 MG (*eliglustat tartrate*) | 2 | PA; SP |
| COMPLEX ESSENTIAL MSD ORAL POWDER (*nutritional supplements*) | 3 | |
| CYSTADANE ORAL POWDER (*betaine*) | 3 | SP |
| CYSTAGON ORAL CAPSULE 150 MG, 50 MG (*cysteamine bitartrate*) | 2 | SP |
| *dalfampridine er oral tablet extended release 12 hour 10 mg* | 2 | PA; QL (2 tablets per day) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DIABETES MONITOR DIGIT ADD-ON KIT | 3 | QL (1 meter or meter kit per year.) |
| DIABETES MONITOR DIGIT SOLN KIT | 3 | QL (1 meter or meter kit per year.) |
| DUVYZAT ORAL SUSPENSION 8.86 MG/ML (*givinostat hcl*) | 4 | PA; QL (420 mL per month.); SP |
| EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (*prasterone (dhea)*) | 3 | |
| ELMIRON ORAL CAPSULE 100 MG (*pentosan polysulfate sodium*) | 4 | ST |
| ENBRACE HR ORAL CAPSULE (*prenat vit-fe gly cys-fa-omega*) | 3 | |
| ENDARI ORAL PACKET 5 GM (*glutamine (sickle cell)*) | 3 | PA; QL (6 packets per day.) |
| EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*) | 2 | |
| EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (*risdiplam*) | 2 | PA; QL (6.7 ml per day, 1280 ml per 180 days.); SP |
| EVRYSDI ORAL TABLET 5 MG (*risdiplam*) | 2 | PA; QL (30 tablets per month.); SP |
| FILSPARI ORAL TABLET 200 MG, 400 MG (*sparsentan*) | 4 | PA; QL (60 tablets per month.); SP |
| FIRDAPSE ORAL TABLET 10 MG (*amifampridine phosphate*) | 2 | PA; QL (300 tablets per month.); SP |
| FORZINITY SUBCUTANEOUS SOLUTION 280 MG/3.5ML (*elamipretide hcl*) | 4 | PA; QL (4 vials (14 ml) per month.); SP |
| GALAFOLD ORAL CAPSULE 123 MG (*migalastat hcl*) | 3 | PA; QL (14 capsules per 21 days.); SP |
| ISTURISA ORAL TABLET 1 MG (*osilodrostat phosphate*) | 4 | PA; QL (8 tablets per day.); SP |
| ISTURISA ORAL TABLET 5 MG (*osilodrostat phosphate*) | 4 | PA; QL (372 tablets per month.); SP |
| KYGEVVI ORAL PACKET 2-2 GM (*doxecitine-doxribtimine*) | 4 | PA; QL (558 packets per month.); SP |
| *levocarnitine oral solution 1 gm/10ml* | 1 | |
| *levocarnitine oral tablet 330 mg* | 1 | |
| *levocarnitine sf oral solution 1 gm/10ml* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *l-glutamine oral packet 5 gm* | 3 | PA; QL (6 packets per day.) |
| LODOCO ORAL TABLET 0.5 MG (*colchicine*) | 3 | QL (1 tablet per day.) |
| *me/naphos/mb/hyo1 oral tablet 81.6 mg* | 1 | |
| *metyrosine oral capsule 250 mg* | 3 | PA |
| *miglustat oral capsule 100 mg* | 2 | |
| NESTABS ONE ORAL CAPSULE 38-1-225 MG (*prenat-fe-methylfol-dha w/o a*) | 3 | |
| OPFOLDA ORAL CAPSULE 65 MG (*miglustat (gaa deficiency)*) | 2 | PA; QL (8 capsules per 21 days.); SP |
| ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (*nitisinone*) | 4 | PA; SP |
| ORFADIN ORAL SUSPENSION 4 MG/ML (*nitisinone*) | 4 | PA; SP |
| PREMESISRX ORAL TABLET 1 MG (*prenatal ca-b6-b12-fa-ginger*) | 3 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (*prenat-fecbn-feasp-meth-fa-dha*) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (*darunavir-cobicistat*) | 2 | |
| PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (*cysteamine bitartrate*) | 4 | PA; ST; SP |
| PROCYSBI ORAL PACKET 300 MG, 75 MG (*cysteamine bitartrate*) | 3 | SP |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| REZUROCK ORAL TABLET 200 MG (*belumosudil mesylate*) | 3 | PA; QL (1 tablet per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (*nedosiran sodium*) | 4 | PA; QL (0.04 ml per day.); SP |
| RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (*nedosiran sodium*) | 4 | PA; QL (0.03 ml per day.); SP |
| RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*nedosiran sodium*) | 4 | PA; QL (0.04 ml per day.); SP |
| *sapropterin dihydrochloride oral packet 100 mg* | 2 | PA; QL (16 packets per day.); SP |
| *sapropterin dihydrochloride oral packet 500 mg* | 2 | PA; QL (4 packets per day.); SP |
| *sapropterin dihydrochloride oral tablet 100 mg* | 2 | PA; QL (16 tablets per day); SP |
| SKYCLARYS ORAL CAPSULE 50 MG (*omaveloxolone*) | 2 | PA; QL (3 capsules per day.); SP |
| SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (*palovarotene*) | 4 | PA; QL (1 capsule per day.); SP |
| STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*) | 2 | QL (1 tablet per day.) |
| SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*) | 3 | QL (1 tablet per day.) |
| *tiopronin oral tablet 100 mg* | 2 | SP; CM |
| *tiopronin oral tablet delayed release 100 mg, 300 mg* | 2 | SP; CM |
| TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| URELLE ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| *uretron d/s oral tablet 81.6 mg* | 1 | |
| UROGESIC-BLUE ORAL TABLET 81.6 MG (*methen-hyosc-meth blue-na phos*) | 2 | |
| VIJOICE ORAL PACKET 50 MG (*alpelisib*) | 4 | PA; QL (28 packets (1 carton) per month.); SP |
| VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (*alpelisib*) | 3 | PA; QL (28 tablets (1 blister pack) per month.); SP |
| VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (*alpelisib*) | 3 | PA; QL (56 tablets (2 blister packs) per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VILEVEV MB ORAL TABLET 81 MG (*meth-hyo-m bl-na phos-ph sal*) | 3 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (*prenat-fe poly-methfol-fa-dha*) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (*prenatal mv-min-fe fum-fa-dha*) | 3 | |
| VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*) | 3 | PA; QL (12 capsules per 365 days.); SP |
| VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (*vosoritide*) | 3 | PA; QL (1 vial per day.); SP |
| VYNDAMAX ORAL CAPSULE 61 MG (*tafamidis*) | 2 | PA; QL (1 capsule per day.); SP |
| WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG | 3 | |
| WESNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| *zelvysia oral packet 100 mg* | 2 | PA; QL (589 packets per month.); SP |
| *zelvysia oral packet 500 mg* | 2 | PA; QL (4 packets per day.); SP |
| ZOKINVY ORAL CAPSULE 50 MG (*lonafarnib*) | 2 | PA; QL (5 capsules per day.); SP |
| ZOKINVY ORAL CAPSULE 75 MG (*lonafarnib*) | 2 | PA; QL (1 tablet per day.); SP |
| **PROTECTIVE AGENTS** | | |
| *adapalene-benzoyl peroxide external gel 0.1-2.5 %* | 3 | QL (45 grams per prescription) |
| *dalfampridine er oral tablet extended release 12 hour 10 mg* | 2 | PA; QL (2 tablets per day) |
| *mesna oral tablet 400 mg* | 2 | SP; CM |
| MESNEX ORAL TABLET 400 MG (*mesna*) | 4 | SP; CM |
| **NONHORMONAL CONTRACEPTIVES - Drugs for Women** | | |
| **NONHORMONAL CONTRACEPTIVES - Drugs for Women** | | |
| CAYA VAGINAL DIAPHRAGM (*diaphragm arc-spring*) | 3 | H |
| CONDOMS | 3 | QL (12 condoms per month.); H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DUREX EXTRA SENSITIVE THIN (*condoms latex lubricated*) | 3 | QL (12 condoms per month.); H |
| DUREX EXTRA SENSITIVE THIN DEVICE (*condoms latex lubricated*) | 3 | QL (12 condoms per month.); H |
| DUREX TROPICAL (*condoms latex lubricated*) | 3 | QL (12 condoms per month.); H |
| ENCARE VAGINAL SUPPOSITORY 100 MG (*nonoxynol-9*) | E | H |
| FC2 FEMALE CONDOM (*condoms - female*) | 3 | QL (12 condoms per month.); H |
| FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (*cervical caps*) | 3 | H |
| OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (*diaphragms*) | 3 | H |
| OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (*nonoxynol-9*) | E | H |
| PHEXX VAGINAL GEL 1.8-1-0.4 % (*lactic ac-citric ac-pot bitart*) | 3 | H |
| TODAY SPONGE VAGINAL 1000 MG (*nonoxynol-9*) | E | H |
| TRUE COVER DEVICE | 3 | QL (12 condoms per month.); H |
| VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (*nonoxynol-9*) | E | H |
| VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (*nonoxynol-9*) | E | H |
| WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*) | 2 | H |
| **OXYTOCICS - Drugs for Women** | | |
| **OXYTOCICS - Drugs for Women** | | |
| CERVIDIL VAGINAL INSERT 10 MG (*dinoprostone*) | 3 | |
| METHERGINE ORAL TABLET 0.2 MG (*methylergonovine maleate*) | 3 | QL (28 tablets per year.) |
| *methylergonovine maleate oral tablet 0.2 mg* | 1 | QL (28 tablets per year.) |
| MIFEPREX ORAL TABLET 200 MG (*mifepristone*) | 3 | SM |
| *mifepristone oral tablet 200 mg* | 1 | SM |
| PREPIDIL VAGINAL GEL 0.5 MG/3GM (*dinoprostone*) | 3 | |
| **PHARMACEUTICAL AIDS** | | |
| **PHARMACEUTICAL AIDS** | | |
| PYROGALLIC ACID EXTERNAL OINTMENT 25-2 % | 2 | |
| VERSAPENN (AG) ANHYDROUS TRANSDERMAL GEL (*transdermal base*) | 3 | |
| VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (*transdermal base*) | 3 | |
| **RESPIRATORY TRACT AGENTS** | | |
| **DUAL PHOSPHODIESTERASE INHIBITOR (48:34)** | | |
| OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (*ensifentrine*) | 3 | PA; QL (150 mL per month.) |
| **RESPIRATORY TRACT AGENTS - Drugs for the Lungs** | | |
| **ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD** | | |
| ADRENALIN NASAL SOLUTION 0.1 % (*epinephrine hcl (nasal)*) | 2 | |
| AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (*epinephrine*) | 2 | QL (2 pens per prescription.) |
| AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (*epinephrine*) | 2 | QL (2 injections per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml* | 1 | QL (2 injections per prescription.) |
| *epinephrine injection solution auto-injector 0.15 mg/0.3ml* | 1 | QL (4 injections per prescription.) |
| EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML | 2 | |
| EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*) | 3 | QL (2 injections per prescription.) |
| **ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD** | | |
| *atropine sulfate ophthalmic solution 1 %* | 1 | |
| ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*) | 3 | QL (0.87 grams per day.) |
| COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*) | 3 | QL (0.28 grams per day.) |
| DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (*aclidinium br-formoterol fum*) | 3 | QL (0.04 mcg per day.) |
| *hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg* | 1 | |
| *hyoscyamine sulfate oral elixir 0.125 mg/5ml* | 1 | |
| *hyoscyamine sulfate oral solution 0.125 mg/ml* | 1 | |
| *hyoscyamine sulfate oral tablet 0.125 mg* | 1 | |
| *hyoscyamine sulfate oral tablet dispersible 0.125 mg* | 1 | |
| *hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyoscyamine sulfate sublingual tablet sublingual 0.125 mg* | 1 | |
| *hyosyne oral elixir 0.125 mg/5ml* | 1 | |
| *hyosyne oral solution 0.125 mg/ml* | 1 | |
| *ipratropium bromide hfa inhalation aerosol solution 17 mcg/act* | 3 | QL (0.87 grams per day.) |
| *ipratropium bromide inhalation solution 0.02 %* | 1 | |
| *ipratropium bromide nasal solution 0.03 %, 0.06 %* | 1 | |
| *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml* | 2 | |
| LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (*hyoscyamine sulfate*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| LEVSIN ORAL TABLET 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| NULEV ORAL TABLET DISPERSIBLE 0.125 MG (*hyoscyamine sulfate*) | 3 | |
| OSCIMIN ORAL TABLET 0.125 MG | 3 | |
| OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG | 3 | |
| SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide*) | 2 | QL (1 capsule per day) |
| SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide*) | 2 | QL (0.15 grams per day.) |
| YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (*revefenacin*) | 3 | PA; QL (3 ml per day.) |
| **ANTIFIBROTIC AGENTS - Drugs for the Lungs** | | |
| JASCAYD ORAL TABLET 18 MG, 9 MG (*nerandomilast*) | 4 | PA; QL (60 tablets per month.); SP |
| *nintedanib esylate oral capsule 100 mg, 150 mg* | 3 | PA; QL (2 capsules per day.); SP |
| *pirfenidone oral capsule 267 mg* | 2 | PA; QL (9 capsules per day.); SP |
| *pirfenidone oral tablet 267 mg* | 2 | PA; QL (9 tablets per day.); SP |
| *pirfenidone oral tablet 534 mg* | 2 | PA; QL (3 tablets per day.) |
| *pirfenidone oral tablet 801 mg* | 2 | PA; QL (3 tablets per day.); SP |
| **ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation** | | |
| BRINSUPRI ORAL TABLET 10 MG, 25 MG (*brensocatib*) | 4 | PA; QL (31 tablets per month.); SP |
| NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mepolizumab*) | 4 | PA; QL (0.04 mL per day.); SP |
| NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mepolizumab*) | 4 | PA; QL (0.04 mL per day.); SP |
| NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (*mepolizumab*) | 4 | PA; QL (0.015 ml per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ANTITUSSIVES - Drugs for Cough and Cold** | | |
| *benzonatate oral capsule 100 mg, 200 mg* | 1 | |
| *codeine sulfate oral tablet 15 mg, 30 mg, 60 mg* | 1 | NTT |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| *guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml* | 1 | |
| *hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml* | 3 | PA; QL (360 ml per month.) |
| *hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml* | 1 | PA; QL (120 mL per prescription and 360 ml per month.) |
| *hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg* | 1 | PA |
| *maxi-tuss ac oral solution 100-10 mg/5ml* | 1 | |
| NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (*phenylephrine-chlorphen-dm*) | 3 | |
| *promethazine-codeine oral solution 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-codeine oral syrup 6.25-10 mg/5ml* | 1 | PA; QL (360 ml per month.) |
| *promethazine-dm oral syrup 6.25-15 mg/5ml* | 1 | |
| *pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml* | 1 | |
| TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*) | 3 | PA; QL (10 tablets per prescription and 30 tablets per month.) |
| **CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation** | | |
| ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*) | 3 | QL (0.4 grams per day.) |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 blister per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 packet per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*) | 3 | QL (2 blisters per day.) |
| *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml* | 2 | QL (120 ml (2 boxes) per 30 days.) |
| *budesonide inhalation suspension 1 mg/2ml* | 2 | QL (60 ml (1 box) per 30 days.) |
| *flunisolide nasal solution 25 mcg/act (0.025%)* | 3 | |
| *fluticasone propionate nasal suspension 50 mcg/act* | 2 | |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT | 2 | QL (0.04 mcg per day.) |
| *mometasone furoate external cream 0.1 %* | 1 | |
| *mometasone furoate external ointment 0.1 %* | 1 | |
| *mometasone furoate external solution 0.1 %* | 1 | |
| *mometasone furoate nasal suspension 50 mcg/act* | 3 | QL (34 grams (2 bottles) per copay.) |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (10.6 grams per month.) |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (42.4 grams per month.) |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*) | 3 | QL (2 blisters per day.) |
| *wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (2 blisters per day.) |
| **CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs** | | |
| ALYFTREK ORAL TABLET 10-50-125 MG (*vanzacaft-tezacaft-deutivacaft*) | 4 | PA; QL (56 tablets per month.); SP |
| ALYFTREK ORAL TABLET 4-20-50 MG (*vanzacaft-tezacaft-deutivacaft*) | 4 | PA; QL (84 tablets per month.); SP |
| ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (728 packets per 356 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ORKAMBI ORAL PACKET 75-94 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (2 packets per day and 56 packets per 21 days.) |
| ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (1456 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (*tezacaftor-ivacaftor*) | 2 | PA; QL (56 tablets per month. 728 tablets per 365 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (*tezacaftor-ivacaftor*) | 2 | PA; QL (56 tablets per month. 728 tablets per 365 days.) |
| TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.); SP |
| TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (3 tablets per day. 1092 tablets per 364 days.); SP |
| TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (2 packets per day. 728 packets per 356 days.); SP |
| **CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs** | | |
| ALYFTREK ORAL TABLET 10-50-125 MG (*vanzacaft-tezacaft-deutivacaft*) | 4 | PA; QL (56 tablets per month.); SP |
| ALYFTREK ORAL TABLET 4-20-50 MG (*vanzacaft-tezacaft-deutivacaft*) | 4 | PA; QL (84 tablets per month.); SP |
| KALYDECO ORAL PACKET 13.4 MG (*ivacaftor*) | 2 | PA; QL (2 packets per day. 728 packets per 356 days.) |
| KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (*ivacaftor*) | 2 | PA; QL (728 packets per 356 days.); SP |
| KALYDECO ORAL PACKET 5.8 MG (*ivacaftor*) | 2 | PA; QL (2 packets per day and 728 packets per 365 days.) |
| KALYDECO ORAL TABLET 150 MG (*ivacaftor*) | 2 | PA; QL (780 tablets per 356 days.); SP |
| ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (728 packets per 356 days.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ORKAMBI ORAL PACKET 75-94 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (2 packets per day and 56 packets per 21 days.) |
| ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (*lumacaftor-ivacaftor*) | 2 | PA; QL (1456 tablets per 356 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (*tezacaftor-ivacaftor*) | 2 | PA; QL (56 tablets per month. 728 tablets per 365 days.); SP |
| SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (*tezacaftor-ivacaftor*) | 2 | PA; QL (56 tablets per month. 728 tablets per 365 days.) |
| TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.); SP |
| TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (3 tablets per day. 1092 tablets per 364 days.); SP |
| TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (*elexacaftor-tezacaftor-ivacaft*) | 2 | PA; QL (2 packets per day. 728 packets per 356 days.); SP |
| **ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs** | | |
| *ambrisentan oral tablet 10 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP |
| *bosentan oral tablet 125 mg, 62.5 mg* | 2 | PA; QL (2 tablets per day.); SP |
| *bosentan oral tablet soluble 32 mg* | 2 | PA; QL (4 tablets per day.); SP |
| FILSPARI ORAL TABLET 200 MG, 400 MG (*sparsentan*) | 4 | PA; QL (60 tablets per month.); SP |
| *macitentan oral tablet 10 mg* | 2 | PA; QL (1 tablet per day.); SP |
| TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*) | 4 | PA; QL (4 tablets per day.); SP |
| TRYVIO ORAL TABLET 12.5 MG (*aprocitentan*) | 4 | PA; QL (1 tablet per day.) |
| VANRAFIA ORAL TABLET 0.75 MG (*atrasentan hcl*) | 4 | PA; QL (30 tablets per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **EXPECTORANTS - Drugs for the Lungs** | | |
| *guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml* | 1 | |
| *iodine strong oral solution 5 %* | 1 | |
| *maxi-tuss ac oral solution 100-10 mg/5ml* | 1 | |
| *potassium iodide (expectorant) oral solution 1 gm/ml* | 1 | |
| SSKI ORAL SOLUTION 1 GM/ML (*potassium iodide (expectorant)*) | 3 | |
| **FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy** | | |
| *carbinoxamine maleate oral solution 4 mg/5ml* | 1 | |
| *carbinoxamine maleate oral tablet 4 mg* | 1 | |
| CARBZAH ORAL SOLUTION 4 MG/5ML | 2 | |
| *clemastine fumarate oral tablet 2.68 mg* | 1 | |
| CLEMSZA ORAL TABLET 2.68 MG (*clemastine fumarate*) | 3 | |
| *cyproheptadine hcl oral syrup 2 mg/5ml* | 1 | |
| *cyproheptadine hcl oral tablet 4 mg* | 1 | |
| DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (*diphenhydramine hcl*) | 3 | PA |
| *diphenhydramine hcl oral elixir 12.5 mg/5ml* | 1 | |
| *promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml* | 1 | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | 1 | |
| PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (*promethazine hcl*) | 3 | |
| **INTERLEUKIN ANTAGONISTS - Drugs for Inflammation** | | |
| ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (*rilonacept*) | 2 | PA; QL (4 vials per 21 days.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*dupilumab*) | 2 | PA; QL (0.09 ml per day.); SP |
| FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (*benralizumab*) | 4 | PA; QL (1 pen every 2 months.) |
| TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (*tezepelumab-ekko*) | 4 | PA; QL (0.07 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **LEUKOTRIENE MODIFIERS - Drugs for Inflammation** | | |
| *montelukast sodium oral packet 4 mg* | 2 | |
| *montelukast sodium oral tablet 10 mg* | 1 | |
| *montelukast sodium oral tablet chewable 4 mg, 5 mg* | 1 | |
| SINGULAIR ORAL PACKET 4 MG (*montelukast sodium*) | 3 | |
| *zafirlukast oral tablet 10 mg, 20 mg* | 1 | |
| *zileuton er oral tablet extended release 12 hour 600 mg* | 3 | |
| **MAST-CELL STABILIZERS - Drugs for Inflammation** | | |
| *cromolyn sodium inhalation nebulization solution 20 mg/2ml* | 1 | |
| *cromolyn sodium ophthalmic solution 4 %* | 1 | |
| *cromolyn sodium oral concentrate 100 mg/5ml* | 1 | |
| **MUCOLYTIC AGENTS - Drugs for the Lungs** | | |
| *acetylcysteine inhalation solution 10 %, 20 %* | 1 | |
| HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (*sodium chloride*) | 2 | |
| NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (*sodium chloride*) | 3 | |
| PULMOSAL INHALATION NEBULIZATION SOLUTION 7 % (*sodium chloride*) | 2 | |
| PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*) | 2 | PA; QL (5 ml per day.); SP |
| *sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %* | 1 | |
| **NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation** | | |
| *flunisolide nasal solution 25 mcg/act (0.025%)* | 3 | |
| *fluticasone propionate nasal suspension 50 mcg/act* | 2 | |
| *mometasone furoate nasal suspension 50 mcg/act* | 3 | QL (34 grams (2 bottles) per copay.) |
| **NEUTROPHIL SERINE PROTEASE INHIBITORS - Drugs for Inflammation** | | |
| BRINSUPRI ORAL TABLET 10 MG, 25 MG (*brensocatib*) | 4 | PA; QL (31 tablets per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation** | | |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 blister per day.) |
| ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*fluticasone furoate*) | 1 | QL (1 packet per day.) |
| *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml* | 2 | QL (120 ml (2 boxes) per 30 days.) |
| *budesonide inhalation suspension 1 mg/2ml* | 2 | QL (60 ml (1 box) per 30 days.) |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (10.6 grams per month.) |
| QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (*beclomethasone diprop hfa*) | 1 | QL (42.4 grams per month.) |
| **PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs** | | |
| JASCAYD ORAL TABLET 18 MG, 9 MG (*nerandomilast*) | 4 | PA; QL (60 tablets per month.); SP |
| *roflumilast oral tablet 250 mcg* | 2 | QL (31 tablets per year.) |
| *roflumilast oral tablet 500 mcg* | 2 | QL (1 tablet per day) |
| ZORYVE EXTERNAL CREAM 0.05 % (*roflumilast*) | 4 | PA; QL (60 Grams per prescription.) |
| ZORYVE EXTERNAL CREAM 0.15 % (*roflumilast*) | 3 | PA; QL (60 grams per copay.) |
| ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per 30 days.) |
| ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per prescription.) |
| **PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs** | | |
| *alyq oral tablet 20 mg* | 2 | PA; QL (2 tablets per day); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sildenafil citrate oral suspension reconstituted 10 mg/ml* | 3 | PA; QL (186 ml per month.); SP |
| *sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg* | 2 | QL (0.5 tablet per day.) |
| *sildenafil citrate oral tablet 20 mg* | 1 | QL (0.5 tablet per day.); SP |
| *tadalafil (pah) oral tablet 20 mg* | 1 | PA; QL (2 tablets per day); SP |
| *tadalafil oral tablet 10 mg, 20 mg* | 2 | QL (0.5 tablet per day.) |
| *tadalafil oral tablet 2.5 mg, 5 mg* | 2 | QL (1 tablet per day.) |
| TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*) | 3 | PA; QL (10 ml per day.); SP |
| VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (*sildenafil citrate*) | 3 | |
| **PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs** | | |
| ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (168 tablets per year.); SP |
| ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (336 tablets per year.); SP |
| ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*) | 3 | PA; QL (252 tablets per year.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (*treprostinil diolamine*) | 3 | PA; QL (6 tablets per day.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (*treprostinil diolamine*) | 3 | PA; QL (744 tablets per month.); SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (*treprostinil*) | 2 | PA; QL (224 cartidges per month.); SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (*treprostinil*) | 2 | PA; SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (*treprostinil*) | 2 | PA; QL (112 cartridges per month.); SP |
| TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (*treprostinil*) | 2 | PA; QL (252 cartridges per 365 days.); SP |
| TYVASO INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (*treprostinil sodium*) | 2 | PA; QL (140 capsules per month.); SP |
| **RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs** | | |
| BRONCHITOL INHALATION CAPSULE 40 MG (*mannitol (cystic fibrosis)*) | 3 | PA; ST; QL (20 capsules per day.); SP; CM |
| BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (*mannitol (cystic fibrosis)*) | 3 | PA; ST; QL (20 capsules per day.); SP; CM |
| *pirfenidone oral capsule 267 mg* | 2 | PA; QL (9 capsules per day.); SP |
| *pirfenidone oral tablet 267 mg* | 2 | PA; QL (9 tablets per day.); SP |
| *pirfenidone oral tablet 534 mg* | 2 | PA; QL (3 tablets per day.) |
| *pirfenidone oral tablet 801 mg* | 2 | PA; QL (3 tablets per day.); SP |
| TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (*tezepelumab-ekko*) | 4 | PA; QL (0.07 ml per day.); SP |
| WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (*sotatercept-csrk*) | 4 | PA; QL (1 kit every 3 weeks.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*omalizumab*) | 2 | PA; QL (2 auto injectors per month.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*omalizumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (*omalizumab*) | 2 | PA; QL (0.04 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*omalizumab*) | 2 | PA; QL (0.08 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*omalizumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*omalizumab*) | 2 | PA; QL (0.04 ml per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy** | | |
| *azelastine hcl nasal solution 0.1 %, 137 mcg/spray* | 2 | |
| *azelastine hcl ophthalmic solution 0.05 %* | 1 | |
| **SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD** | | |
| AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*) | 3 | QL (10.7 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (1 inhaler per copay.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (1 inhaler per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (18 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (6.7 grams per prescription.) |
| *albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation* | 2 | QL (8.5 grams per prescription.) |
| *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml* | 1 | |
| *albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation* | 1 | |
| ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION | 3 | |
| *albuterol sulfate oral syrup 2 mg/5ml* | 1 | |
| *albuterol sulfate oral tablet 2 mg, 4 mg* | 3 | PA |
| *arformoterol tartrate inhalation nebulization solution 15 mcg/2ml* | 3 | QL (2 nebules per day) |
| *formoterol fumarate inhalation nebulization solution 20 mcg/2ml* | 3 | QL (2 vials per day.) |
| *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml* | 3 | QL (90 ml per prescription.) |
| *levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml* | 3 | QL (30 vials per prescription) |
| LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT | 3 | QL (15 grams per prescription.) |
| PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (*formoterol fumarate*) | 3 | QL (2 vials per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*) | 2 | QL (1 diskus (60 blisters) per month.) |
| STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*) | 2 | QL (0.15 grams per day.) |
| *terbutaline sulfate oral tablet 2.5 mg, 5 mg* | 1 | |
| XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (*levalbuterol tartrate*) | 3 | QL (15 grams per prescription.) |
| **VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs** | | |
| ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*) | 2 | PA; QL (3 tablets per day.); SP |
| *alyq oral tablet 20 mg* | 2 | PA; QL (2 tablets per day); SP |
| *ambrisentan oral tablet 10 mg, 5 mg* | 2 | PA; QL (1 tablet per day.); SP |
| *bosentan oral tablet 125 mg, 62.5 mg* | 2 | PA; QL (2 tablets per day.); SP |
| *bosentan oral tablet soluble 32 mg* | 2 | PA; QL (4 tablets per day.); SP |
| *macitentan oral tablet 10 mg* | 2 | PA; QL (1 tablet per day.); SP |
| ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (168 tablets per year.); SP |
| ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*) | 3 | PA; QL (336 tablets per year.); SP |
| ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*) | 3 | PA; QL (252 tablets per year.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (*treprostinil diolamine*) | 3 | PA; QL (6 tablets per day.); SP |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (*treprostinil diolamine*) | 3 | PA; QL (744 tablets per month.); SP |
| *sildenafil citrate oral suspension reconstituted 10 mg/ml* | 3 | PA; QL (186 ml per month.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg* | 2 | QL (0.5 tablet per day.) |
| *sildenafil citrate oral tablet 20 mg* | 1 | QL (0.5 tablet per day.); SP |
| *tadalafil (pah) oral tablet 20 mg* | 1 | PA; QL (2 tablets per day); SP |
| TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*) | 3 | PA; QL (10 ml per day.); SP |
| TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*) | 4 | PA; QL (4 tablets per day.); SP |
| TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (*treprostinil*) | 2 | PA; QL (112 cartridges per month.); SP |
| TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (*treprostinil*) | 2 | PA; QL (252 cartridges per 365 days.); SP |
| TYVASO INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*) | 2 | PA; SP |
| UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*) | 3 | PA; QL (2 tablets per day.); SP |
| UPTRAVI TABLET 200 MCG ORAL (*selexipag*) | 3 | PA; QL (140 tablets per 365 days.); SP |
| UPTRAVI TABLET 200 MCG ORAL (*selexipag*) | 3 | PA; QL (2 tablets per day.); SP |
| UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*) | 3 | PA; QL (200 tablets per year.); SP |
| **VASODILATING AGENTS, MISC (48:48) - Drugs for the Lungs** | | |
| ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*) | 2 | PA; QL (3 tablets per day.); SP |
| UPTRAVI ORAL TABLET 100 MCG, 150 MCG (*selexipag*) | 3 | PA |
| UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*) | 3 | PA; QL (2 tablets per day.); SP |
| UPTRAVI TABLET 200 MCG ORAL (*selexipag*) | 3 | PA; QL (140 tablets per 365 days.); SP |
| UPTRAVI TABLET 200 MCG ORAL (*selexipag*) | 3 | PA; QL (2 tablets per day.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*) | 3 | PA; QL (200 tablets per year.); SP |
| **XANTHINE DERIVATIVES - Drugs for Asthma/COPD** | | |
| *elixophyllin oral elixir 80 mg/15ml* | 3 | |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*) | 3 | |
| *theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg* | 1 | |
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | 1 | |
| *theophylline oral elixir 80 mg/15ml* | 1 | |
| *theophylline oral solution 80 mg/15ml* | 1 | |
| **SKIN AND MUCOUS MEMBRANE AGENTS** | | |
| **ANTIPROLIFERANTS** | | |
| AMELUZ EXTERNAL GEL 10 % (*aminolevulinic acid hcl*) | 3 | |
| *bexarotene external gel 1 %* | 4 | QL (60 grams per prescription.); SP |
| *bexarotene oral capsule 75 mg* | 2 | CM |
| *fluorouracil external cream 5 %* | 1 | |
| *fluorouracil external solution 2 %, 5 %* | 1 | |
| *imiquimod external cream 5 %* | 1 | |
| KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (*tirbanibulin*) | 3 | ST; QL (5 units per prescription) |
| KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (*tirbanibulin*) | 3 | ST; QL (5 units per prescription) |
| LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (*aminolevulinic acid hcl*) | 3 | |
| PANRETIN EXTERNAL GEL 0.1 % (*alitretinoin*) | 3 | |
| VALCHLOR EXTERNAL GEL 0.016 % (*mechlorethamine hcl (topical)*) | 2 | PA; QL (120 grams per prescription.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin** | | |
| **ADRENERGIC AGONISTS - Drugs for the Skin** | | |
| ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (*brimonidine tartrate*) | 2 | QL (10 ml per prescription) |
| ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (*brimonidine tartrate*) | 3 | QL (10 ml per prescription) |
| *brimonidine tartrate external gel 0.33 %* | 3 | PA; QL (30 grams per prescription.) |
| *brimonidine tartrate ophthalmic solution 0.15 %* | 2 | QL (10 ml per prescription) |
| *brimonidine tartrate ophthalmic solution 0.2 %* | 1 | |
| COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (*brimonidine tartrate-timolol*) | 2 | QL (5 ml per prescription) |
| MIRVASO EXTERNAL GEL 0.33 % (*brimonidine tartrate*) | 2 | PA; QL (30 grams per prescription.) |
| *oxymetazoline hcl external cream 1 %* | 3 | PA; QL (30 grams per prescription.) |
| RHOFADE EXTERNAL CREAM 1 % (*oxymetazoline hcl*) | 3 | PA; QL (30 grams per prescription.) |
| **ANTIBACTERIALS (84:04) - Drugs for the Skin** | | |
| AMZEEQ EXTERNAL FOAM 4 % (*minocycline hcl micronized*) | 3 | QL (30 grams per prescription.) |
| AVAR CLEANSER EXTERNAL LIQUID 10-5 % (*sulfacetamide sodium-sulfur*) | 3 | |
| AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (*sulfacetamide sodium-sulfur*) | 3 | |
| AVIDOXY ORAL TABLET 100 MG | 3 | |
| *azelaic acid external gel 15 %* | 3 | |
| AZELEX EXTERNAL CREAM 20 % (*azelaic acid*) | 3 | QL (30 grams per prescription.) |
| *bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm* | 1 | |
| *bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %* | 1 | |
| BENZAMYCIN EXTERNAL GEL 5-3 % (*benzoyl peroxide-erythromycin*) | 2 | QL (23.3 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *benzoyl peroxide-erythromycin external gel 5-3 %* | 1 | QL (23.3 grams per prescription.) |
| *bp 10-1 external emulsion 10-1 %* | 1 | |
| CLEOCIN ORAL CAPSULE 150 MG, 300 MG (*clindamycin hcl*) | 3 | |
| CLEOCIN ORAL CAPSULE 75 MG (*clindamycin hcl*) | 2 | |
| CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (*clindamycin palmitate hcl*) | 3 | |
| CLEOCIN VAGINAL CREAM 2 % (*clindamycin phosphate*) | 3 | |
| CLEOCIN VAGINAL SUPPOSITORY 100 MG (*clindamycin phosphate*) | 2 | |
| CLEOCIN-T EXTERNAL LOTION 1 % (*clindamycin phosphate*) | 3 | |
| *clindacin etz external swab 1 %* | 1 | |
| *clindacin external foam 1 %* | 3 | |
| *clindacin-p external swab 1 %* | 1 | |
| *clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg* | 1 | |
| *clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml* | 2 | |
| *clindamycin phos (twice-daily) external gel 1 %* | 2 | QL (75 grams per prescription.) |
| *clindamycin phos-benzoyl perox external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| *clindamycin phosphate external foam 1 %* | 3 | |
| *clindamycin phosphate external lotion 1 %* | 3 | |
| *clindamycin phosphate external solution 1 %* | 1 | |
| *clindamycin phosphate external swab 1 %* | 1 | |
| *clindamycin phosphate vaginal cream 2 %* | 2 | |
| CLINDESSE VAGINAL CREAM 2 % (*clindamycin phosphate (1 dose)*) | 2 | |
| CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (*clindamycin-tretinoin-cholesty*) | 3 | PA |
| *dapsone external gel 5 %, 7.5 %* | 3 | QL (60 grams per prescription.) |
| *dapsone oral tablet 100 mg, 25 mg* | 2 | |
| *doxycycline hyclate oral capsule 100 mg, 50 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *doxycycline hyclate oral tablet 100 mg* | 2 | |
| *doxycycline hyclate oral tablet 20 mg* | 1 | |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | 1 | |
| *doxycycline monohydrate oral suspension reconstituted 25 mg/5ml* | 3 | |
| *doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg* | 1 | |
| ERY EXTERNAL PAD 2 % | 3 | |
| *erythromycin external gel 2 %* | 1 | |
| *erythromycin external solution 2 %* | 1 | |
| FINACEA EXTERNAL FOAM 15 % (*azelaic acid*) | 3 | |
| *gentamicin sulfate external cream 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate external ointment 0.1 %* | 1 | QL (30 grams per prescription.) |
| *gentamicin sulfate ophthalmic solution 0.3 %* | 1 | QL (15 ml per prescription.) |
| KLARON EXTERNAL LOTION 10 % (*sulfacetamide sodium (acne)*) | 3 | |
| *levofloxacin oral solution 25 mg/ml* | 1 | |
| *levofloxacin oral tablet 250 mg, 500 mg, 750 mg* | 1 | |
| LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*) | 3 | |
| *metronidazole external cream 0.75 %* | 1 | |
| *metronidazole external gel 0.75 %* | 1 | |
| *metronidazole external lotion 0.75 %* | 1 | |
| *metronidazole oral capsule 375 mg* | 1 | |
| *metronidazole oral tablet 250 mg, 500 mg* | 1 | |
| *metronidazole vaginal gel 0.75 %* | 2 | |
| *minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg* | 2 | |
| *minocycline hcl oral capsule 100 mg, 50 mg, 75 mg* | 1 | |
| *moxifloxacin hcl oral tablet 400 mg* | 3 | |
| *mupirocin calcium external cream 2 %* | 3 | QL (15 grams per prescription) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *mupirocin external ointment 2 %* | 1 | QL (22 grams per prescription.) |
| *neomycin sulfate oral tablet 500 mg* | 1 | |
| *neuac external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| *polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%* | 1 | |
| *sodium sulfacetamide external shampoo 10 %* | 1 | |
| *sodium sulfacetamide wash external liquid 10 %* | 1 | |
| *sss 10-5 external cream 10-5 %* | 1 | |
| *sulfacetamide sodium (acne) external lotion 10 %* | 1 | |
| *sulfacetamide sodium (cleans) external gel 10 %* | 1 | |
| *sulfacetamide sodium external liquid 10 %* | 1 | |
| *sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %* | 1 | |
| *sulfacetamide sodium-sulfur external emulsion 10-1 %* | 1 | |
| *sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %* | 1 | |
| *sulfacetamide sodium-sulfur external lotion 10-5 %* | 1 | |
| *sulfacetamide sodium-sulfur external suspension 10-5 %* | 1 | |
| *sulfacetamide sod-sulfur wash external liquid 9-4 %* | 1 | |
| *sulfacetamide-sulfur in urea external emulsion 10-5 %* | 1 | |
| SULFAMYLON EXTERNAL CREAM 85 MG/GM (*mafenide acetate*) | 3 | |
| SUMAXIN EXTERNAL PAD 10-4 % (*sulfacetamide sodium-sulfur*) | 3 | |
| *tetracycline hcl oral capsule 250 mg, 500 mg* | 3 | |
| VANDAZOLE VAGINAL GEL 0.75 % (*metronidazole*) | 3 | |
| XACIATO VAGINAL GEL 2 % (*clindamycin phosphate*) | 2 | QL (1 gel tube (8 grams) per prescription.) |
| XEPI EXTERNAL CREAM 1 % (*ozenoxacin*) | 3 | |
| ZILXI EXTERNAL FOAM 1.5 % (*minocycline hcl micronized*) | 3 | PA; ST; QL (30 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin** | | |
| EXODERM EXTERNAL LOTION 25-1 % (*sod thiosulfate-salicylic acd*) | 3 | |
| **ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin** | | |
| EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*) | 3 | ST; QL (60 grams per prescription.) |
| VTAMA EXTERNAL CREAM 1 % (*tapinarof*) | 3 | PA; QL (60 grams per prescription.) |
| **ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin** | | |
| ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANALPRAM HC EXTERNAL LOTION 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (*hc-pramoxine-chloroxylenol*) | 3 | |
| DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (*lidocaine-benzalkonium (pod)*) | 3 | |
| *doxepin hcl external cream 5 %* | 3 | PA; QL (45 grams per prescription.) |
| *doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | 1 | |
| *doxepin hcl oral concentrate 10 mg/ml* | 1 | |
| DYCLOPRO EXTERNAL SOLUTION 0.5 % | 3 | |
| ENOVARX-LIDOCAINE HCL EXTERNAL CREAM 10 %, 5 % | 3 | PA |
| EPIFOAM EXTERNAL FOAM 1-1 % (*pramoxine-hc*) | 2 | |
| FBL KIT EXTERNAL CREAM 15-4-5 % | 3 | PA |
| FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (*dph-lido-alhydr-mghydr-simeth*) | 3 | PA |
| *glydo external prefilled syringe 2 %* | 1 | |
| *hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %* | 1 | |
| *hydrocort-pramoxine (perianal) external cream 2.5-1 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (*ketoprofen-baclofen-gabap-lido*) | 3 | PA |
| *lidocaine external ointment 5 %* | 2 | QL (1.19 grams per day.) |
| *lidocaine external patch 5 %* | 3 | PA |
| *lidocaine hcl external solution 4 %* | 1 | |
| *lidocaine hcl urethral/mucosal external gel 2 %* | 1 | |
| *lidocaine hcl urethral/mucosal external prefilled syringe 2 %* | 1 | |
| *lidocaine-prilocaine external cream 2.5-2.5 %* | 1 | |
| LIDOPIN EXTERNAL CREAM 3.25 % | 3 | |
| LIDTOPIC MAX EXTERNAL CREAM 10 % (*lidocaine*) | 3 | PA |
| *phenazopyridine hcl oral tablet 100 mg, 200 mg* | 1 | |
| PRAMOSONE EXTERNAL CREAM 1-1 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-1 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (*pramoxine-hc*) | 3 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*) | 2 | |
| PYRIDIUM ORAL TABLET 100 MG, 200 MG (*phenazopyridine hcl*) | 3 | |
| VP GKL KIT EXTERNAL CREAM 20-2-10 % | 3 | PA |
| ZTLIDO EXTERNAL PATCH 1.8 % (*lidocaine*) | 3 | PA; QL (3 patches per day.) |
| **ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| *acyclovir external ointment 5 %* | 3 | |
| *acyclovir oral capsule 200 mg* | 1 | |
| *acyclovir oral suspension 200 mg/5ml* | 1 | |
| *acyclovir oral tablet 400 mg, 800 mg* | 1 | |
| ZELSUVMI EXTERNAL GEL 10.3 % (*berdazimer sodium*) | 4 | QL (31 grams (1 box) per copay) |
| **ASTRINGENTS (84:12) - Drugs for the Skin** | | |
| BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*) | 2 | QL (0.36 grams per day.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CUVPOSA ORAL SOLUTION 1 MG/5ML (*glycopyrrolate*) | 3 | |
| DRYSOL EXTERNAL SOLUTION 20 % (*aluminum chloride*) | 3 | |
| *glycopyrrolate oral solution 1 mg/5ml* | 3 | |
| *glycopyrrolate oral tablet 1 mg, 2 mg* | 1 | |
| **ASTRINGENTS, ANTI-INFECTIVE - Drugs for the Skin** | | |
| *benzalkonium chloride external solution* | 2 | |
| *benzalkonium chloride external solution 50 %* | 1 | |
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | 1 | |
| *hydrocortisone-iodoquinol external cream 1-1 %* | 1 | |
| *iodine strong oral solution 5 %* | 1 | |
| *iodine tincture external tincture 2 %* | 1 | |
| LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 % | 3 | |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (*chlorhexidine gluconate*) | 3 | |
| *periogard mouth/throat solution 0.12 %* | 1 | |
| *selenium sulfide external lotion 2.5 %* | 1 | |
| SILVADENE EXTERNAL CREAM 1 % (*silver sulfadiazine*) | 3 | |
| *silver sulfadiazine external cream 1 %* | 1 | |
| *ssd external cream 1 %* | 1 | |
| **AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| *clotrimazole mouth/throat troche 10 mg* | 1 | |
| *clotrimazole-betamethasone external cream 1-0.05 %* | 1 | |
| *clotrimazole-betamethasone external lotion 1-0.05 %* | 1 | |
| *econazole nitrate external cream 1 %* | 2 | |
| EXELDERM EXTERNAL CREAM 1 % (*sulconazole nitrate*) | 3 | |
| EXELDERM EXTERNAL SOLUTION 1 % (*sulconazole nitrate*) | 3 | |
| GYNAZOLE-1 VAGINAL CREAM 2 % (*butoconazole nitrate (1 dose)*) | 3 | |
| JUBLIA EXTERNAL SOLUTION 10 % (*efinaconazole*) | 3 | PA; ST; QL (4 ml per month.) |
| *ketoconazole external cream 2 %* | 1 | QL (30 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *ketoconazole external foam 2 %* | 3 | ST |
| *ketoconazole external shampoo 2 %* | 1 | |
| *ketodan external foam 2 %* | 3 | ST |
| *miconazole 3 vaginal suppository 200 mg* | 1 | |
| ORAVIG BUCCAL TABLET 50 MG (*miconazole*) | 3 | |
| *oxiconazole nitrate external cream 1 %* | 3 | QL (30 grams per prescription.) |
| SULCONAZOLE NITRATE EXTERNAL CREAM 1 % | 3 | |
| SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 % | 3 | |
| *terconazole vaginal cream 0.4 %, 0.8 %* | 1 | |
| *terconazole vaginal suppository 80 mg* | 1 | |
| **BASIC LOTIONS AND LINIMENTS - Drugs for the Skin** | | |
| GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (*salicylic acid-lactic acid*) | 2 | |
| *methyl salicylate external liquid* | 1 | |
| PRONAL EXTERNAL GEL 40-10 % (*urea-lactic acid*) | 3 | |
| SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (*salicylic acid-urea in lactac*) | 3 | |
| *turpentine external spirit* | 1 | |
| VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID | 3 | |
| XIRUN EXTERNAL GEL 40-10 % | 3 | |
| ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (*benzoyl peroxide-hyaluronate*) | 3 | |
| **BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin** | | |
| ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (*fibrin sealant component*) | 3 | |
| *calcipotriene external cream 0.005 %* | 2 | QL (60 grams per prescription) |
| *calcipotriene external ointment 0.005 %* | 2 | |
| *calcipotriene external solution 0.005 %* | 1 | QL (60 mL per prescription) |
| CALCITRENE EXTERNAL OINTMENT 0.005 % (*calcipotriene*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| *nitroglycerin rectal ointment 0.4 %* | 3 | QL (30 grams per month.) |
| RECTIV RECTAL OINTMENT 0.4 % (*nitroglycerin*) | 3 | QL (30 grams per month.) |
| SANTYL EXTERNAL OINTMENT 250 UNIT/GM (*collagenase*) | 3 | QL (90 grams per prescription.) |
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (*fibrin sealant component*) | 3 | |
| VTAMA EXTERNAL CREAM 1 % (*tapinarof*) | 3 | PA; QL (60 grams per prescription.) |
| **BASIC POWDERS AND DEMULCENTS - Drugs for the Skin** | | |
| *benzoin external tincture* | 1 | |
| **CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin** | | |
| CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (*clindamycin-tretinoin-cholesty*) | 3 | PA |
| *finasteride oral tablet 5 mg* | 1 | |
| *minoxidil oral tablet 10 mg, 2.5 mg* | 1 | |
| *tretinoin external cream 0.025 %, 0.05 %, 0.1 %* | 3 | QL (20 grams per prescription.) |
| *tretinoin oral capsule 10 mg* | 2 | QL (279 capsules per prescription.); SP; CM |
| **CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| *alclometasone dipropionate external cream 0.05 %* | 1 | |
| *alclometasone dipropionate external ointment 0.05 %* | 1 | |
| *amcinonide external cream 0.1 %* | 3 | |
| *amcinonide external ointment 0.1 %* | 1 | |
| ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |
| ANALPRAM HC EXTERNAL LOTION 2.5-1 % (*hydrocortisone ace-pramoxine*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| ANUCORT-HC RECTAL SUPPOSITORY 25 MG | 2 | |
| ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| *betamethasone dipropionate aug external cream 0.05 %* | 1 | |
| *betamethasone dipropionate aug external gel 0.05 %* | 1 | |
| *betamethasone dipropionate aug external lotion 0.05 %* | 3 | |
| *betamethasone dipropionate aug external ointment 0.05 %* | 3 | |
| *betamethasone dipropionate external cream 0.05 %* | 2 | |
| *betamethasone dipropionate external lotion 0.05 %* | 1 | |
| *betamethasone dipropionate external ointment 0.05 %* | 2 | |
| *betamethasone valerate external cream 0.1 %* | 1 | |
| *betamethasone valerate external lotion 0.1 %* | 1 | |
| *betamethasone valerate external ointment 0.1 %* | 1 | |
| *budesonide rectal foam 2 mg, 2 mg/act* | 2 | |
| *clobetasol prop emollient base external cream 0.05 %* | 2 | QL (30 grams per prescription.) |
| *clobetasol propionate e external cream 0.05 %* | 2 | QL (30 grams per prescription.) |
| *clobetasol propionate external cream 0.05 %* | 2 | QL (30 grams per prescription.) |
| *clobetasol propionate external gel 0.05 %* | 2 | QL (30 grams per prescription.) |
| *clobetasol propionate external liquid 0.05 %* | 1 | QL (59 ml per prescription) |
| *clobetasol propionate external ointment 0.05 %* | 2 | QL (30 grams per prescription.) |
| *clobetasol propionate external solution 0.05 %* | 1 | QL (25 ml per prescription.) |
| *clocortolone pivalate external cream 0.1 %* | 3 | ST; QL (75 grams per prescription.) |
| *clotrimazole-betamethasone external cream 1-0.05 %* | 1 | |
| *clotrimazole-betamethasone external lotion 1-0.05 %* | 1 | |
| CORDRAN EXTERNAL TAPE 4 MCG/SQCM (*flurandrenolide*) | 3 | QL (1 packet per prescription.) |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (*hc-pramoxine-chloroxylenol*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (*hydrocortisone*) | 3 | |
| CORTENEMA RECTAL ENEMA 100 MG/60ML (*hydrocortisone*) | 3 | |
| CORTIFOAM EXTERNAL FOAM 10 % (*hydrocortisone acetate*) | 2 | |
| DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*) | 3 | QL (118.28 ml per prescription.) |
| DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*) | 3 | |
| DERMOTIC OTIC OIL 0.01 % (*fluocinolone acetonide*) | 3 | |
| *desonide external cream 0.05 %* | 2 | QL (15 grams per prescription.) |
| *desonide external gel 0.05 %* | 3 | ST; QL (60 grams per prescription) |
| *desonide external lotion 0.05 %* | 3 | QL (60 ml per prescription.) |
| *desonide external ointment 0.05 %* | 2 | QL (15 grams per prescription.) |
| *desoximetasone external cream 0.05 %* | 1 | QL (60 gm per prescription.) |
| *desoximetasone external cream 0.25 %* | 1 | QL (15 grams per prescription.) |
| *desoximetasone external gel 0.05 %* | 3 | QL (15 grams per prescription.) |
| *desoximetasone external ointment 0.05 %* | 3 | QL (60 grams per prescription.) |
| *desoximetasone external ointment 0.25 %* | 3 | QL (15 grams per prescription.) |
| *diflorasone diacetate external cream 0.05 %* | 3 | QL (30 grams per prescription.) |
| DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*) | 3 | |
| DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 % | 3 | |
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| EPIFOAM EXTERNAL FOAM 1-1 % (*pramoxine-hc*) | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *fluocinolone acetonide body external oil 0.01 %* | 3 | QL (118.28 ml per prescription.) |
| *fluocinolone acetonide external cream 0.01 %* | 3 | QL (15 grams per prescription.) |
| *fluocinolone acetonide external cream 0.025 %* | 3 | QL (120 grams per copay.) |
| *fluocinolone acetonide external ointment 0.025 %* | 2 | QL (120 grams per copay.) |
| *fluocinolone acetonide external solution 0.01 %* | 1 | |
| *fluocinolone acetonide otic oil 0.01 %* | 1 | |
| *fluocinolone acetonide scalp external oil 0.01 %* | 3 | |
| *fluocinonide emulsified base external cream 0.05 %* | 1 | |
| *fluocinonide external cream 0.05 %* | 1 | |
| *fluocinonide external gel 0.05 %* | 1 | |
| *fluocinonide external ointment 0.05 %* | 1 | |
| *fluocinonide external solution 0.05 %* | 1 | |
| *flurandrenolide external lotion 0.05 %* | 3 | ST; QL (120 ml per prescription.) |
| *fluticasone propionate external cream 0.05 %* | 1 | |
| *fluticasone propionate external lotion 0.05 %* | 3 | ST; QL (60 ml per prescription.) |
| *fluticasone propionate external ointment 0.005 %* | 1 | |
| *halcinonide external cream 0.1 %* | 3 | ST; QL (30 grams per prescription.) |
| *halobetasol propionate external cream 0.05 %* | 2 | QL (15 grams per prescription.) |
| *halobetasol propionate external foam 0.05 %* | 3 | QL (50 grams per prescription.) |
| *halobetasol propionate external ointment 0.05 %* | 2 | QL (15 grams per prescription.) |
| HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (*hydrocortisone acetate*) | 3 | |
| *hydrocortisone (perianal) external cream 2.5 %* | 1 | |
| *hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %* | 1 | |
| *hydrocortisone acetate rectal suppository 25 mg, 30 mg* | 2 | |
| *hydrocortisone butyrate external cream 0.1 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *hydrocortisone butyrate external ointment 0.1 %* | 1 | |
| *hydrocortisone butyrate external solution 0.1 %* | 1 | |
| *hydrocortisone external cream 2.5 %* | 1 | |
| *hydrocortisone external lotion 2.5 %* | 1 | |
| *hydrocortisone external ointment 1 %, 2.5 %* | 1 | |
| *hydrocortisone oral tablet 10 mg, 20 mg, 5 mg* | 1 | |
| *hydrocortisone rectal enema 100 mg/60ml* | 1 | |
| *hydrocortisone valerate external cream 0.2 %* | 2 | QL (15 grams per prescription.) |
| *hydrocortisone valerate external ointment 0.2 %* | 3 | QL (15 grams per prescription.) |
| *hydrocortisone-acetic acid otic solution 1-2 %* | 1 | |
| *hydrocortisone-iodoquinol external cream 1-1 %* | 1 | |
| *hydrocort-pramoxine (perianal) external cream 2.5-1 %* | 1 | |
| KHINDIVI ORAL SOLUTION 1 MG/ML (*hydrocortisone*) | 3 | PA |
| KOURZEQ MOUTH/THROAT PASTE 0.1 % (*triamcinolone acetonide*) | 2 | |
| *mometasone furoate external cream 0.1 %* | 1 | |
| *mometasone furoate external ointment 0.1 %* | 1 | |
| *mometasone furoate external solution 0.1 %* | 1 | |
| NUCORT EXTERNAL LOTION 2 % (*hydrocortisone acetate*) | 3 | |
| *nystatin-triamcinolone external cream 100000-0.1 unit/gm-%* | 2 | |
| *nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%* | 2 | |
| ORALONE MOUTH/THROAT PASTE 0.1 % (*triamcinolone acetonide*) | 2 | |
| PRAMOSONE EXTERNAL CREAM 1-1 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-1 % (*pramoxine-hc*) | 2 | |
| PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (*pramoxine-hc*) | 3 | |
| PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*) | 2 | |
| *procto-med hc external cream 2.5 %* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| PROCTOSOL HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| PROCTOZONE-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*) | 3 | |
| SCALACORT DK EXTERNAL KIT 2 & 2-2 % (*hc & sal acid-sulfur & shampoo*) | 3 | |
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*) | 2 | |
| TOPICORT EXTERNAL OINTMENT 0.05 % (*desoximetasone*) | 3 | QL (60 grams per prescription.) |
| TOPICORT EXTERNAL OINTMENT 0.25 % (*desoximetasone*) | 3 | QL (15 grams per prescription.) |
| *triamcinolone acetonide external aerosol solution 0.147 mg/gm* | 2 | QL (63 grams per prescription.) |
| *triamcinolone acetonide external cream 0.025 %, 0.1 %* | 1 | |
| *triamcinolone acetonide external cream 0.5 %* | 1 | QL (15 grams per prescription.) |
| *triamcinolone acetonide external lotion 0.025 %, 0.1 %* | 1 | |
| *triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %* | 1 | |
| *triamcinolone acetonide mouth/throat paste 0.1 %* | 1 | |
| *triderm external cream 0.5 %* | 1 | QL (15 grams per prescription.) |
| **HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| *ciclodan external solution 8 %* | 1 | |
| *ciclopirox external gel 0.77 %* | 1 | |
| *ciclopirox external shampoo 1 %* | 2 | |
| *ciclopirox external solution 8 %* | 1 | |
| *ciclopirox olamine external cream 0.77 %* | 1 | |
| *ciclopirox olamine external suspension 0.77 %* | 1 | |
| CICLOPIROX TREATMENT EXTERNAL KIT 8 % | 3 | |
| DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 % | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **IMMUNOMODULATORY AGENTS (84:06) - Drugs for the Skin** | | |
| ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*tralokinumab-ldrm*) | 2 | PA; QL (2 auto-injectors per month.); SP |
| ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*tralokinumab-ldrm*) | 2 | PA; QL (0.15 ml per day.); SP |
| BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (1 auto-injector per month.); SP |
| BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (2 ml (1 syringe) per month.); SP |
| BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (1 syringe per month.); SP |
| BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (2 ml (1 syringe) per month.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (*dupilumab*) | 2 | PA; QL (0.09 ml per day.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*dupilumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*dupilumab*) | 2 | PA; QL (0.09 ml per day.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*dupilumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (*lebrikizumab-lbkz*) | 2 | PA; QL (1 pen (2 ml) per month.); SP |
| EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (*lebrikizumab-lbkz*) | 2 | PA; QL (1 pen (2 ml) per month.); SP |
| HYFTOR EXTERNAL GEL 0.2 % (*sirolimus*) | 3 | PA; QL (10 g per 23 days.) |
| ICOTYDE ORAL TABLET 200 MG (*icotrokinra hcl*) | 2 | PA; QL (30 tablets per month.); SP |
| NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (*nemolizumab-ilto*) | 2 | PA; QL (2 pens every 4 weeks.); SP |
| *pimecrolimus external cream 1 %* | 3 | QL (30 grams per prescription.) |
| PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (*tacrolimus*) | 3 | |
| PROGRAF ORAL PACKET 0.2 MG, 1 MG (*tacrolimus*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| RHAPSIDO ORAL TABLET 25 MG (*remibrutinib*) | 2 | PA; QL (60 tablets per month.); SP |
| *sirolimus oral solution 1 mg/ml* | 2 | |
| *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg* | 1 | |
| SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled syringe (150 mg) every 12 weeks.); SP |
| SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled syringe (150 mg) every 12 weeks.); SP |
| SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 55 MG/0.37ML (*risankizumab-rzaa*) | 2 | PA; SP |
| SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*spesolimab-sbzo*) | 4 | PA; QL (2 Prefilled syringes per month.); SP |
| SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*spesolimab-sbzo*) | 4 | PA; QL (1 prefilled syringe per month.); SP |
| *tacrolimus external ointment 0.03 %, 0.1 %* | 2 | QL (30 grams per prescription.) |
| *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg* | 1 | |
| TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 device) every 8 weeks.); SP |
| TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 device) every 8 weeks.); SP |
| TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*) | 2 | PA; QL (2 ml (1 auto-injector) per month.) |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 syringe) every 8 weeks.); SP |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*guselkumab*) | 2 | PA; QL (2 ml (1 syringe) per month.) |
| TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*) | 2 | PA; QL (4 ml (2 pens/1 box) per month.) |
| **JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin** | | |
| ANZUPGO EXTERNAL CREAM 20 MG/GM (*delgocitinib*) | 4 | PA; QL (60 Grams per Month.); SP |
| CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (*ruxolitinib phosphate*) | 2 | PA; QL (2 tablets per day.); SP; CM |
| JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (*ruxolitinib phosphate*) | 2 | PA; SP; CM |
| LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*) | 3 | PA; QL (1 capsule per day.); SP |
| OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*) | 3 | PA; QL (240 grams per prescription and 1200 grams per 365 days.); SP |
| *roflumilast oral tablet 250 mcg* | 2 | QL (31 tablets per year.) |
| *roflumilast oral tablet 500 mcg* | 2 | QL (1 tablet per day) |
| SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*) | 2 | PA; QL (1 tablet per day.); SP |
| ZORYVE EXTERNAL CREAM 0.15 % (*roflumilast*) | 3 | PA; QL (60 grams per copay.) |
| ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per 30 days.) |
| ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per prescription.) |
| **KERATOLYTIC AGENTS - Drugs for the Skin** | | |
| *accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| *acitretin oral capsule 10 mg, 17.5 mg, 25 mg* | 1 | |
| *adapalene-benzoyl peroxide external gel 0.1-2.5 %* | 3 | QL (45 grams per prescription) |
| AKLIEF EXTERNAL CREAM 0.005 % (*trifarotene*) | 3 | PA; QL (45 grams per prescription.) |
| *amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| AVAR CLEANSER EXTERNAL LIQUID 10-5 % (*sulfacetamide sodium-sulfur*) | 3 | |
| AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (*sulfacetamide sodium-sulfur*) | 3 | |
| AVIDOXY DK COMBINATION KIT 100 MG (*doxycycline-suncreen-sal acid*) | 3 | |
| *bp 10-1 external emulsion 10-1 %* | 1 | |
| *claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| CONDYLOX EXTERNAL GEL 0.5 % (*podofilox*) | 3 | |
| DERMACINRX UREA EXTERNAL CREAM 41 % (*urea*) | 3 | |
| DERMACURE EXTERNAL CREAM 41 % (*urea*) | 3 | |
| DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 % | 3 | |
| EXODERM EXTERNAL LOTION 25-1 % (*sod thiosulfate-salicylic acd*) | 3 | |
| GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (*salicylic acid-lactic acid*) | 2 | |
| HYDRO 40 EXTERNAL FOAM 40 % (*urea*) | 3 | |
| *isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| PODOCON-25 EXTERNAL SOLUTION 25 % (*podophyllum resin*) | 3 | |
| *podofilox external gel 0.5 %* | 3 | |
| *podofilox external solution 0.5 %* | 1 | |
| PRONAL EXTERNAL GEL 40-10 % (*urea-lactic acid*) | 3 | |
| PYROGALLIC ACID EXTERNAL OINTMENT 25-2 % | 2 | |
| SALICATE EXTERNAL LIQUID 10 % (*salicylic acid*) | 3 | |
| *salicylic acid external solution 26 %* | 1 | |
| SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (*salicylic acid-urea in lactac*) | 3 | |
| SCALACORT DK EXTERNAL KIT 2 & 2-2 % (*hc & sal acid-sulfur & shampoo*) | 3 | |
| *sss 10-5 external cream 10-5 %* | 1 | |
| *sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %* | 1 | |
| *sulfacetamide sodium-sulfur external emulsion 10-1 %* | 1 | |
| *sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %* | 1 | |
| *sulfacetamide sodium-sulfur external lotion 10-5 %* | 1 | |
| *sulfacetamide sodium-sulfur external suspension 10-5 %* | 1 | |
| *sulfacetamide sod-sulfur wash external liquid 9-4 %* | 1 | |
| *sulfacetamide-sulfur in urea external emulsion 10-5 %* | 1 | |
| SUMAXIN EXTERNAL PAD 10-4 % (*sulfacetamide sodium-sulfur*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *tazarotene external cream 0.05 %, 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| *tazarotene external gel 0.05 %, 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (*tazarotene*) | 3 | PA; QL (30 grams per prescription.) |
| TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (*tazarotene*) | 3 | PA; QL (30 grams per prescription.) |
| *trilitas external gel 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| *urea external cream 20 %, 40 %* | 1 | |
| *urea external cream 41 %* | 3 | |
| *urea external lotion 40 %* | 1 | |
| VEREGEN EXTERNAL OINTMENT 15 % (*sinecatechins*) | 3 | ST; QL (30 grams per prescription.) |
| XIRUN EXTERNAL GEL 40-10 % | 3 | |
| *zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| **KERATOPLASTIC AGENTS - Drugs for the Skin** | | |
| *coal tar external solution 20 %* | 1 | |
| **LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin** | | |
| *adapalene-benzoyl peroxide external gel 0.1-2.5 %* | 3 | QL (45 grams per prescription) |
| *benzalkonium chloride external solution* | 2 | |
| *benzalkonium chloride external solution 50 %* | 1 | |
| BENZAMYCIN EXTERNAL GEL 5-3 % (*benzoyl peroxide-erythromycin*) | 2 | QL (23.3 grams per prescription.) |
| *benzoyl peroxide-erythromycin external gel 5-3 %* | 1 | QL (23.3 grams per prescription.) |
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | 1 | |
| *clindamycin phos-benzoyl perox external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (*hc-pramoxine-chloroxylenol*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (*sulfuric acid-sulf phenolics*) | 2 | |
| DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (*lidocaine-benzalkonium (pod)*) | 3 | |
| FEM PH VAGINAL GEL 0.9-0.025 % (*acetic acid-oxyquinoline*) | 3 | |
| *hydrocortisone-iodoquinol external cream 1-1 %* | 1 | |
| *iodine tincture external tincture 2 %* | 1 | |
| LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 % | 3 | |
| *neuac external gel 1.2-5 %* | 3 | QL (1 bottle (45 grams) per month.) |
| PERIDEX MOUTH/THROAT SOLUTION 0.12 % (*chlorhexidine gluconate*) | 3 | |
| *periogard mouth/throat solution 0.12 %* | 1 | |
| *selenium sulfide external lotion 2.5 %* | 1 | |
| SILVADENE EXTERNAL CREAM 1 % (*silver sulfadiazine*) | 3 | |
| *silver sulfadiazine external cream 1 %* | 1 | |
| *ssd external cream 1 %* | 1 | |
| SULFAMYLON EXTERNAL CREAM 85 MG/GM (*mafenide acetate*) | 3 | |
| ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (*benzoyl peroxide-hyaluronate*) | 3 | |
| ZACLIR CLEANSING EXTERNAL LOTION 8 % | 3 | |
| **NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin** | | |
| *diclofenac sodium external gel 3 %* | 2 | PA; QL (100 grams per prescription.) |
| ENOVARX-IBUPROFEN EXTERNAL CREAM 10 % | 3 | PA |
| ENOVARX-NAPROXEN EXTERNAL CREAM 10 % | 3 | PA |
| FBL KIT EXTERNAL CREAM 15-4-5 % | 3 | PA |
| FROTEK EXTERNAL CREAM 10 % (*ketoprofen*) | 3 | PA |
| K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (*ketoprofen-baclofen-gabap-lido*) | 3 | PA |
| KETORUB EXTERNAL CREAM 10 % (*ketoprofen*) | 3 | PA |
| VP FC KIT EXTERNAL CREAM | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VP GKL KIT EXTERNAL CREAM 20-2-10 % | 3 | PA |
| **OXABOROLES - Drugs for the Skin** | | |
| *tavaborole external solution 5 %* | 3 | PA; ST; QL (10 mL per month.) |
| **PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin** | | |
| EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*) | 3 | ST; QL (60 grams per prescription.) |
| JASCAYD ORAL TABLET 18 MG, 9 MG (*nerandomilast*) | 4 | PA; QL (60 tablets per month.); SP |
| *roflumilast oral tablet 250 mcg* | 2 | QL (31 tablets per year.) |
| *roflumilast oral tablet 500 mcg* | 2 | QL (1 tablet per day) |
| ZORYVE EXTERNAL CREAM 0.05 % (*roflumilast*) | 4 | PA; QL (60 Grams per prescription.) |
| ZORYVE EXTERNAL CREAM 0.15 % (*roflumilast*) | 3 | PA; QL (60 grams per copay.) |
| ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per 30 days.) |
| **PIGMENTING AGENTS - Drugs for the Skin** | | |
| *methoxsalen rapid oral capsule 10 mg* | 1 | |
| **POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin** | | |
| *klayesta external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |
| *nystatin external cream 100000 unit/gm* | 1 | QL (90 grams per prescription.) |
| *nystatin external ointment 100000 unit/gm* | 1 | QL (90 grams per prescription.) |
| *nystatin external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |
| *nystatin mouth/throat suspension 100000 unit/ml* | 1 | |
| *nystatin-triamcinolone external cream 100000-0.1 unit/gm-%* | 2 | |
| *nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%* | 2 | |
| *nystop external powder 100000 unit/gm* | 1 | QL (120 grams per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| **SCABICIDES AND PEDICULICIDES - Drugs for the Skin** | | |
| CROTAN EXTERNAL LOTION 10 % (*crotamiton*) | 3 | |
| EURAX EXTERNAL CREAM 10 % (*crotamiton*) | 2 | |
| *malathion external lotion 0.5 %* | 1 | |
| OVIDE EXTERNAL LOTION 0.5 % (*malathion*) | 3 | |
| *permethrin external cream 5 %* | 1 | |
| PRURADIK EXTERNAL LOTION 10 % (*crotamiton*) | 3 | |
| SOOLANTRA EXTERNAL CREAM 1 % (*ivermectin*) | 3 | QL (45 grams per prescription.) |
| *spinosad external suspension 0.9 %* | 3 | |
| *sulfurated lime external solution* | 1 | |
| **SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin** | | |
| A.A.G.C. KIT IN TERODERM EXTERNAL CREAM 8-4-10-4 % (*amantad-amitrip-gabap-cycloben*) | 3 | PA |
| *accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| *acitretin oral capsule 10 mg, 17.5 mg, 25 mg* | 1 | |
| *adapalene-benzoyl peroxide external gel 0.1-2.5 %* | 3 | QL (45 grams per prescription) |
| ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*tralokinumab-ldrm*) | 2 | PA; QL (0.15 ml per day.); SP |
| AKLIEF EXTERNAL CREAM 0.005 % (*trifarotene*) | 3 | PA; QL (45 grams per prescription.) |
| AMELUZ EXTERNAL GEL 10 % (*aminolevulinic acid hcl*) | 3 | |
| *amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (*fibrin sealant component*) | 3 | |
| *azelaic acid external gel 15 %* | 3 | |
| AZELEX EXTERNAL CREAM 20 % (*azelaic acid*) | 3 | QL (30 grams per prescription.) |
| B & C EXTERNAL OINTMENT | 3 | |
| *balsam peru-castor oil external ointment* | 1 | |
| *bexarotene external gel 1 %* | 4 | QL (60 grams per prescription.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (1 auto-injector per month.); SP |
| BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*) | 4 | PA; ST; QL (1 syringe per month.); SP |
| *brimonidine tartrate external gel 0.33 %* | 3 | PA; QL (30 grams per prescription.) |
| *calcipotriene external cream 0.005 %* | 2 | QL (60 grams per prescription) |
| *calcipotriene external ointment 0.005 %* | 2 | |
| *calcipotriene external solution 0.005 %* | 1 | QL (60 mL per prescription) |
| CALCITRENE EXTERNAL OINTMENT 0.005 % (*calcipotriene*) | 3 | |
| *calcitriol external ointment 3 mcg/gm* | 1 | QL (100 grams per prescription) |
| CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*) | 2 | PA; QL (1 tablet per day.); SP; CM |
| *claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (*clindamycin-tretinoin-cholesty*) | 3 | PA |
| CONDYLOX EXTERNAL GEL 0.5 % (*podofilox*) | 3 | |
| COPASIL EXTERNAL GEL (*scar treatment products*) | 3 | PA |
| COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*secukinumab*) | 2 | PA; QL (0.018 ml per day.); SP |
| COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*) | 2 | PA; QL (0.036 ml per day.); SP |
| COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*) | 2 | PA; QL (0.072 ml per day.); SP |
| *dapsone external gel 5 %, 7.5 %* | 3 | QL (60 grams per prescription.) |
| *dapsone oral tablet 100 mg, 25 mg* | 2 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (*dupilumab*) | 2 | PA; QL (0.09 ml per day.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*dupilumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*dupilumab*) | 2 | PA; QL (0.15 ml per day.); SP |
| ENDARI ORAL PACKET 5 GM (*glutamine (sickle cell)*) | 3 | PA; QL (6 packets per day.) |
| ENOVARX-TRAMADOL EXTERNAL CREAM 5 % | 3 | PA |
| ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| FBL KIT EXTERNAL CREAM 15-4-5 % | 3 | PA |
| FEM PH VAGINAL GEL 0.9-0.025 % (*acetic acid-oxyquinoline*) | 3 | |
| FILSUVEZ EXTERNAL GEL 10 % (*birch triterpenes*) | 4 | PA; QL (14.4 grams per day.); SP |
| FINACEA EXTERNAL FOAM 15 % (*azelaic acid*) | 3 | |
| *fluorouracil external cream 5 %* | 1 | |
| *fluorouracil external solution 2 %, 5 %* | 1 | |
| HALUCORT EXTERNAL GEL (*dermatological products, misc.*) | 3 | PA |
| HYFTOR EXTERNAL GEL 0.2 % (*sirolimus*) | 3 | PA; QL (10 g per 23 days.) |
| *imiquimod external cream 5 %* | 1 | |
| *isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (*ketoprofen-baclofen-gabap-lido*) | 3 | PA |
| KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (*tirbanibulin*) | 3 | ST; QL (5 units per prescription) |
| KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (*tirbanibulin*) | 3 | ST; QL (5 units per prescription) |
| LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (*aminolevulinic acid hcl*) | 3 | |
| *l-glutamine oral packet 5 gm* | 3 | PA; QL (6 packets per day.) |
| LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*) | 3 | PA; QL (1 capsule per day.); SP |
| MEDERMA SPF 30 EXTERNAL CREAM (*scar treatment products*) | 3 | PA |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg* | 2 | |
| MIRVASO EXTERNAL GEL 0.33 % (*brimonidine tartrate*) | 2 | PA; QL (30 grams per prescription.) |
| *nitroglycerin rectal ointment 0.4 %* | 3 | QL (30 grams per month.) |
| OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*) | 3 | PA; QL (240 grams per prescription and 1200 grams per 365 days.); SP |
| OTEZLA ORAL TABLET 20 MG (*apremilast*) | 2 | PA; QL (60 tablets per month.) |
| OTEZLA ORAL TABLET 30 MG (*apremilast*) | 4 | PA; QL (2 tablets per day.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*) | 2 | PA; QL (55 tablets (one starter pack) per year.); SP |
| OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (*apremilast*) | 2 | PA; QL (1 starter pack per year.) |
| *oxymetazoline hcl external cream 1 %* | 3 | PA; QL (30 grams per prescription.) |
| PANRETIN EXTERNAL GEL 0.1 % (*alitretinoin*) | 3 | |
| *pimecrolimus external cream 1 %* | 3 | QL (30 grams per prescription.) |
| PODOCON-25 EXTERNAL SOLUTION 25 % (*podophyllum resin*) | 3 | |
| *podofilox external gel 0.5 %* | 3 | |
| *podofilox external solution 0.5 %* | 1 | |
| PYROGALLIC ACID EXTERNAL OINTMENT 25-2 % | 2 | |
| RECTIV RECTAL OINTMENT 0.4 % (*nitroglycerin*) | 3 | QL (30 grams per month.) |
| RHOFADE EXTERNAL CREAM 1 % (*oxymetazoline hcl*) | 3 | PA; QL (30 grams per prescription.) |
| SANTYL EXTERNAL OINTMENT 250 UNIT/GM (*collagenase*) | 3 | QL (90 grams per prescription.) |
| SCARCIN EXTERNAL CREAM | 3 | PA |
| SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled syringe (150 mg) every 12 weeks.); SP |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*risankizumab-rzaa*) | 2 | PA; QL (1 prefilled syringe (150 mg) every 12 weeks.); SP |
| SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*) | 2 | PA; QL (1 tablet per day.); SP |
| TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (*calcipotriene-betameth diprop*) | 3 | QL (60 grams per prescription.) |
| *tacrolimus external ointment 0.03 %, 0.1 %* | 2 | QL (30 grams per prescription.) |
| *tazarotene external cream 0.05 %, 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| *tazarotene external gel 0.05 %, 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (*tazarotene*) | 3 | PA; QL (30 grams per prescription.) |
| TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (*tazarotene*) | 3 | PA; QL (30 grams per prescription.) |
| TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (*fibrin sealant component*) | 3 | |
| TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 device) every 8 weeks.); SP |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*) | 2 | PA; QL (1 mL (1 syringe) every 8 weeks.); SP |
| *trilitas external gel 0.1 %* | 3 | PA; QL (30 grams per prescription.) |
| VALCHLOR EXTERNAL GEL 0.016 % (*mechlorethamine hcl (topical)*) | 2 | PA; QL (120 grams per prescription.); SP |
| VENELEX EXTERNAL OINTMENT (*balsam peru-castor oil*) | 3 | |
| VEREGEN EXTERNAL OINTMENT 15 % (*sinecatechins*) | 3 | ST; QL (30 grams per prescription.) |
| VP FC KIT EXTERNAL CREAM | 3 | PA |
| VP GKL KIT EXTERNAL CREAM 20-2-10 % | 3 | PA |
| VTAMA EXTERNAL CREAM 1 % (*tapinarof*) | 3 | PA; QL (60 grams per prescription.) |
| ZELSUVMI EXTERNAL GEL 10.3 % (*berdazimer sodium*) | 4 | QL (31 grams (1 box) per copay) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | 2 | |
| ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per 30 days.) |
| ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast*) | 3 | PA; QL (60 grams per prescription.) |
| **SUNSCREEN AGENTS - Drugs for the Skin** | | |
| AVIDOXY DK COMBINATION KIT 100 MG (*doxycycline-suncreen-sal acid*) | 3 | |
| **SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles** | | |
| **ANTIMUSCARINICS - Drugs for the Urinary System** | | |
| COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (*xanomeline-trospium chloride*) | 3 | PA; QL (62 capsules per month.) |
| COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (*xanomeline-trospium chloride*) | 3 | PA; QL (1 starter pack per year.) |
| *darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg* | 3 | ST |
| *flavoxate hcl oral tablet 100 mg* | 1 | |
| *oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg* | 2 | |
| *oxybutynin chloride oral solution 5 mg/5ml* | 1 | |
| *oxybutynin chloride oral tablet 2.5 mg* | 3 | |
| *oxybutynin chloride oral tablet 5 mg* | 1 | |
| *solifenacin succinate oral tablet 10 mg, 5 mg* | 2 | |
| *tolterodine tartrate oral tablet 1 mg, 2 mg* | 3 | |
| *trospium chloride oral tablet 20 mg* | 3 | |
| **RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs** | | |
| *elixophyllin oral elixir 80 mg/15ml* | 3 | |
| *sildenafil citrate oral suspension reconstituted 10 mg/ml* | 3 | PA; QL (186 ml per month.); SP |
| *sildenafil citrate oral tablet 20 mg* | 1 | QL (0.5 tablet per day.); SP |
| THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg* | 1 | |
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | 1 | |
| *theophylline oral elixir 80 mg/15ml* | 1 | |
| *theophylline oral solution 80 mg/15ml* | 1 | |
| **SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System** | | |
| *mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg* | 3 | ST |
| **VITAMINS** | | |
| **MULTIVITAMIN PREPARATIONS** | | |
| ELITE-OB ORAL TABLET 50-1.25 MG (*prenatal vit-iron carbonyl-fa*) | 3 | |
| ENBRACE HR ORAL CAPSULE (*prenat vit-fe gly cys-fa-omega*) | 3 | |
| FLOTREX ORAL TABLET CHEWABLE 1 MG (*pediatric multivitamins-fl*) | 3 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| *multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| *multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml* | 1 | |
| NATAL PNV ORAL TABLET 6-0.5 MG | 3 | |
| NEONATAL COMPLETE ORAL TABLET 27-1 MG | 3 | |
| NEONATAL PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| NESTABS ONE ORAL CAPSULE 38-1-225 MG (*prenat-fe-methylfol-dha w/o a*) | 3 | |
| NESTABS ORAL TABLET 32-1 MG (*prenat-fe bisgly-fa-w/o vit a*) | 3 | |
| ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG | 3 | |
| ONENATAL RX ORAL TABLET 1 MG (*prenatal multivit-min-fe-fa*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| *pnv 27-ca/fe/fa oral tablet 60-1 mg* | 1 | |
| POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (*ped multivitamins-fl-iron*) | 3 | |
| POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (*ped multivitamins-fl-iron*) | 3 | |
| PREMESISRX ORAL TABLET 1 MG (*prenatal ca-b6-b12-fa-ginger*) | 3 | |
| *prenatal oral tablet 27-1 mg* | 1 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (*prenatal-feaspgly-methylfol-fa*) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (*prenat-fecbn-feasp-meth-fa-dha*) | 3 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (*prenat mv-min-methylfolate-fa*) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (*prenatal vit-fe psac cmplx-fa*) | 3 | |
| TRINATE ORAL TABLET (*prenatal vit-fe fumarate-fa*) | 3 | |
| TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (*prenat-fe poly-methfol-fa-dha*) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (*prenatal mv-min-fe fum-fa-dha*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| VITATHELY WITH GINGER ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG | 3 | |
| WESNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| **VITAMIN A** | | |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| **VITAMIN B COMPLEX** | | |
| CALCIFOL ORAL WAFER 1342-1.6 MG (*ca carb-fa-d-b6-b12-boron-mg*) | 3 | |
| *cyanocobalamin injection solution 1000 mcg/ml* | 1 | |
| CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML | 3 | |
| *cyanocobalamin nasal solution 500 mcg/0.1ml* | 3 | |
| *drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg* | 3 | H |
| *drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg* | 1 | H |
| ELITE-OB ORAL TABLET 50-1.25 MG (*prenatal vit-iron carbonyl-fa*) | 3 | |
| ENBRACE HR ORAL CAPSULE (*prenat vit-fe gly cys-fa-omega*) | 3 | |
| *folic acid oral tablet 400 mcg, 800 mcg* | E | H |
| *folic acid tablet 1 mg oral (rx)* | 1 | |
| *ft folic acid oral tablet 400 mcg, 800 mcg* | E | H |
| HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG | 3 | |
| *lederle leucovorin oral tablet 5 mg* | 1 | |
| *leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg* | 1 | |
| M-NATAL PLUS ORAL TABLET 27-1 MG | 3 | |
| *multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg* | 1 | |
| NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (*cyanocobalamin*) | 3 | |
| NATAL PNV ORAL TABLET 6-0.5 MG | 3 | |
| NEONATAL COMPLETE ORAL TABLET 27-1 MG | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| NEONATAL PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| NESTABS ONE ORAL CAPSULE 38-1-225 MG (*prenat-fe-methylfol-dha w/o a*) | 3 | |
| NESTABS ORAL TABLET 32-1 MG (*prenat-fe bisgly-fa-w/o vit a*) | 3 | |
| *niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg* | 2 | |
| ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG | 3 | |
| ONENATAL RX ORAL TABLET 1 MG (*prenatal multivit-min-fe-fa*) | 3 | |
| *pnv 27-ca/fe/fa oral tablet 60-1 mg* | 1 | |
| PREMESISRX ORAL TABLET 1 MG (*prenatal ca-b6-b12-fa-ginger*) | 3 | |
| *prenatal oral tablet 27-1 mg* | 1 | |
| PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (*prenatal-feaspgly-methylfol-fa*) | 3 | |
| PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (*prenat-fecbn-feasp-meth-fa-dha*) | 3 | |
| PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (*prenat mv-min-methylfolate-fa*) | 3 | |
| PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (*prenat-feasp-meth-fa-dha w/o a*) | 3 | |
| PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (*prenat w/o a-fe-methfol-fa-dha*) | 3 | |
| RELNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (*prenatal vit-fe psac cmplx-fa*) | 3 | |
| TRINATE ORAL TABLET (*prenatal vit-fe fumarate-fa*) | 3 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| TRUE FOLIC ACID ORAL TABLET 400 MCG | E | H |
| *tydemy oral tablet 3-0.03-0.451 mg* | 1 | H |
| VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (*prenat-fe poly-methfol-fa-dha*) | 3 | |
| VITAFOL-OB+DHA ORAL 65-1 & 250 MG (*prenatal mv-min-fe fum-fa-dha*) | 3 | |
| VITATHELY WITH GINGER ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*) | 3 | |
| WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG | 3 | |
| WESNATE DHA ORAL CAPSULE 28-1-200 MG | 3 | |
| WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG | 3 | |
| **VITAMIN C** | | |
| MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (*peg-kcl-nacl-nasulf-na asc-c*) | 3 | QL (1 kit per prescription.) |
| *peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm* | 3 | QL (1 kit per prescription.) |
| *peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm* | 3 | QL (1 kit per prescription.) |
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| **VITAMIN D** | | |
| CALCIFOL ORAL WAFER 1342-1.6 MG (*ca carb-fa-d-b6-b12-boron-mg*) | 3 | |
| *calcitriol oral capsule 0.25 mcg, 0.5 mcg* | 1 | |
| *calcitriol oral solution 1 mcg/ml* | 1 | |
| *doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg* | 1 | |
| *ergocalciferol oral capsule 1.25 mg (50000 ut)* | 1 | |
| FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (*sodium fluoride-vitamin d*) | 3 | |
| FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (*alendronate-cholecalciferol*) | 3 | |
| *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg* | 1 | |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

| Prescription drug name | Drug tier | Coverage requirements & limits |
|---|---|---|
| TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML | 3 | |
| *tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | 1 | |
| *vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)* | 1 | |
| ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (*paricalcitol*) | 3 | |
| **VITAMIN E** | | |
| *wheat germ oil oral oil* | 1 | |
| **VITAMIN K ACTIVITY** | | |
| *phytonadione oral tablet 5 mg* | 3 | QL (5 tablets per prescription.) |

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Health Care Reform Preventive; H-N: Part of Health Care Reform Preventive with submission of age and/or condition appropriate preventive use; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

**Index of Drugs**


A.A.G.C. KIT IN TERODERM . 334
*abacavir sulfate* ..... 35
*abacavir sulfate-lamivudine* ..... 35
*abigale* ..... 236, 249
*abigale lo* ..... 236, 249
*abiraterone acetate* ..... 46
*abirtega* ..... 46
ABRYSVO ..... 61
*acamprosate calcium* ..... 16, 140
*acarbose* ..... 223
ACCU-CHEK AVIVA ..... 167
ACCU-CHEK FASTCLIX LANCET KIT ..... 167
ACCU-CHEK GUIDE ..... 167
ACCU-CHEK GUIDE CONTROL ..... 167
ACCU-CHEK GUIDE ME ..... 167
ACCU-CHEK GUIDE TEST .... 180
ACCU-CHEK SMARTVIEW CONTROL ..... 167
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT ..... 168
*accutane* ..... 329, 334
ACD-A NOCLOT-50 ..... 78
*acebutolol hcl* ..... 76, 96, 102, 105, 111
*acetaminophen-codeine* ..... 121, 148, 150
*acetazolamide* ..... 91, 102, 124, 185, 198
*acetazolamide er* ..... 91, 102, 124, 185, 198
*acetic acid* ..... 203
*acetylcysteine* ..... 16, 271, 305
*acitretin* ..... 329, 334
ACTEMRA ..... 266, 279, 283
ACTEMRA ACTPEN ..... 266, 279, 283
ACTHAR ..... 179, 247
ACTHAR GEL ..... 179, 247
ACTHIB ..... 61
ACTIMMUNE ..... 283
ACTIVELLA ..... 236, 249
ACTOPLUS MET ..... 227, 260
ACULAR ..... 158, 204
ACULAR LS ..... 158, 204
*acyclovir* ..... 40, 318
ADACEL ..... 61
ADALIMUMAB-AATY (1 PEN) ..... 213, 269, 279, 283, 284
ADALIMUMAB-AATY (2 PEN) ..... 213, 269, 279, 284
ADALIMUMAB-AATY (2 SYRINGE) ..... 213, 269, 279, 284
ADALIMUMAB-AATY CD/UC/HS START ..... 214, 270, 279, 284
ADALIMUMAB-ADAZ ..... 214, 270, 279, 284
*adapalene-benzoyl peroxide* ..... 295, 329, 331, 334
ADBRY ..... 327, 334
ADDYI ..... 140
*adefovir dipivoxil* ..... 40
ADEMPAS ..... 310, 311
ADRENALIN ..... 66, 206, 297
ADVAIR HFA .... 74, 198, 219, 300
ADVANTAGE SAFETY LANCETS 28G ..... 168
ADVATE ..... 82
ADVOCATE SAFETY LANCETS 21G ..... 168
ADVOCATE SAFETY LANCETS 23G ..... 168
ADVOCATE SAFETY LANCETS 28G ..... 168
ADYNOVATE ..... 82
AEROCHAMBER HOLDING CHAMBER ..... 168
AEROCHAMBER PLS FLOVU MTHPIECE ..... 168
AEROCHAMBER PLUS FLO-VU INTERM ..... 168
AEROCHAMBER PLUS FLO-VU LARGE ..... 168
AEROCHAMBER PLUS FLO-VU MEDIUM ..... 168
AEROCHAMBER PLUS FLO-VU SMALL ..... 168
AEROCHAMBER2GO ANTI-STATIC ..... 168
*afirmelle* ..... 228, 236, 249
AFSTYLA ..... 82
*aftera* ..... 225, 228, 249
AIMOVIG ..... 140
AIRSUPRA ..... 74, 198, 219, 300, 306, 309
AKEEGA ..... 46
AKLIEF ..... 329, 334
AKTEN ..... 205
AKYNZEO ..... 208, 216
*albendazole* ..... 24
*albuterol sulfate* ..... 75, 309
ALBUTEROL SULFATE ... 75, 309
*albuterol sulfate hfa* ..... 74, 309
ALCAINE ..... 205
*alclometasone dipropionate* .... 321
ALCOHOL PREP PADS ..... 168
ALECENSA ..... 46
*alendronate sodium* ..... 274
*alfuzosin hcl er* ..... 74
*aliskiren fumarate* ..... 115
*allopurinol* ..... 273
*almotriptan malate* ..... 160
ALOGLIPTIN BENZOATE ..... 235
ALOGLIPTIN-METFORMIN HCL ..... 227, 235
ALOGLIPTIN-PIOGLITAZONE ..... 235, 260
ALORA ..... 236, 274
*alosetron hcl* ..... 209
ALPHAGAN P ..... 193, 313
ALPHANATE ..... 82
ALPHANINE SD ..... 82
*alprazolam* ..... 138
*alprazolam er* ..... 138
*alprazolam intensol* ..... 138
*alprazolam xr* ..... 138
ALPROLIX ..... 82
ALREX ..... 199
ALTACAINE ..... 205, 271
*altavera* ..... 228, 236, 249
ALTUVIIIO ..... 82
ALUNBRIG ..... 46
ALVAIZ ..... 80
*alvimopan* ..... 207, 214
*alyacen 1/35* ..... 228, 236, 249
*alyacen 7/7/7* ..... 228, 236, 249
ALYFTREK ..... 301, 302
*alyq* ..... 114, 306, 310
*amantadine hcl* ..... 22, 119
*ambrisentan* ..... 116, 303, 310
*amcinonide* ..... 321
AMELUZ ..... 312, 334
*amethyst* ..... 228, 236, 249
*amiloride hcl* ..... 92, 115, 187
*amiloride-hydrochlorothiazide* ..... 187, 189
*aminocaproic acid* ..... 82
*amiodarone hcl* ..... 106
*amitriptyline hcl* ..... 163
AMJEVITA ..... 214, 270, 279, 280, 284

AMJEVITA-PED 15KG TO <30KG .....214, 270, 280, 284
AMLODIPINE BES+SYRSPEND SF ..... 107, 108, 116
*amlodipine besylate* 107, 108, 116
*amlodipine besylate-benazepril hcl* ..... 95, 107
*amlodipine besylate-valsartan* ..... 93, 107
*amlodipine-olmesartan* .....93, 108
*amnesteem* ..... 329, 334
*amoxapine* ..... 163
*amoxicillin* ..... 23, 210
*amoxicillin trihydrate* ..... 23, 210
*amoxicillin-potassium clavulanate* .....24
*amphetamine sulfate* .....120
*amphetamine-dextroamphetamine* ..... 120
*amphetamine-dextroamphetamine er* ..... 120
*amphet-dextroamphet 3-bead er* .....120
*ampicillin* ..... 24
AMZEEQ .....25, 44, 194, 313
*anagrelide hcl* .....90
ANALPRAM HC ..... 199, 219, 317, 321
*anastrozole* ..... 46, 225
ANCOBON .....43
ANDEMBRY .....91
ANGELIQ ..... 236, 249
ANNOVERA .....228, 236, 249
ANORO ELLIPTA ..... 67, 75
ANTICOAGULANT SODIUM CITRATE .....78
ANUCORT-HC .....199, 219, 322
ANUSOL-HC .....199, 219, 322
ANZUPGO ..... 328
*apap-caff-dihydrocodeine* ..... 121, 148, 150, 156
APOKYN .....147
*apomorphine hcl* ..... 147
*apraclonidine hcl* ..... 193, 203
*aprepitant* ..... 216, 217
*apri* .....228, 236, 249
APRISO ..... 209
APTIOM ..... 124, 145
APTIVUS .....37
AQ INSULIN SYRINGE ..... 168
AQINJECT PEN NEEDLE ..... 168
AQNEURSA .....291
AQUORAL ..... 203
AQVESME ..... 78
ARAKODA ..... 25
*aranelle* ..... 228, 236, 249
ARANESP (ALBUMIN FREE) ..... 77, 80
ARBLI .....94
ARCALYST .....291, 304
AREXVY ..... 62
*arformoterol tartrate* ..... 75, 309
ARIKAYCE .....23
*aripiprazole* ..... 129, 135
*armodafinil* ..... 164
ARMOUR THYROID .....260
ARNUITY ELLIPTA ..... 199, 219, 300, 306
ARTISS .....320, 334
ARZOL SILVER NIT APPLICATORS .....196
*ascomp-codeine* ..... 137, 150, 156, 159
*asenapine maleate* .....129, 135
*ashlyna* .....228, 236, 249
*aspirin* ..... 89, 90, 132, 159
*aspirin 81* ..... 89, 90, 132, 159
*aspirin adult low dose* ..... 89, 90, 132, 159
*aspirin adult low strength* ..... 89, 90, 132, 159
*aspirin childrens* .. 89, 90, 132, 159
*aspirin ec adult low dose* ..... 89, 90, 132, 159
*aspirin ec low dose* ..... 89, 90, 132, 159
*aspirin ec low strength* ..... 89, 90, 132, 159
*aspirin low dose* .. 89, 90, 132, 159
*aspirin regimen* ... 89, 90, 132, 159
*aspirin-dipyridamole er* ..... 89, 114, 159, 179
ASSURE CONTROL SOLUTION 2/3 .....168
ASSURE ID DUO PRO PEN NEEDLES ..... 168
ASSURE ID PRO PEN NEEDLES ..... 168
ASTRINGYN ..... 82
*atazanavir sulfate* .....37
*atenolol* ..... 76, 96, 102, 105, 112
ATENOLOL+SYRSPEND SF ..... 76, 96, 102, 105, 112
*atenolol-chlorthalidone* ..... 96, 102, 191
ATMEKSI ..... 70
*atomoxetine hcl* .....140, 156
ATORVALIQ ..... 110
*atorvastatin calcium* ..... 110
*atovaquone* ..... 26
*atovaquone-proguanil hcl* .....25
*atropine sulfate* ... 16, 67, 205, 298
ATROVENT HFA ..... 67, 298
ATTRUBY ..... 102
*aubra eq* .....228, 236, 249
AUGTYRO ..... 46
AUM INSULIN SAFETY PEN NEEDLE .....168
AUM MINI INSULIN PEN NEEDLE .....168
AUM PEN NEEDLE ..... 169
AUM READYGARD DUO PEN NEEDLE .....169
AUM SAFETY PEN NEEDLE . 169
AURANOFIN ... 218, 263, 280, 285
*aurovela 1.5/30* ..... 228, 236, 249
*aurovela 1/20* ..... 228, 236, 249
*aurovela 24 fe* ..... 228, 236, 249
*aurovela fe 1.5/30* ... 228, 236, 249
*aurovela fe 1/20* ..... 228, 236, 249
AUSTEDO .....163
AUSTEDO XR .....163, 164
AUSTEDO XR PATIENT TITRATION .....164
AUTOKEEPER SAFETY PEN NEEDLE .....169
AUTOLET LANCING DEVICE 169
AUTOLET LITE LANCING DEVICE .....169
AUVELITY .....128
AUVELITY TITRATION PACK 128
AUVI-Q .....66, 297
*avanafil* .....114
AVAR CLEANSER .....313, 329
AVAR-E EMOLLIENT ..... 313, 329
*aviane* ..... 228, 236, 249
AVIDOXY .....25, 44, 313
AVIDOXY DK ..... 44, 329, 339
AVMAPKI FAKZYNJA CO-PACK ..... 46
AVONEX PEN .....265, 285
AVONEX PREFILLED .... 266, 285
AVTOZMA .....266
*ayuna* ..... 228, 236, 249
AYVAKIT .....46
AZASAN .....262, 280, 285, 289

AZASITE ..... 194
*azathioprine* .... 262, 280, 285, 289
*azelaic acid* ..... 313, 334
*azelastine hcl* ..... 194, 309
AZELEX ..... 313, 334
*azithromycin* ..... 41
AZSTARYS ..... 156
AZULFIDINE
..... 44, 209, 263, 280, 285
AZULFIDINE EN-TABS
..... 44, 209, 263, 280, 285
*azurette* ..... 228, 236, 249
B & C ..... 334
*bac (butalbital-acetamin-caff)*
..... 121, 137, 148, 156
*bacitracin-polymyxin b*
..... 29, 194, 313
*bacitra-neomycin-polymyxin-hc*
..... 30, 194, 199, 313
*baclofen* ..... 71
BACTRIM ..... 26, 44, 45
BACTRIM DS ..... 26, 44, 45
BAFIERTAM ..... 264, 285
*balsalazide disodium* ..... 209
*balsam peru-castor oil* ..... 334
BALVERSA ..... 46, 47
*balziva* ..... 228, 237, 249
BANZEL ..... 124, 145
BAQSIMI ONE PACK 16, 244, 271
BAQSIMI TWO PACK
..... 16, 244, 272
BARACLUDE ..... 40
BAXDELA ..... 43
BD AUTOSHIELD DUO PEN
NEEDLES ..... 169
BD BLUNT FILL NEEDLE ..... 169
BD ECLIPSE LUER-LOK
NEEDLE ..... 169
BD ECLIPSE NEEDLE ..... 169
BD PEN NEEDLE MICRO
ULTRAFINE ..... 169
BD PEN NEEDLE MINI
ULTRAFINE ..... 169
BD PEN NEEDLE NANO
ULTRAFINE ..... 169
BD PEN NEEDLE ORIG
ULTRAFINE ..... 169
BD PEN NEEDLE SHORT
ULTRAFINE ..... 169
BD SAFETYGLIDE NEEDLE .. 169
BD SHARPS COLLECTOR .... 169
BD ULTRA-FINE INSULIN
SYRINGES ..... 169
BD ULTRA-FINE PEN
NEEDLES ..... 170
BD VEO INSULIN SYR
ULTRAFINE ..... 170
BELBUCA ..... 154
*belladonna alkaloids-opium*
..... 67, 150
BELSOMRA ..... 134, 155
*benazepril hcl* ..... 94, 95
*benazepril-hydrochlorothiazide*
..... 95, 190
BENEFIX ..... 82
BENLYSTA ..... 265, 289
*benzalkonium chloride* .... 319, 331
BENZAMYCIN ..... 313, 331
BENZNIDAZOLE ..... 26, 39
*benzoin* ..... 321
*benzonatate* ..... 300
*benzoyl peroxide-erythromycin*
..... 314, 331
*benzphetamine hcl* ..... 120
*benztropine mesylate* ..... 69, 124
BERINERT ..... 278
BESIFLOXACIN HCL ..... 194
BESIVANCE ..... 194
BESREMI ..... 37, 47, 285
BESREMI PEN ..... 37, 47, 285
BETADINE OPHTHALMIC
PREP ..... 196
*betaine* ..... 291
*betamethasone dipropionate*
..... 219, 322
*betamethasone dipropionate*
*aug* ..... 219, 322
*betamethasone valerate* . 219, 322
BETAPACE AF
..... 71, 97, 103, 105, 106, 112
BETASERON ..... 266, 285
*betaxolol hcl*
..... 76, 97, 103, 105, 112, 197
*bethanechol chloride* ..... 73
BETIMOL ..... 72, 97, 105, 197
BEVESPI AEROSPHERE
..... 67, 75, 318
*bexarotene* ..... 47, 312, 334
BEXSERO ..... 62
BEYFORTUS ..... 38
*bicalutamide* ..... 47
BIGFOOT UNITY PROGRAM 170
BIJUVA ..... 237, 249
BIKTARVY ..... 33, 34, 35
BILTRICIDE ..... 24
*bimatoprost* ..... 206
BIMZELX ..... 327, 335
BINAXNOW COVID-19 AG
HOME TEST ..... 180
*bis subcit-metronid-tetracyc*
..... 24, 26, 44, 208, 210
*bisacodyl ec* ..... 210
*bismuth/metronidaz/tetracyclin*
..... 25, 26, 44, 208, 210
*bisoprolol fumarate*
..... 76, 97, 103, 105, 112
*bisoprolol-hydrochlorothiazide*
..... 97, 103, 190
*blisovi 24 fe* ..... 228, 237, 249
*blisovi fe 1.5/30* ..... 228, 237, 250
*blisovi fe 1/20* ..... 228, 237, 250
BLUJEPA ..... 45
BONSITY ..... 247, 274
BOOSTRIX ..... 61, 62
*bosentan* ..... 116, 303, 310
BOSULIF ..... 47
*bosutinib* ..... 47
*bp 10-1* ..... 314, 329
BRAFTOVI ..... 47
BREATHE COMFORT
CHAMBER/ADULT ..... 170
BREATHE COMFORT
CHAMBER/CHILD ..... 170
BRENZAVVY ..... 258
BREO ELLIPTA 75, 199, 219, 301
BREZTRI AEROSPHERE
..... 67, 75, 219
*briellyn* ..... 228, 237, 250
*brimonidine tartrate* . 193, 313, 335
BRINSUPRI ..... 299, 305
*brinzolamide* ..... 198
*brivaracetam* ..... 124
BRIVIACT ..... 124
*bromocriptine mesylate* ..... 143
BRONCHITOL ..... 308
BRONCHITOL TOLERANCE
TEST ..... 308
BRUKINSA ..... 47
BRYNOVIN ..... 235
*budesonide* ..... 220, 301, 306, 322
*bumetanide* ..... 91, 110, 185
BUMEX ..... 91, 110, 185
*buprenorphine* ..... 155
*buprenorphine hcl* ..... 154
*buprenorphine hcl-naloxone*
*hcl* ..... 153, 154, 155
*bupropion hcl* ..... 129

*bupropion hcl er (smoking det)* ..... 64, 128
*bupropion hcl er (sr)* ..... 129
*bupropion hcl er (xl)* ..... 129
*buspirone hcl* ..... 134, 147
*butalbital-acetaminophen* ..... 121, 137, 148
*butalbital-apap-caff-cod* ..... 121, 137, 148, 150, 156
*butalbital-apap-caffeine* ..... 121, 137, 148, 156
BUTALBITAL-APAP-CAFFEINE ..... 121, 137, 148, 156
*butalbital-asa-caff-codeine* ..... 137, 150, 156, 159
*butalbital-aspirin-caffeine* ..... 137, 156, 159
*butorphanol tartrate* ..... 132, 155
BYLVAY ..... 212, 214
BYLVAY (PELLETS) ..... 212, 214
*cabergoline* ..... 143
CABLIVI ..... 78, 90
CABOMETYX ..... 47
CAFERGOT ..... 73, 132, 156
*caffeine citrate* ..... 132, 156
CALCIFOL ..... 187, 342, 344
*calcipotriene* ..... 320, 335
*calcitonin (salmon)* ..... 226, 274
CALCITRENE ..... 320, 335
*calcitriol* ..... 335, 344
*calcium acetate* ..... 186, 187
*calcium acetate (phos binder)* ..... 186, 187
CALQUENCE ..... 47
*camila* ..... 228, 250
CAMINO PRO COMPLETE/GLYTACTIN ..... 183
*camrese* ..... 228, 237, 250
*camrese lo* ..... 228, 237, 250
CAMZYOS ..... 102
*candesartan cilexetil* ..... 93, 94
*candesartan cilexetil-hctz* ..94, 190
*capecitabine* ..... 47
CAPLYTA ..... 135
CAPRELSA ..... 47, 48
*captopril* ..... 94, 95
*captopril-hydrochlorothiazide* ..... 95, 190
CAPVAXIVE ..... 62
*carbamazepine* ..... 124, 129
*carbamazepine er* ..... 124, 129
CARBATROL ..... 124, 129
*carbidopa* ..... 142
*carbidopa-levodopa* ..... 142
*carbidopa-levodopa er* ..... 142
*carbidopa-levodopa-entacapone* ..... 140, 142
*carbinoxamine maleate* ..... 18, 19, 304
CARBZAH ..... 19, 304
CARDAMYST ..... 100, 106
CARDURA ..... 72, 92, 93, 97
CARDURA XL ..... 72, 93, 97
CAREPOINT POLY HUB NEEDLE ..... 170
CAREPOINT PRECISION POLY HUB ..... 170
CAREPOINT SAFETY 1ST NEEDLE ..... 170
CARESENS CONTROL SOLUTION A/B ..... 170
CARESENS LANCETS 30G ..... 170
CARESENS S CONTROL SOLN A/B ..... 170
CARESTART COVID-19 HOME TEST ..... 180
CARETOUCH CONTROL SOL LEVEL 2 ..... 170
CARETOUCH HYPODERMIC NEEDLE ..... 170
CARETOUCH LANCING/EJECTOR ..... 170
*carglumic acid* ..... 182
*carisoprodol* ..... 70
CARNITOR ..... 291
CARNITOR SF ..... 291
CAROSPIR 92, 111, 115, 116, 187
*carteolol hcl* ..... 198
*cartia xt* ..... 99, 100, 101, 106, 116
*carvedilol* ..... 72, 74, 93, 97, 103, 105, 112
CAVERJECT ..... 109, 117
CAVERJECT IMPULSE ..109, 117
CAYA ..... 295
CAYSTON ..... 38
*cefaclor* ..... 21
*cefaclor er* ..... 21
*cefadroxil* ..... 21
*cefdinir* ..... 22
*cefixime* ..... 22
CEFIXIME ..... 22
*cefpodoxime proxetil* ..... 22
*cefprozil* ..... 21
*cefuroxime axetil* ..... 21
*celecoxib* ..... 142
CELONTIN ..... 162
*cephalexin* ..... 21
CEQUR SIMPLICITY 1U EXTND WEAR ..... 170
CEQUR SIMPLICITY 2U ..... 170
CEQUR SIMPLICITY 2U EXTND WEAR ..... 170
CERDELGA ..... 192, 291
CERVIDIL ..... 297
CETRAXAL ..... 194
*cevimeline hcl* ..... 73
*charlotte 24 fe* ..... 229, 237, 250
*chateal eq* ..... 229, 237, 250
CHEMET ..... 16, 218, 272
CHEMSTRIP BG LOG BOOK ..170
CHEMSTRIP K ..... 181
CHEMSTRIP UGK ..... 181
*chlordiazepoxide hcl* ..... 138
*chlordiazepoxide-amitriptyline* ..... 138, 163
*chlordiazepoxide-clidinium* 67, 138
*chlorhexidine gluconate* ..... 22, 197, 319, 331
*chloroquine phosphate* ..... 25
*chlorpromazine hcl* ..... 155
*chlorthalidone* ..... 92, 116, 191
*chlorzoxazone* ..... 70
CHOLBAM ..... 212, 215
*cholestyramine* ..... 98
*cholestyramine light* ..... 98
CHOSEN LANCETS 30G ..... 171
CHOSEN LANCING DEVICE ..171
CHOSEN SAFETY LANCETS 28G ..... 171
CIBINQO ..... 267, 280, 328, 335
*ciclodan* ..... 326
*ciclopirox* ..... 326
*ciclopirox olamine* ..... 326
CICLOPIROX TREATMENT ...326
*cilostazol* ..... 89, 114, 115
CILOXAN ..... 194
CIMDUO ..... 35
*cimetidine* ..... 20, 216
*cimetidine hcl* ..... 20, 216
CIMZIA (1 SYRINGE) ..... 215, 263, 270, 280, 285
CIMZIA (2 SYRINGE) ..... 215, 263, 270, 280, 285
CIMZIA-STARTER ..... 215, 263, 270, 280, 285
*cinacalcet hcl* ..... 226
CIPRO ..... 27, 43
CIPRO HC ..... 194, 199
*ciprofloxacin hcl* ..... 28, 43, 194

*ciprofloxacin-dexamethasone* ..... 194, 199
*ciprofloxacin-hydrocortisone* ..... 194, 199
*citalopram hydrobromide* ..... 161
*cladribine (10 tabs)* ..... 48, 261, 285, 289
*cladribine (4 tabs)* ..... 48, 261, 285, 289
*cladribine (5 tabs)* ..... 48, 261, 285, 289
*cladribine (6 tabs)* ..... 48, 261, 285, 289
*cladribine (7 tabs)* ..... 48, 262, 285, 289
*cladribine (8 tabs)* ..... 48, 262, 286, 289
*cladribine (9 tabs)* ..... 48, 262, 286, 290
*claravis* ..... 329, 335
*clarithromycin* ..... 28, 41, 210
*clarithromycin er* ..... 28, 41, 210
CLEARDETECT COVID-19 AG HOME ..... 180
*clearlax* ..... 210
*clemastine fumarate* ..... 19, 304
CLEMSZA ..... 19, 304
CLENPIQ ..... 210
CLEOCIN ..... 37, 38, 314
CLEOCIN-T ..... 38, 314
CLEVER CHOICE COMFORT EZ ..... 171
CLIMARA PRO ..... 237, 250
*clindacin* ..... 38, 314
*clindacin etz* ..... 38, 314
*clindacin-p* ..... 38, 314
*clindamycin hcl* ..... 38, 314
*clindamycin palmitate hcl* .. 38, 314
*clindamycin phos (twice-daily)* ..... 38, 314
*clindamycin phos-benzoyl perox* ..... 38, 314, 331
*clindamycin phosphate* ..... 38, 314
CLINDESSE ..... 38, 314
CLINITEST RAPID COVID-19 TEST ..... 180
CLINOIN ..... 98, 314, 321, 335
CLINPRO 5000 ..... 165, 276
*clobazam* ..... 137, 138
*clobetasol prop emollient base* 322
*clobetasol propionate* ..... 322
*clobetasol propionate e* ..... 322
*clocortolone pivalate* ..... 322
*clomipramine hcl* ..... 163
*clonazepam* ..... 137, 138, 139
*clonidine* ..... 66, 103, 109
*clonidine hcl* ..... 66, 103, 109
*clonidine hcl er* ..... 66, 109
*clopidogrel bisulfate* ..... 89
*clorazepate dipotassium* . 137, 139
*clotrimazole* ..... 319
*clotrimazole-betamethasone* ..... 319, 322
*clozapine* ..... 135
CLOZARIL ..... 135
COAGADEX ..... 82
*coal tar* ..... 331
COARTEM ..... 25
COBENFY ..... 134, 339
COBENFY STARTER PACK ..... 134, 339
*codeine sulfate* ..... 150, 300
*colchicine* ..... 273
*colchicine-probenecid* ..... 191, 273
*colesevelam hcl* ..... 98, 224, 225
COLESTID ..... 98
*colestipol hcl* ..... 98
*colistimethate sodium (cba)* ..... 42
COLY-MYCIN M ..... 42
COMBIGAN ..... 193, 198, 313
COMBIPATCH ..... 237, 250
COMBIVENT RESPIMAT ..... 67, 75, 298
COMETRIQ ..... 48
COMFORT EZ PRO PEN NEEDLES ..... 171
COMFORT TOUCH TWIST LANCET 30G ..... 171
COMPLERA ..... 34, 35, 40
COMPLEX ESSENTIAL MSD ..... 183, 291
COMPRO ..... 155, 209
CONDOMS ..... 295
CONDYLOX ..... 330, 335
*constulose* ..... 182
CONTOUR CONTROL ..... 171
CONTOUR NEXT CONTROL . 171
CONTOUR NEXT EZ ..... 171
CONTOUR NEXT GEN MONITOR ..... 171
CONTOUR NEXT MONITOR . 171
CONTOUR NEXT ONE ..... 171
CONTOUR NEXT TEST ..... 180
CONTOUR PLUS BLUE ..... 171
CONTOUR PLUS CONTROL SOLUTION ..... 171
CONTOUR PLUS TEST ..... 180
CONTRAVE ..... 122, 123
COPASIL ..... 335
COPIKTRA ..... 48
CORDRAN ..... 322
CORIFACT ..... 83
CORLANOR ..... 102, 117
CORTANE-B ..... 199, 220, 317, 322, 331
CORTEF ..... 199, 220, 323
CORTENEMA ..... 199, 220, 323
CORTIFOAM ..... 199, 220, 323
CORTISPORIN-TC ..... 194, 199
CORTROPHIN ..... 179, 247
CORTROPHIN GEL ..... 179, 247
CORTROSYN ..... 179
COSENTYX (300 MG DOSE) ..... 266, 280, 335
COSENTYX 150 MG/ML ..... 266, 280, 335
COSENTYX SENSOREADY (300 MG) ..... 267, 280, 335
COSENTYX SENSOREADY PEN ..... 267, 281, 335
COSENTYX UNOREADY ..... 267, 281, 335
COSOPT ..... 198
*cosyntropin* ..... 179
COTELLIC ..... 48
COVARYX ..... 224, 237
COVARYX HS ..... 223, 237
COVID-19 AT HOME ANTIGEN TEST ..... 180
COVID-19 AT-HOME TEST .... 180
CRENESSITY ..... 83, 247, 248
CREON ..... 192, 213
CRESEMBA ..... 29
CREXONT ..... 142
CRINONE ..... 250
*cromolyn sodium* ..... 194, 203, 305
CROTAN ..... 334
*cryselle* ..... 229, 237, 250
CTEXLI ..... 212
CUVPOSA ..... 67, 319
*cyanocobalamin* ..... 88, 342
CYANOCOBALAMIN ..... 88, 342
*cyclobenzaprine hcl* ..... 70
CYCLOGYL ..... 205
CYCLOMYDRIL ..... 205, 206
*cyclopentolate hcl* ..... 205
*cyclophosphamide* .... 48, 265, 290

CYCLOPHOSPHAMIDE ..... 48, 265, 290
*cycloserine* ..... 28
CYCLOSET ..... 225
*cyclosporine* ..... 197, 262, 281, 286, 290
*cyclosporine modified* ..... 197, 262, 281, 286, 290
*cyproheptadine hcl* ..... 19, 304
*cyred eq* ..... 229, 237, 250
CYSTADANE ..... 291
CYSTADROPS ..... 204, 205
CYSTAGON ..... 291
CYSTARAN ..... 204, 205
CYTOTEC ..... 217
*cytra k crystals* ..... 182
*dabigatran etexilate mesylate* ... 80
*dalfampridine er* ..... 291, 295
*danazol* ..... 224
DANTRIUM ..... 71
*dantrolene sodium* ..... 71
*dapsone* ..... 25, 26, 27, 314, 335
DAPTACEL ..... 61, 62
DARAPRIM ..... 25
*darifenacin hydrobromide er* ... 339
*darunavir* ..... 37
*dasatinib* ..... 48, 49
*dasetta 1/35 (28)* ..... 229, 237, 250
*dasetta 7/7/7* ..... 229, 237, 250
DAURISMO ..... 49
DAYBUE ..... 140
DAYBUE STIX ..... 141
*daysee* ..... 229, 237, 250
DEBACTEROL ..... 204, 332
*deblitane* ..... 229, 250
*deferasirox* ..... 218
*deferasirox granules* ..... 218
*deferiprone* ..... 218
DELESTROGEN ..... 237, 274
DELSTRIGO ..... 34, 35
*delyla* ..... 229, 237, 250
*demeclocycline hcl* ..... 44
DENGVAXIA ..... 62
DENTA 5000 PLUS 164, 165, 276
DENTA 5000 PLUS SENSITIVE ..... 166, 276
DENTAGEL ..... 164, 166, 276
DEPAKOTE ..... 125, 130, 132, 143
DEPAKOTE ER ..... 124, 129, 132, 143
DEPAKOTE SPRINKLES ..... 125, 130, 132
DEPEN TITRATABS ..... 16, 218, 281
DEPO-ESTRADIOL ..... 237, 274
DEPO-PROVERA ..... 229, 250
DEPO-SUBQ PROVERA 104 ..... 229, 250
DEPO-TESTOSTERONE 224, 225
DERMACINRX UREA ..... 91, 186, 206, 330
DERMACURE ..... 91, 186, 206, 330
DERMA-SMOOTHE/FS BODY ..... 199, 323
DERMA-SMOOTHE/FS SCALP ..... 199, 323
DERMOTIC ..... 199, 323
DESCOVY ..... 35, 40
*desipramine hcl* ..... 163
DESMODA ..... 83, 248
*desmopressin ace spray refrig* ..... 83, 248
*desmopressin acetate* ..... 83, 248
DESMOPRESSIN ACETATE ..... 83, 248
*desmopressin acetate pf* ... 83, 248
*desmopressin acetate spray* ..... 83, 248
*desonide* ..... 323
*desoximetasone* ..... 323
*desvenlafaxine succinate er* .... 160
*dexamethasone* ..... 200, 220
*dexamethasone intensol* ..... 200, 220
*dexamethasone sodium phosphate* ..... 200
DEXCOM G6 RECEIVER ..... 171
DEXCOM G6 SENSOR ..... 171
DEXCOM G6 TRANSMITTER 171
DEXCOM G7 15 DAY SENSOR ..... 172
DEXCOM G7 RECEIVER ..... 172
DEXCOM G7 SENSOR ..... 172
*dexmethylphenidate hcl* ..... 157
*dexmethylphenidate hcl er* ..... 156
*dextroamphetamine sulfate* ..... 120
*dextroamphetamine sulfate er* 120
*dextromethorphan-quinidine* ... 141
DIABECIN HR ..... 317, 332
DIABETES MONITOR DIGIT ADD-ON ..... 172, 292
DIABETES MONITOR DIGIT SOLN ..... 172, 292
DIACOMIT ..... 125, 143
DIASTIX REAGENT ..... 181
DIATRUST COVID-19 HOME TEST ..... 180
*diazepam* ..... 137, 138, 139
*diazepam intensol* ..... 137, 139
*diazoxide* ..... 226
*dichlorphenamide* ..... 91, 276
*diclofenac potassium* ..... 148
*diclofenac sodium* ..... 149, 158, 164, 204, 332
*diclofenac sodium er* ..... 149
*diclofenac-misoprostol* .... 149, 217
*dicloxacillin sodium* ..... 42
DICOPANOL FUSEPAQ ..... 19, 69, 124, 134, 300, 304
*dicyclomine hcl* ..... 67
*diethylpropion hcl* ..... 119
*diethylpropion hcl er* ..... 119
DIFICID ..... 41
*diflorasone diacetate* ..... 323
*diflunisal* ..... 149, 158
*difluprednate* ..... 200
*digoxin* ..... 96, 102
*dihydroergotamine mesylate* ..... 73, 132
DILANTIN ..... 104, 144
DILANTIN INFATABS ..... 104, 144
DILANTIN-125 ..... 104, 144
*diltiazem hcl* ..... 99, 100, 101, 107, 117
*diltiazem hcl er* ..... 99, 100, 101, 107, 117
*diltiazem hcl er beads* ..... 99, 100, 101, 107, 117
*diltiazem hcl er coated beads* ..... 99, 100, 101, 107, 117
*dilt-xr* ..... 99, 100, 101, 107, 117
*dimethyl fumarate* ... 264, 265, 286
*dimethyl fumarate starter pack* ..... 265, 286
DIPENTUM ..... 209
*diphenhydramine hcl* ..... 19, 69, 124, 134, 300, 304
*diphenoxylate-atropine* ..... 67, 208
DIPROLENE ..... 220, 323
*dipyridamole* ..... 89, 114, 117, 179
*diskets* ..... 150
*disopyramide phosphate* ..... 104
*disulfiram* ..... 16, 271
*divalproex sodium* ..... 125, 130, 132, 133, 143
*divalproex sodium er* ..... 125, 130, 132, 143
DIVIGEL ..... 237, 274
*dofetilide* ..... 106
DOJOLVI ..... 183
*dolishale* ..... 229, 237, 250

*donepezil hcl* ..... 73
DOPTELET ..... 80
DOPTELET SPRINKLE ..... 80
DOREVI ..... 323, 326, 330
DORZOLAMIDE HCL ..... 198
*dorzolamide hcl* ..... 198
*dorzolamide hcl-timolol mal* .... 198
*dotti* ..... 238, 274
DOUBLE PM ..... 194, 200
DOVATO ..... 33, 35
*doxazosin mesylate* 72, 92, 93, 97
*doxepin hcl* ..... 163, 317
*doxercalciferol* ..... 344
*doxycycline hyclate* ..... 25, 44, 314, 315
*doxycycline monohydrate* ..... 25, 44, 315
DRIZALMA SPRINKLE ..... 160
*dronabinol* ..... 208, 215
DROPLET MICRON ..... 172
DROPSAFE ACTI-LANCE 23G ..... 172
DROPSAFE AUTOPROTECT DUO ..... 172
DROPSAFE MEDLANCE LANCET 30G ..... 172
DROPSAFE SAFETY SYRINGE/NEEDLE ..... 172
DROPSAFE SICURA ..... 172
*drospiren-eth estrad-levomefol* ..... 229, 238, 250, 342
*drospirenone-ethinyl estradiol* ..... 229, 238, 250
DROXIA ..... 49
*droxidopa* ..... 66
DRYSOL ..... 319
DUAKLIR PRESSAIR . 67, 75, 298
DUAVEE ..... 235, 238
DUETACT ..... 259, 260
*duloxetine hcl* ..... 143, 160
DUOPA ..... 142
DUPIXENT ..... 304, 327, 336
DUREX EXTRA SENSITIVE THIN ..... 296
DUREX TROPICAL ..... 296
*dutasteride* ..... 271
DUVYZAT ..... 292
DYCLOPRO ..... 317
E.E.S. GRANULES ..... 30
EAA SUPPLEMENT ..... 183
EASIVENT ..... 172
EASY COMFORT SHARPS CONTAINER ..... 172
EASY TOUCH HEALTHPRO HIGH/LOW ..... 172
EASYGEL ..... 164, 166, 276
EASYMAX 15 LEVEL 2-3 CONTROL ..... 172
EASYMAX CONTROL ..... 172
EASYMAX CONTROL NORMAL/HIGH ..... 172
EBGLYSS ..... 327
*econazole nitrate* ..... 319
*econtra one-step* ..... 225, 229, 251
EC-RX DHEA ..... 292
EC-RX ESTRADIOL ..... 238, 274
EC-RX PROGESTERONE ..... 251
EC-RX TESTOSTERONE ..... 224
EDEX (2 CARTRIDGE) ... 109, 117
EDEX (6 CARTRIDGE) ... 109, 117
EDURANT ..... 34
EDURANT PED ..... 34
EEMT ..... 224, 238
EEMT HS ..... 224, 238
*efavirenz* ..... 34
*efavirenz-emtricitab-tenofo df* ..... 34, 35
*efavirenz-lamivudine-tenofovir* ..... 34, 35
EFFER-K ..... 187
*effer-k* ..... 187
EGATEN ..... 24
EGRIFTA SV ..... 259
EGRIFTA WR ..... 259
ELESTRIN ..... 238, 274
*eletriptan hydrobromide* ..... 161
*elinest* ..... 229, 238, 251
ELIQUIS ..... 79
ELIQUIS (1.5 MG PACK) ..... 79
ELIQUIS (2 MG PACK) ..... 79
ELIQUIS DVT/PE STARTER PACK ..... 79
ELITE-OB ..... 87, 340, 342
*elixophyllin* ..... 109, 157, 185, 312, 339
ELLA ..... 229, 251
ELLUME COVID-19 HOME TEST ..... 180
ELMIRON ..... 292
ELOCTATE ..... 83
*eltrombopag olamine* ..... 81
*eluryng* ..... 229, 238, 251
EMBECTA AUTOSHIELD DUO ..... 172
EMBECTA INS SYR U/F 1/2 UNIT ..... 172
EMBECTA INSULIN SYR ULTRAFINE ..... 173
EMBECTA INSULIN SYRINGE ..... 173
EMBECTA INSULIN SYRINGE U-100 ..... 173
EMBECTA INSULIN SYRINGE U-500 ..... 173
EMBECTA PEN NEEDLE NANO ..... 173
EMBECTA PEN NEEDLE NANO 2 GEN ..... 173
EMBECTA PEN NEEDLE ULTRAFINE ..... 173
EMBRACE PEN NEEDLES ..... 173
EMBRACE WAVE GLUCOSE CONTROL ..... 173
EMEND ..... 217
EMGALITY ..... 140
EMPAVELI ..... 278
EMSAM ..... 146
*emtricitabine* ..... 35
*emtricitabine-tenofovir df* ..... 35, 40
*emtricitab-rilpivir-tenofov df* ..... 34, 35, 40
EMTRIVA ..... 36
EMVERM ..... 24
*emzahh* ..... 229, 251
*enalapril maleate* ..... 94, 95
*enalapril-hydrochlorothiazide* ..... 95, 190
ENBRACE HR .. 87, 292, 340, 342
ENBREL ..... 271, 281, 286
ENBREL MINI ..... 270, 281, 286
ENBREL SURECLICK ..... 271, 281, 286
ENBUMYST ..... 91, 185
ENCALA ..... 183
ENCARE ..... 296
ENDARI ..... 292, 336
*endocet* ..... 121, 148, 150
ENDOMETRIN ..... 251
ENFLONSIA ..... 39
ENGERIX-B ..... 62
*enilloring* ..... 229, 238, 251
ENLITE GLUCOSE SENSOR . 173
ENOVARX-AMITRIPTYLINE .. 163
ENOVARX-BACLOFEN ..... 71
ENOVARX-CYCLOBENZAPRINE HCL ..... 70
ENOVARX-IBUPROFEN ..... 332
ENOVARX-LIDOCAINE HCL .. 317
ENOVARX-NAPROXEN ..... 332

ENOVARX-TRAMADOL ..... 336
*enoxaparin sodium* .....85, 86
ENSACOVE ..... 49
*enskyce* .....229, 238, 251
ENSPRYNG .....268, 286
ENSTILAR ..... 321, 323, 336
ENSURE ORIGINAL .....183
ENSURE PLUS .....183
*entacapone* ..... 140
*entecavir* ..... 40
ENTRESTO ..... 93, 94, 115
ENTYVIO PEN .....207, 215, 263
*enulose* ..... 182
EOHILIA .....220
EPCLUSA ..... 31, 32
EPIDIOLEX ..... 125
EPIFOAM .....317, 323
*epinastine hcl* .....21, 194
*epinephrine* ..... 66, 298
EPINEPHRINE .....66, 298
EPIPEN 2-PAK ..... 66, 298
EPIVIR ..... 36
*eplerenone* 92, 111, 115, 116, 187
EQUETRO ..... 125, 130
*ergocalciferol* .....344
ERGOMAR ..... 73, 133
*ergotamine-caffeine* .. 73, 133, 157
ERIVEDGE ..... 49
ERLEADA ..... 49
*erlotinib hcl* .....49
*errin* .....229, 251
ERY .....30, 194, 315
ERYPED 400 ..... 30
*erythromycin* ..... 30, 194, 195, 315
*erythromycin base* .....30
*erythromycin ethylsuccinate* .....30
*escitalopram oxalate* ..... 161
*eslicarbazepine acetate* .. 125, 145
*esomeprazole magnesium* .....217
*est estrogens-methyltest* .224, 238
*est estrogens-methyltest ds* ..... 224, 238
*est estrogens-methyltest hs* ..... 224, 238
*estarylla* .....229, 238, 251
*estazolam* .....139
*estradiol* ..... 238, 274, 275
*estradiol valerate* .....239, 275
*estradiol-norethindrone acet* ..... 239, 251
ESTRATEST H.S. .....224, 239
ESTRING .....239, 275
*estrogens conjugated* .....239, 275
*eszopiclone* .....134, 147
*ethacrynic acid* ..... 91, 111, 185
*ethambutol hcl* .....28
*ethosuximide* .....162
*etodolac* ..... 149, 158
*etodolac er* ..... 149, 158
*etonogestrel-ethinyl estradiol* ..... 229, 239, 251
*etoposide* ..... 49
*etravirine* ..... 34
EUCRISA .....317, 333
EURAX .....334
EVAMIST ..... 239, 275
*everolimus* .....49, 265, 290
EVEXITHROID .....260
EVOTAZ .....37, 292
EVRYSDI ..... 292
EXELDERM ..... 319
*exemestane* ..... 49, 225
EXODERM .....18, 317, 330
EXXUA .....162
EXXUA TITRATION PACK ..... 162
EYSUVIS ..... 200
*ezetimibe* .....104
*ezetimibe-simvastatin* ..... 104, 110
FABHALTA ..... 263, 278
*falmina* ..... 229, 239, 251
*famciclovir* ..... 40
*famotidine* ..... 20, 216
FANAPT .....135
FANAPT TITRATION PACK A 135
FANAPT TITRATION PACK B 135
FANAPT TITRATION PACK C 135
FANATREX FUSEPAQ ...121, 125
FASENRA PEN .....304
FASTEP COVID-19 ANTIGEN TEST .....180
FBL KIT ..... 71, 317, 332, 336
FC2 FEMALE CONDOM ..... 296
*febuxostat* ..... 273
FEIBA .....83
*feirza 1.5/30* ..... 229, 239, 251
*feirza 1/20* ..... 230, 239, 251
*felbamate* ..... 125
FELBATOL .....125
*felodipine er* ..... 108
FEM PH ..... 332, 336
FEMCAP ..... 296
FEMLYV .....230, 239, 251
FEMRING ..... 239, 275
*fenofibrate* .....110
*fenofibrate micronized* .....110
*fenofibric acid* .....110
*fentanyl* ..... 150
FERRIPROX ..... 218
FETZIMA .....160
FETZIMA TITRATION .....160
*fidaxomicin* ..... 41
FILSPARI ..... 115, 283, 292, 303
FILSUVEZ .....336
FINACEA ..... 315, 336
*finasteride* ..... 271, 321
*fingolimod hcl* .....269, 286
FINTEPLA .....125
*finzala* .....230, 239, 251
FIORICET ..... 121, 137, 148, 157
FIRDAPSE ..... 73, 292
FIRMAGON .....49, 225
FIRMAGON (240 MG DOSE) ..... 49, 225
FIRST-LANSOPRAZOLE ..... 217
FIRST-MOUTHWASH BLM ..... 19, 205, 207, 209, 210, 317
FIRVANQ ..... 31
FLAREX ..... 200
*flavoxate hcl* .....339
*flecainide acetate* .....105
FLEXICHAMBER .....173
FLEXICHAMBER ADULT MASK/SMALL .....173
FLEXICHAMBER CHILD MASK/LARGE .....173
FLEXICHAMBER CHILD MASK/SMALL .....173
FLOLIPID .....110
FLORIVA .....165, 166, 276, 344
FLOTREX ..... 165, 166, 276, 340
FLOWFLEX COVID-19 AG HOME TEST ..... 180
FLUAD ..... 62
FLUARIX .....62
FLUCELVAX ..... 62
*fluconazole* .....29
*flucytosine* ..... 43
*fludrocortisone acetate* .....220
FLULAVAL ..... 62
FLUMIST .....62
*flunisolide* ..... 200, 220, 301, 305
*fluocinolone acetonide* .... 200, 324
*fluocinolone acetonide body* ..... 200, 324
*fluocinolone acetonide scalp* ..... 200, 324
*fluocinonide* .....324
*fluocinonide emulsified base* ...324
FLUORIDEX ..... 166, 276

FLUORIDEX DAILY RENEWAL ..... 165, 166, 276
FLUORIDEX ENHANCED WHITENING ..... 166, 276
FLUORIMAX 5000 ..... 166, 276
FLUORIMAX 5000 SENSITIVE ..... 166, 276
*fluorometholone* ..... 200
*fluorouracil* ..... 49, 312, 336
*fluoxetine hcl* ..... 161
*fluphenazine hcl* ..... 155
*flurandrenolide* ..... 324
*flurazepam hcl* ..... 139
*flurbiprofen* ..... 149, 158, 204
*flurbiprofen sodium* ..... 158, 204
*fluticasone propionate* ..... 200, 220, 301, 305, 324
*fluticasone-salmeterol* ..... 75, 200, 220, 301
FLUTICASONE-SALMETEROL .. 75, 200, 220, 301
*fluvastatin sodium* ..... 110
*fluvastatin sodium er* ..... 110
*fluvoxamine maleate* ..... 161
*fluvoxamine maleate er* ..... 161
FLUZONE ..... 62
FLUZONE HIGH-DOSE ..... 62
FML FORTE ..... 200
FML LIQUIFILM ..... 201
FOCALIN ..... 157
*folic acid* ..... 342
*fondaparinux sodium* ..... 78, 87
FONDCIRCLE CONTROL SOLUTION ..... 173
FONDCIRCLE LANCING DEVICE ..... 173
FONDCIRCLE SINGLE USE LANCETS ..... 173
FORA TEST N' GO ADVANCE ..... 174
FORA TEST N'GO ADV-VOICE-6 CON ..... 180
FORANE ..... 145
*formaldehyde* ..... 181
*formoterol fumarate* ..... 75, 309
FORZINITY ..... 292
FOSAMAX ..... 275
FOSAMAX PLUS D ..... 275, 344
*fosamprenavir calcium* ..... 37
*fosfomycin tromethamine* ..... 45
*fosinopril sodium* ..... 94, 95
*fosinopril sodium-hctz* ..... 95, 190
FOSRENOL ..... 186, 272
FOTIVDA ..... 50
FRAGMIN ..... 86
FREESTYLE LIBRE 14 DAY READER ..... 174
FREESTYLE LIBRE 14 DAY SENSOR ..... 174
FREESTYLE LIBRE 2 PLUS SENSOR ..... 174
FREESTYLE LIBRE 2 READER ..... 174
FREESTYLE LIBRE 2 SENSOR ..... 174
FREESTYLE LIBRE 3 PLUS SENSOR ..... 174
FREESTYLE LIBRE 3 READER ..... 174
FREESTYLE LIBRE 3 SENSOR ..... 174
FROTEK ..... 332
*frovatriptan succinate* ..... 161
FRUZAQLA ..... 50
*ft aspirin* ..... 89, 90, 133, 160
*ft aspirin adult low dose* ..... 89, 90, 133, 159
*ft aspirin low dose* 89, 90, 133, 160
*ft clearlax* ..... 211
*ft folic acid* ..... 342
*ft laxative* ..... 211
*ft magnesium citrate* ..... 211
*ft naloxone hcl* ..... 16, 153
*ft nicotine* ..... 65, 69
*ft nicotine mini* ..... 64, 69
*furosemide* ..... 91, 111, 185
*fyavolv* ..... 239, 251
FYCOMPA ..... 125
*gabapentin* ..... 121, 125, 144
GALAFOLD ..... 191, 292
*galantamine hydrobromide* ..... 73
*galantamine hydrobromide er* ... 73
*galbriela* ..... 230, 239, 251
*gallifrey* ..... 251
GALZIN ..... 187
GARDASIL 9 ..... 62
*gatifloxacin* ..... 195
GATTEX ..... 213, 215
*gavilax* ..... 211
*gavilyte-c* ..... 211
*gavilyte-g* ..... 211
*gavilyte-n with flavor pack* ..... 211
GAVRETO ..... 50
*gefitinib* ..... 50
GELFILM ..... 83
*gemfibrozil* ..... 110
*gemmily* ..... 230, 239, 251
*generlac* ..... 182
*gengraf* .... 197, 262, 281, 286, 290
*gentamicin sulfate* ..... 23, 195, 315
*gentle laxative* ..... 211
GENVOYA ..... 33, 36
GILENYA ..... 269, 286
GILOTRIF ..... 50
*glatiramer acetate* ..... 261, 286
*glatopa* ..... 261, 286
GLEOSTINE ..... 50
*glimepiride* ..... 260
*glipizide* ..... 260
*glipizide er* ..... 260
*glipizide-metformin hcl* .... 227, 260
GLOPERBA ..... 273
*glucagon emergency kit* ..... 16, 244, 272
GLUCAGON EMERGENCY KIT ..... 16, 244, 272
GLUCOTROL XL ..... 260
*glutaraldehyde* ..... 181
*glyburide* ..... 260
*glyburide-metformin* ..... 227, 260
*glycerol phenylbutyrate* ..... 182
*glycolax* ..... 211
*glycopyrrolate* ..... 67, 68, 319
*glydo* ..... 317
GLYTACTIN BETTERMILK 15183
GLYTACTIN BETTERMILK DE-LITE ..... 183
GLYTACTIN BUILD 10PE ..... 183
GLYTACTIN BUILD 20/20 ..... 183
GLYTACTIN BUILD 20/20 PKU ..... 183
GLYTACTIN BURST ..... 183
GLYTACTIN COMPLETE 10PE ..... 183
GLYTACTIN RESTORE 10 .... 183
GLYTACTIN RESTORE 5 ..... 183
GLYTACTIN RESTORE LITE 10 ..... 183
GLYTACTIN RESTORE LITE 10PE ..... 183
GLYTACTIN RTD 10 ..... 183
GLYTACTIN RTD 15 ..... 183
GLYTACTIN RTD LITE 15 ..... 183
GLYTACTIN SWIRL 15 ..... 184
GLYTACTIN SWIRL 15PE ..... 184
GLYXAMBI ..... 235, 258
GOLYTELY ..... 211
GOMEKLI ..... 50

*goodsense aspirin low dose* ..... 89, 90, 133, 160
*goodsense clearlax* ..... 211
*goodsense nicotine* ..... 65, 69
*goodsense nicotine policrilex* ..... 65, 70
GORDOFILM ..... 320, 330
*granisetron hcl* ..... 208
GRANISOL ..... 208
GRASTEK ..... 60
*griseofulvin microsize* ..... 24
*griseofulvin ultramicrosize* ..... 24
*guaifenesin-codeine* ..... 300, 304
*guanfacine hcl* ..... 103, 109, 141
*guanfacine hcl er* ..... 141
GUARDIAN 4 GLUCOSE SENSOR ..... 174
GUARDIAN 4 TRANSMITTER 174
GUARDIAN REAL-TIME CHARGER ..... 174
GUARDIAN REAL-TIME TEST PLUG ..... 174
GUARDIAN SENSOR 3 ..... 174
GVOKE HYPOPEN 1-PACK ..... 16, 244, 272
GVOKE HYPOPEN 2-PACK ..... 16, 244, 272
GVOKE KIT ..... 16, 244, 272
GVOKE PFS ..... 16, 244, 272
GYNAZOLE-1 ..... 319
*habitrol* ..... 65, 70
HAEGARDA ..... 278
*hailey 1.5/30* ..... 230, 239, 251
*hailey 24 fe* ..... 230, 239, 251
*hailey fe 1.5/30* ..... 230, 239, 251
*hailey fe 1/20* ..... 230, 239, 251
*halcinonide* ..... 324
*halobetasol propionate* ..... 324
*haloperidol* ..... 139
*haloperidol lactate* ..... 139
HALUCORT ..... 336
HAN-EASE ..... 174
HARLIKU ..... 192
HARVONI ..... 31, 32, 33
HAVRIX ..... 63
*heather* ..... 230, 251
HEMANGEOL ..... 72, 97, 103, 105, 112, 133
HEMATINIC/FOLIC ACID . 87, 342
HEMLIBRA ..... 83
HEMMOREX-HC .... 201, 221, 324
HEMOFIL M ..... 83
*heparin na (pork) lock flsh pf* ..... 86
*heparin sod (pork) lock flush* ..... 86
*heparin sodium (porcine)* ..... 86
*heparin sodium (porcine) +rfid* .. 86
*heparin sodium (porcine) pf* ..... 86
HEPCLUDEX ..... 30
HEPLISAV-B ..... 63
HEPZATO W/50MM CATHETER ..... 50
HEPZATO W/62MM CATHETER ..... 50
*her style* ..... 225, 230, 251
HERNEXEOS ..... 50
HETLIOZ ..... 134, 146
HETLIOZ LQ ..... 134, 146
HIBERIX ..... 63
HUMALOG ..... 257
HUMALOG KWIKPEN ..... 257
HUMALOG MIX 50/50 KWIKPEN ..... 257
HUMALOG MIX 75/25 KWIKPEN ..... 257
HUMALOG MIX 75/25 VIAL .... 257
HUMALOG U-100 JUNIOR KWIKPEN ..... 257
HUMATE-P ..... 83
HUMATIN ..... 22, 23
HUMULIN 70/30 KWIKPEN ..... 246, 258
HUMULIN 70/30 VIAL ..... 246, 258
HUMULIN N KWIKPEN ..... 246
HUMULIN N VIAL ..... 246
HUMULIN R U-500 KWIKPEN 258
HUMULIN R VIAL ..... 258
HYCAMTIN ..... 50
*hydralazine hcl* ..... 109
HYDRO 40 ..... 91, 186, 206, 330
*hydrochlorothiazide* ... 92, 116, 190
*hydrocod poli-chlorphe poli er* ..... 19, 21, 300
*hydrocodone bitartrate er* ..... 150
*hydrocodone bit-homatrop mbr* ..... 68, 300
*hydrocodone-acetaminophen* ..... 121, 148, 150
*hydrocodone-ibuprofen* ..... 149, 151, 158
*hydrocortisone* ..... 201, 221, 325
*hydrocortisone (perianal)* ..... 201, 221, 324
*hydrocortisone ace-pramoxine* ..... 201, 221, 317, 324
*hydrocortisone acetate* ..... 201, 221, 324
*hydrocortisone butyrate* ..... 201, 221, 324, 325
*hydrocortisone valerate* ..... 201, 221, 325
*hydrocortisone-acetic acid* ..... 201, 204, 221, 325
*hydrocortisone-iodoquinol* ..... 22, 319, 325, 332
*hydrocort-pramoxine (perianal)* ..... 201, 221, 317, 325
*hydromorphone hcl* ..... 151
*hydromorphone hcl er* ..... 151
*hydroxychloroquine sulfate* ..... 25, 264, 281, 286
*hydroxyurea* ..... 50
*hydroxyzine hcl* ..... 19, 20, 134
*hydroxyzine pamoate* .. 19, 20, 134
HYFTOR ..... 268, 290, 327, 336
HYMPAVZI ..... 83
*hyoscyamine sulfate* ... 17, 68, 298
*hyoscyamine sulfate er* 16, 68, 298
*hyoscyamine sulfate sl* 17, 68, 298
*hyosyne* ..... 17, 68, 298
HYPERSAL ..... 305
HYRNUO ..... 50
*ibandronate sodium* ..... 275
IBRANCE ..... 50, 51
IBTROZI ..... 51
*ibuprofen* ..... 133, 149, 158
*icatibant acetate* ..... 90, 276, 278
*iclevia* ..... 230, 239, 251
ICLUSIG ..... 51
ICOTYDE ..... 327
IDELVION ..... 84
IDHIFA ..... 51
IDVYNSO ..... 34, 36
IHEALTH CONTROL SOLUTION ..... 174
IHEALTH COVID-19 RAPID TEST ..... 180
IHEALTH LANCING DEVICE . 174
*imatinib mesylate* ..... 51
IMBRUVICA ..... 51
*imipramine hcl* ..... 163
*imipramine pamoate* ..... 163
*imiquimod* ..... 312, 336
IMKELDI ..... 51
IMPAVIDO ..... 27, 39
IMVEXXY MAINTENANCE PACK ..... 239
IMVEXXY STARTER PACK ... 239

INBRIJA ..... 142
*incassia* ..... 230, 252
INCRELEX ..... 259
*indapamide* ..... 92, 116, 191
INDICAID COVID-19 RAPID TEST ..... 180
*indomethacin* ..... 149, 158, 273
*indomethacin er* ..... 149, 158, 273
INFANRIX ..... 61, 63
INGREZZA ..... 164
INLURIYO ..... 51
INLYTA ..... 51
INPEN 100-BLUE-LILLY-HUMALOG ..... 174
INPEN 100-BLUE-NOVOLOG-FIASP ..... 175
INPEN 100-GREY-LILLY-HUMALOG ..... 175
INPEN 100-GREY-NOVOLOG-FIASP ..... 175
INPEN 100-PINK-LILLY-HUMALOG ..... 175
INPEN 100-PINK-NOVOLOG-FIASP ..... 175
INQOVI ..... 51
INREBIC ..... 51
INSPIREASE RESERVOIR BAGS ..... 175
INSULIN LISPRO ..... 257
INSULIN LISPRO (1 UNIT DIAL) ..... 257
INSULIN LISPRO JUNIOR KWIKPEN ..... 257
INSULIN LISPRO PROT & LISPRO ..... 257
INSULIN PEN NEEDLES 175, 177
INSULIN SYRINGES ..... 175
INSUPEN32G EXTR3ME ..... 175
INTELENCE ..... 34
INTELISWAB COVID-19 RAPID TEST ..... 181
INTRAROSA ..... 221
*introvale* ..... 230, 240, 252
INVELTYS ..... 201
INZIRQO ..... 92, 190
*iodine strong* 17, 24, 226, 304, 319
*iodine tincture* ..... 319, 332
IOPIDINE ..... 193, 204
IPOL ..... 63
*ipratropium bromide* ..... 68, 298
*ipratropium bromide hfa* ..... 68, 298
*ipratropium-albuterol* ..... 68, 75, 298
IQIRVO ..... 212, 215
*irbesartan* ..... 93, 94
*irbesartan-hydrochlorothiazide* ..... 94, 190
IRESSA ..... 51
ISENTRESS ..... 33, 34
ISENTRESS HD ..... 33
*isibloom* ..... 230, 240, 252
*isoflurane* ..... 145
*isoniazid* ..... 28
*isosorb dinitrate-hydralazine* ..... 109, 112, 113
*isosorbide dinitrate* ..... 112, 113
*isosorbide mononitrate* ..... 112, 113
*isosorbide mononitrate er* 112, 113
*isotretinoin* ..... 330, 336
*isradipine* ..... 108
ISTALOL ..... 72, 97, 105, 198
ISTURISA ..... 221, 292
ITOVEBI ..... 51, 52
*itraconazole* ..... 29
*ivabradine hcl* ..... 102, 117
*ivermectin* ..... 24
IWILFIN ..... 52
*jaimiess* ..... 230, 240, 252
JAKAFI ..... 52, 329
JAKAFI XR ..... 52, 329
JARDIANCE ..... 258
JASCAYD ..... 299, 306, 333
*jasmiel* ..... 230, 240, 252
JAVADIN ..... 66, 103
JAYPIRCA ..... 52
*jencycla* ..... 230, 252
JENTADUETO ..... 227, 235
JENTADUETO XR ..... 227, 235
*jinteli* ..... 240, 252
JIVI ..... 84
JOENJA ..... 286
*jolessa* ..... 230, 240, 252
JOURNAVX ..... 121
*joyeaux* ..... 230, 240, 252
JUBLIA ..... 319
*juleber* ..... 230, 240, 252
JULUCA ..... 34
*junel 1.5/30* ..... 230, 240, 252
*junel 1/20* ..... 230, 240, 252
*junel fe 1.5/30* ..... 230, 240, 252
*junel fe 1/20* ..... 230, 240, 252
*junel fe 24* ..... 230, 240, 252
JUST RIGHT 5000 ..... 166, 276
JUXTAPID ..... 96, 111
JYLAMVO ..... 52, 264, 281, 287, 290
K.B.G.L IN TERODERM ..... 71, 149, 318, 332, 336
*kaitlib fe* ..... 230, 240, 252
KALETRA ..... 37
*kalliga* ..... 230, 240, 252
KALYDECO ..... 302
KAPSPARGO SPRINKLE ..... 76, 97, 103, 105, 112
*kariva* ..... 230, 240, 252
*kelnor 1/35* ..... 230, 240, 252
KEPPRA ..... 125
KEPPRA XR ..... 125
KERENDIA ..... 111
KESIMPTA ..... 268, 287
*ketoconazole* ..... 29, 319, 320
*ketodan* ..... 29, 320
KETO-DIASTIX ..... 181
KETONE CARE ..... 181
*ketorolac tromethamine* ..... 149, 158, 204
KETORUB ..... 332
KETOSTIX ..... 181
KEVZARA ..... 267, 281
KHINDIVI ..... 201, 221, 325
KINERET ..... 267, 281, 287
KISQALI (200 MG DOSE) ..... 52
KISQALI (400 MG DOSE) ..... 52
KISQALI (600 MG DOSE) ..... 52
KLARON ..... 315
*klayesta* ..... 42, 333
KLISYRI (250 MG) ..... 312, 336
KLISYRI (350 MG) ..... 312, 336
*klor-con* ..... 188
*klor-con 10* ..... 187
*klor-con m10* ..... 187
*klor-con m15* ..... 188
*klor-con m20* ..... 188
KLOXXADO ..... 17, 153
KOATE ..... 84
KOATE-DVI ..... 84
KOMZIFTI ..... 52
KOSELUGO ..... 52
KOURZEQ ..... 325
KOVALTRY ..... 84
K-PHOS ..... 188
K-PHOS NO 2 ..... 182
K-PHOS-NEUTRAL ..... 188
KRAZATI ..... 52
KRINTAFEL ..... 25
KRISTALOSE ..... 182
KT TAPE CGM PATCH ..... 175
*kurvelo* ..... 230, 240, 252
KYGEVVI ..... 292

KYZATREX ..... 224, 225
*labetalol hcl* ..... 72, 74, 93, 97, 103, 105, 112
*lacosamide* ..... 125, 126, 145
*lactulose* ..... 182
*lactulose encephalopathy* ..... 182
LAGEVRIO ..... 40
LAMICTAL ..... 126, 130
LAMICTAL ODT ..... 126, 130
LAMICTAL STARTER ..... 126, 130
LAMICTAL XR ..... 126, 130
*lamivudine* ..... 36
*lamivudine-zidovudine* ..... 36
*lamotrigine* ..... 126, 130
*lamotrigine er* ..... 126, 130
*lamotrigine odt* ..... 126, 130
*lamotrigine starter kit-blue* ..... 126, 131
*lamotrigine starter kit-green* ..... 126, 131
*lamotrigine starter kit-orange* ..... 126, 131
LAMPIT ..... 27
LANCETS ..... 176
LANCETS 28G THIN ..... 176
LANCETS SUPER THIN ..... 176
LANOXIN ..... 96, 102
*lansoprazole* ..... 218
*lanthanum carbonate* ..... 186, 272
LANTUS SOLOSTAR ..... 246
LANTUS U-100 VIAL ..... 246
*lapatinib ditosylate* ..... 52
*larin 1.5/30* ..... 231, 240, 252
*larin 1/20* ..... 231, 240, 252
*larin 24 fe* ..... 231, 240, 252
*larin fe 1.5/30* ..... 231, 240, 252
*larin fe 1/20* ..... 231, 240, 252
LASIX ..... 91, 111, 185
LASIX ONYU ..... 91, 185
LATANOPROST ..... 206
*latanoprost* ..... 206
*laxative osmotic* ..... 211
LAZCLUZE ..... 52
*lederle leucovorin* ..... 18, 272, 342
LEDIPASVIR-SOFOSBUVIR ..... 31, 33
*leflunomide* ..... 268, 281, 287, 290
*lenalidomide* ..... 53, 287
LENVIMA ..... 53
LEQEMBI IQLIK ..... 268
*lessina* ..... 231, 240, 252
*letrozole* ..... 53, 225
LETS ..... 66, 271
*leucovorin calcium* ..... 18, 272, 342
LEUKERAN ..... 53
LEUKINE ..... 81
*leuprolide acetate* ..... 53, 245
*levalbuterol hcl* ..... 75, 309
LEVALBUTEROL HFA ..... 76, 309
LEVBID ..... 17, 68, 298
*levetiracetam* ..... 126
*levetiracetam er* ..... 126
*levobunolol hcl* ..... 198
*levocarnitine* ..... 292
*levocarnitine sf* ..... 292
*levocetirizine dihydrochloride* ..... 21
*levofloxacin* ..... 28, 43, 195, 315
*levonest* ..... 231, 240, 252
*levonorgest-eth estrad 91-day* ..... 231, 240, 252
*levonorgest-eth estradiol-iron* ..... 231, 240, 252
*levonorgestrel* ..... 225, 231, 252
*levonorgestrel-ethinyl estrad* ..... 231, 240, 252
*levonorg-eth estrad triphasic* ..... 231, 240, 253
*levorphanol tartrate* ..... 151
*levothyroxine sodium* ..... 260
*levoxyl* ..... 260
LEVSIN ..... 17, 68, 299
LEVSIN/SL ..... 17, 68, 299
LEVULAN KERASTICK ..... 312, 336
*l-glutamine* ..... 293, 336
*lidocaine* ..... 318
*lidocaine hcl* ..... 205, 318
*lidocaine hcl urethral/mucosal* ..... 318
*lidocaine viscous hcl* ..... 205
*lidocaine-prilocaine* ..... 318
LIDOPIN ..... 318
LIDTOPIC MAX ..... 318
LIFYORLI (125 MG DOSE) ..... 53
LIFYORLI (150 MG DOSE) ..... 53
LIKMEZ ..... 22, 27, 39, 210, 315
*linezolid* ..... 42
LINZESS ..... 207, 215
*liomny* ..... 260
*liothyronine sodium* ..... 261
*liraglutide* ..... 123, 245
*liraglutide -weight management* ..... 123, 245
*lisdexamfetamine dimesylate* ..... 120
*lisinopril* ..... 94, 95
*lisinopril-hydrochlorothiazide* ..... 95, 190
L-ISOLEUCINE ..... 184
LITFULO ..... 329, 336
*lithium* ..... 131
*lithium carbonate* ..... 131
*lithium carbonate er* ..... 131
LITHOBID ..... 131
LITHOSTAT ..... 182
LIVDELZI ..... 212
LIVMARLI ..... 212, 215
LIVTENCITY ..... 28
LO LOESTRIN FE ..... 231, 241, 253
LODOCO ..... 78, 293
*lofexidine hcl* ..... 66
*lojaimiess* ..... 231, 241, 253
LOKELMA ..... 186
LOMAIRA ..... 120
LOMOTIL ..... 68, 208
*lomustine* ..... 53
LONSURF ..... 53
LOPID ..... 110
*lopinavir-ritonavir* ..... 37
LOPRESSOR ..... 76, 97, 105
*lorazepam* ..... 138, 139
*lorazepam intensol* ..... 138, 139
LORBRENA ..... 54
*loryna* ..... 231, 241, 253
*losartan potassium* ..... 93, 94
*losartan potassium-hctz* ..... 94, 190
LOTEMAX ..... 201
LOTEMAX SM ..... 201
LOTENSIN ..... 95
LOTENSIN HCT ..... 95, 190
*loteprednol etabonate* ..... 201
*loteprednol-tobramycin* ..... 195, 201
*lovastatin* ..... 110
*low-ogestrel* ..... 231, 241, 253
*loxapine succinate* ..... 134, 142
*lo-zumandimine* ..... 231, 241, 253
*lubiprostone* ..... 207, 215
LUGOLS STRONG IODINE ..... 319, 332
*luizza 1.5/30* ..... 231, 241, 253
*luizza 1/20* ..... 231, 241, 253
LUMAKRAS ..... 54
LUMIGAN ..... 206
LUMRYZ ..... 141, 164, 273
LUMRYZ STARTER PACK ..... 164, 273
LUPKYNIS ..... 269, 290
*lurasidone hcl* ..... 135
LURBIRO ..... 149, 158, 204
*lutera* ..... 231, 241, 253
*lyleq* ..... 231, 253
*lyllana* ..... 241, 275

LYNKUET ..... 141
LYNPARZA ..... 54
LYRICA ..... 126, 127, 143, 144
LYSODREN ..... 54
LYTGOBI (12 MG DAILY DOSE) ..... 54
LYTGOBI (16 MG DAILY DOSE) ..... 54
LYTGOBI (20 MG DAILY DOSE) ..... 54
LYUMJEV KWIKPEN ..... 258
LYUMJEV VIAL ..... 258
*lyza* ..... 231, 253
*macitentan* ..... 117, 303, 310
MACROBID ..... 45
*magnesium citrate* ..... 211
MALARONE ..... 25
*malathion* ..... 334
MALTOCARB ..... 184
*maraviroc* ..... 33
*marlissa* ..... 231, 241, 253
MARPLAN ..... 146
MATULANE ..... 54
*matzim la* ... 99, 100, 101, 107, 117
MAVENCLAD .... 54, 262, 287, 290
MAVYRET ..... 32, 33
MAXIDEX ..... 201
MAXITROL ..... 195, 202
*maxi-tuss ac* ..... 300, 304
MAYZENT ..... 269, 287
MAYZENT STARTER PACK ..... 269, 287
*me/naphos/mb/hyo1* ... 45, 68, 293
*meclofenamate sodium* ... 149, 158
MEDERMA SPF 30 ..... 336
MEDROL ..... 221
*medroxyprogesterone acetate* ..... 231, 253
*mefenamic acid* ..... 149, 159
*mefloquine hcl* ..... 25
*megestrol acetate* ..... 54, 253
MEKINIST ..... 54
MEKTOVI ..... 54
*meleya* ..... 231, 253
MELOXICAM ..... 149, 159
*meloxicam* ..... 149, 159
*memantine hcl* ..... 141
*memantine hcl er* ..... 141
*memantine hcl-donepezil hcl er* ..... 73, 141
MENOSTAR ..... 241, 275
MENQUADFI ..... 63
MENVEO ..... 63
*meperidine hcl* ..... 151
*meprobamate* ..... 134, 147
*mercaptopurine* ..... 54, 265, 290
*mesalamine* ..... 209
*mesalamine-cleanser* ..... 209
*mesna* ..... 295
MESNEX ..... 295
MESTINON ..... 73
*metaxalone* ..... 70
*metformin hcl* ..... 227
*metformin hcl er* ..... 227
*methadone hcl* ..... 151
*methadone hcl intensol* ..... 151
METHADOSE ..... 151
*methadose* ..... 151
METHADOSE SUGAR-FREE ..... 151
*methamphetamine hcl* ..... 120
*methazolamide* ..... 91, 102, 198
*methenamine hippurate* ..... 45
*methenamine mandelate* ..... 45
METHERGINE ..... 297
*methimazole* ..... 226
METHITEST ..... 224
*methocarbamol* ..... 34, 70
*methotrexate sodium* ..... 55, 264, 281, 287, 290
*methotrexate sodium (pf)* ..... 55, 264, 281, 287, 290
*methoxsalen rapid* ..... 333
*methscopolamine bromide* ..... 68
*methsuximide* ..... 162
*methyl salicylate* ..... 320
*methyldopa* ..... 66, 103, 109
*methylergonovine maleate* ..... 297
METHYLIN ..... 157
*methylphenidate hcl* ..... 157
*methylphenidate hcl er* ..... 157
*methylphenidate hcl er (cd)* ..... 157
*methylphenidate hcl er (la)* ..... 157
*methylphenidate hcl er (osm)* ..... 157
*methylprednisolone* ..... 221
*methyltestosterone* ..... 224
*metoclopramide hcl* ..... 217
*metolazone* ..... 92, 116, 191
METOPIRONE ..... 181
*metoprolol succinate er* ..... 77, 97, 103, 105, 112
*metoprolol tartrate* ..... 77, 97, 103, 105, 112
*metoprolol-hydrochlorothiazide* ..... 97, 103, 190
*metronidazole* 22, 27, 39, 210, 315
*metyrosine* ..... 181, 293
*mexiletine hcl* ..... 104
MIACALCIN ..... 226, 275
*mibelas 24 fe* ..... 231, 241, 253
*miconazole 3* ..... 320
*microgestin 1.5/30* ... 231, 241, 253
*microgestin 1/20* ..... 232, 241, 253
*microgestin fe 1.5/30* ..... 232, 241, 253
*microgestin fe 1/20* .. 232, 241, 253
MICROLET NEXT LANCETS ..... 176
MICROLET NEXT LANCING DEVICE ..... 176
*midazolam hcl* ..... 139
MIDAZOLAM+SYRSPEND SF ..... 139
*midodrine hcl* ..... 67
MIEBO ..... 197, 204
MIFEPREX ..... 297
*mifepristone* ..... 225, 297
MIGERGOT ..... 73, 133, 157
*miglitol* ..... 223
*miglustat* ..... 192, 293
*mili* ..... 232, 241, 253
*milnacipran hcl* ..... 143, 160
*mimvey* ..... 241, 253
MINIMED INSTINCT GLUC SENSOR ..... 176
*minocycline hcl* .... 26, 45, 195, 315
*minocycline hcl er* ..... 26, 45, 195, 315, 337
*minoxidil* ..... 109, 321
*minzoya* ..... 232, 241, 253
MIPLYFFA ..... 191
*mirabegron er* ..... 340
*mirtazapine* ..... 129, 162
MIRVASO ..... 194, 313, 337
*misoprostol* ..... 217
MITIGARE ..... 273
MITOSOL ..... 195
*mm aspirin* ..... 89, 90, 133, 160
*mm clearlax* ..... 211
M-M-R II ..... 63
M-NATAL PLUS ..... 87, 340, 342
MNEXSPIKE ..... 63
MOBILE LANCETS 30G ..... 176
*modafinil* ..... 164
MODEYSO ..... 55
*moexipril hcl* ..... 95
*molindone hcl* ..... 134, 142
*mometasone furoate* ..... 202, 221, 222, 301, 305, 325
*mono-linyah* ..... 232, 241, 253

MONSELS FERRIC SUBSULFATE ..... 84
*montelukast sodium* ..... 305
*morphine sulfate* ..... 152
*morphine sulfate (concentrate)* 151
*morphine sulfate er* ..... 152
*morphine sulfate er beads* ..... 151
MOTPOLY XR ..... 127, 145
MOUNJARO ..... 245
MOVIPREP ..... 211, 344
*moxifloxacin hcl* ... 28, 43, 195, 315
*moxifloxacin hcl (2x day)* ... 43, 195
MOZOBIL ..... 81
MUCOSITISRX ..... 204
MULPLETA ..... 81
MULTAQ ..... 106
*multivitamin w/fluoride* ..... 165, 166, 276, 340
*multivitamin/fluoride* ..... 165, 166, 276, 340, 342
*multi-vitamin/fluoride/iron* ..... 87, 276, 340
*mupirocin* ..... 316
*mupirocin calcium* ..... 315
*my choice* ..... 225, 232, 254
*my way* ..... 225, 232, 254
MYALEPT ..... 246
*mycophenolate mofetil* .... 262, 290
*mycophenolate sodium* ..... 290
*mycophenolic acid* ..... 290
MYFEMBREE ..... 225, 241, 254
MYHIBBIN ..... 290
MYLERAN ..... 55
MYSOLINE ..... 136
MYTESI ..... 208
MYXREDLIN ..... 188, 258
*na sulfate-k sulfate-mg sulf* ..... 211
*nabumetone* ..... 149, 159
*nadolol* ..... 72, 77, 92, 97, 103, 105, 112
*naloxone hcl* ..... 17, 18, 153, 272
*naltrexone hcl* ..... 16, 18, 65, 153, 271, 272
NAMZARIC ..... 73, 141
*naproxen* ..... 133, 149, 159, 273
*naproxen dr* ..... 133, 149, 159, 273
*naproxen sodium* ..... 133, 149, 159, 273
*naratriptan hcl* ..... 161
NARCAN ..... 17, 153
NARDIL ..... 146
NASCOBAL ..... 88, 342
NATACYN ..... 196
NATAL PNV ..... 87, 340, 342
NATAZIA ..... 232, 241, 254
*nateglinide* ..... 247
NAYZILAM ..... 138, 139
*nebivolol hcl* ..... 72, 97, 103, 105
NEBUPENT ..... 27
NEBUSAL ..... 305
*necon 0.5/35 (28)* .... 232, 241, 254
*nefazodone hcl* ..... 162
NEFFY ..... 66
NEMLUVIO ..... 327
NEOCATE SYNEO JUNIOR ... 184
*neomycin sulfate* ..... 23, 195, 316
*neomycin-bacitracin zn-polymyx* ..... 195
*neomycin-polymyxin-dexameth* ..... 195, 202
*neomycin-polymyxin-gramicidin* ..... 195
*neomycin-polymyxin-hc* .. 195, 202
NEONATAL COMPLETE ..... 87, 340, 342
NEONATAL PLUS .... 87, 340, 343
NEOTUSS PLUS .. 19, 21, 67, 300
NERLYNX ..... 55
NESTABS ..... 87, 340, 343
NESTABS ONE 87, 293, 340, 343
*neuac* ..... 38, 316, 332
NEULASTA ..... 81
NEUPRO ..... 147
NEURAPTINE ..... 121, 144
NEURONTIN ... 121, 122, 127, 144
NEURORUB ..... 122, 144
NEVANAC ..... 204
*nevirapine* ..... 35
*nevirapine er* ..... 35
*new day* ..... 225, 232, 254
NEXLETOL ..... 92, 96
NEXLIZET ..... 92, 96, 104
NEXTSTELLIS ..... 232, 241, 254
NGENLA ..... 248
*niacin er (antihyperlipidemic)* ..... 96, 343
*nicardipine hcl* ..... 108, 117
NICORETTE ..... 65, 70
NICORETTE MINI ..... 65, 70
*nicotine* ..... 65, 70
*nicotine mini* ..... 65, 70
*nicotine polacrilex* ..... 65, 70
*nicotine polacrilex mini* ..... 65, 70
*nicotine step 1* ..... 65, 70
*nicotine step 2* ..... 65, 70
*nicotine step 3* ..... 65, 70
NICOTROL NS ..... 65, 70
*nifedipine* ..... 108, 117
*nifedipine er* ..... 108, 117
*nifedipine er osmotic release* ..... 108, 117
*nikki* ..... 232, 241, 254
*nilotinib hcl* ..... 55
*nimodipine* ..... 108, 118
NIMODIPINE ..... 108, 109, 118
NINLARO ..... 55
*nintedanib esylate* ..... 299
*nisoldipine er* ..... 108, 109
*nitazoxanide* ..... 26, 27
*nitro-bid* ..... 112, 113
NITRO-DUR ..... 112, 113
*nitrofurantoin* ..... 45
*nitrofurantoin macrocrystal* ..... 45
*nitrofurantoin monohydrate macrocrystals* ..... 45
*nitroglycerin* ..... 112, 113, 321, 337
NITROSTAT ..... 113
NITRO-TIME ..... 113
NIVA THYROID ..... 261
NIVESTYM ..... 81
*nora-be* ..... 232, 254
NORDIPEN 5 INJECTION DEVICE ..... 176
NORDITROPIN FLEXPRO ..... 248, 259
*norelgestromin-eth estradiol* ..... 232, 241, 254
*norethin ace-eth estrad-fe* ..... 232, 242, 254
*norethindrone* ..... 232, 254
*norethindrone acetate* ..... 254
*norethindrone acet-ethinyl est* ..... 232, 242, 254
*norethindrone-eth estradiol* ..... 242, 254
*norgestimate-eth estradiol* ..... 232, 242, 254
*norgestimate-ethinyl estradiol triphasic* ..... 232, 242, 254
NORLIQVA ..... 108, 109, 118
*norlyroc* ..... 232, 254
NORPACE ..... 104
NORPRAMIN ..... 163
*nortrel 0.5/35 (28)* ... 232, 242, 254
*nortrel 1/35 (21)* ..... 232, 242, 254
*nortrel 1/35 (28)* ..... 232, 242, 254
*nortrel 7/7/7* ..... 232, 242, 254
*nortriptyline hcl* ..... 163
NORVIR ..... 37

NOURIANZ ..... 119, 141
NOVOEIGHT ..... 84
NOVOFINE PEN NEEDLE ..... 176
NOVOFINE PLUS PEN NEEDLE ..... 176
NOVOPEN ECHO ..... 176
NOVOSEVEN RT ..... 84
NOXAFIL ..... 29
*np thyroid* ..... 261
NUBEQA ..... 55
NUCALA ..... 299
NUCORT ..... 202, 222, 325
NUCYNTA ..... 152
NUCYNTA ER ..... 152
NUEDEXTA ..... 141
NULEV ..... 17, 68, 299
NUPLAZID ..... 136
NURTEC ..... 140
NUWIQ ..... 84
NUZYRA ..... 23
*nylia 1/35* ..... 233, 242, 254
*nylia 7/7/7* ..... 233, 242, 255
NYMALIZE ..... 108, 109, 118
*nystatin* ..... 42, 333
*nystatin-triamcinolone* ..... 42, 325, 333
*nystop* ..... 42, 333
OBIZUR ..... 84
*octreotide acetate* ..... 215, 259
OCUFLOX ..... 43, 195
ODACTRA ..... 60
ODEFSEY ..... 35, 36, 40
ODOMZO ..... 55
*ofloxacin* ..... 43, 195, 196
OGSIVEO ..... 55
OHTUVAYRE ..... 297
OJEMDA ..... 55
OJJAARA ..... 55
*olanzapine* ..... 131, 136, 208
*olanzapine-fluoxetine hcl* ..... 131, 136, 161, 209
*olmesartan medoxomil* ..... 93, 94
*olmesartan medoxomil-hctz* ..... 94, 190
*olopatadine hcl* ..... 20, 194
OLUMIANT ..... 267, 281
*omega-3-acid ethyl esters* ..... 96, 114
*omeprazole* ..... 218
OMNIFLEX DIAPHRAGM ..... 296
OMNIPOD 5 DEXG7G6 INTRO GEN 5 ..... 176
OMNIPOD 5 DEXG7G6 PODS GEN 5 ..... 176
OMNIPOD 5 LIBRE INTRO ..... 176
OMNIPOD 5 LIBRE PODS ..... 176
OMNITROPE ..... 248, 259
OMVOH ..... 207
OMVOH (300 MG DOSE) ..... 207
ON/GO COVID-19 ANTIGEN TEST ..... 181
ON/GO ONE COVID-19 HOME TEST ..... 181
*ondansetron hcl* ..... 208
*ondansetron odt* ..... 208
ONE VITE WOMENS PLUS ..... 87, 340, 343
ONENATAL RX ..... 87, 188, 340, 343
ONETOUCH DELICA PLUS LANCING ..... 176
ONETOUCH DELICA SAFETY LANCING ..... 176
ONETOUCH ULTRA ..... 176
ONETOUCH VERIO ..... 176
ONFI ..... 138, 139
ONTRALFY ..... 70
ONUREG ..... 55
ONYDA XR ..... 67
*opcicon one-step* ..... 225, 233, 255
OPFOLDA ..... 192, 293
OPILL ..... 233, 255
*opium* ..... 152, 208
*option 2* ..... 225, 233, 255
OPTIONS GYNOL II CONTRACEPTIVE ..... 296
OPVEE ..... 153
OPZELURA ..... 55, 329, 337
ORACIT ..... 182
ORALAIR ..... 60
ORALAIR ADULT STARTER PACK ..... 60
ORALAIR CHILDRENS STARTER PACK ..... 60
ORALONE ..... 325
ORAPRED ODT ..... 202, 222
ORAVIG ..... 320
ORENCIA ..... 263, 282, 287
ORENCIA CLICKJECT ..... 263, 282, 287
ORENITRAM ..... 118, 307, 310
ORENITRAM MONTH 1 ..... 118, 307, 310
ORENITRAM MONTH 2 ..... 118, 307, 310
ORENITRAM MONTH 3 ..... 118, 307, 310
ORFADIN ..... 192, 293
ORGOVYX ..... 55, 225
ORIAHNN ..... 225, 242, 255
ORILISSA ..... 225, 226
ORKAMBI ..... 301, 302, 303
ORLISTAT ..... 215
ORLYNVAH ..... 45, 191, 273
*orphenadrine citrate er* ..... 71, 77, 124
*orquidea* ..... 233, 255
ORSERDU ..... 55, 56
OSCIMIN ..... 17, 68, 299
*oseltamivir phosphate* ..... 39
OSPHENA ..... 235
OTEZLA ..... 268, 269, 282, 287, 288, 337
OTEZLA XR ..... 269
OTEZLA/OTEZLA XR INITIATION PK ..... 269
OVIDE ..... 334
*oxaprozin* ..... 149, 159
*oxazepam* ..... 139
*oxcarbazepine* ..... 127, 145
OXERVATE ..... 197, 204
*oxiconazole nitrate* ..... 320
*oxybutynin chloride* ..... 339
*oxybutynin chloride er* ..... 339
*oxycodone hcl* ..... 152
*oxycodone-acetaminophen* ..... 122, 148, 152
*oxymetazoline hcl* ..... 206, 313, 337
*oxymorphone hcl* ..... 152
*oxymorphone hcl er* ..... 152
OZEMPIC ..... 245
OZOBAX DS ..... 71
PACERONE ..... 106
*paliperidone er* ..... 136
PALYNZIQ ..... 192
PANCREAZE ..... 193, 213
PANRETIN ..... 312, 337
*pantoprazole sodium* ..... 218
PARI VORTEX ADULT MASK ..... 176
PARI VORTEX PEDIATRIC MASK ..... 177
*paricalcitol* ..... 344
PARNATE ..... 146
*paroxetine hcl* ..... 162
*paroxetine hcl er* ..... 162
PAXLOVID (150/100) ..... 28, 30
PAXLOVID (300/100 & 150/100) ..... 28, 30
PAXLOVID (300/100) ..... 28, 30
*pazopanib hcl* ..... 56
PEDIARIX ..... 61, 63
PEDVAXHIB ..... 63

*peg 3350* ..... 211
*peg 3350-kcl-na bicarb-nacl* ....211
*peg-3350/electrolytes* .....211
*peg-3350/electrolytes/ascorbat* ..... 211, 344
PEGASYS .....37, 56, 266, 288
*peg-kcl-nacl-nasulf-na asc-c* ..... 211, 344
PEG-PREP ..... 211
PEMAZYRE ..... 56
PEN NEEDLE/5-BEVEL TIP ...177
PENBRAYA ..... 63
*penicillamine* ..... 17, 218, 282
*penicillin v potassium* ..... 39
PENMENVY ..... 63
PENTACEL ..... 61, 63
*pentamidine isethionate* ..... 27
*pentazocine-naloxone hcl*153, 155
*pentoxifylline er* ..... 82
PEPTICATE ..... 184
*perampanel* ..... 127
PERFECT POINT SAFETY LANCETS ..... 177
PERFECT POINT SAFETY NEEDLE .....177
PERFOROMIST .....76, 309
PERIDEX ..... 22, 197, 319, 332
*perindopril erbumine* ..... 95
*periogard* .....22, 197, 319, 332
*permethrin* .....334
*perphenazine* ..... 156
*perphenazine-amitriptyline* ..... 156, 163
PERTZYE ..... 193, 213
*phenazopyridine hcl* ..... 318
*phendimetrazine tartrate* ..... 120
*phendimetrazine tartrate er* .....120
*phenelzine sulfate* ..... 146
*phenobarbital* ..... 136, 137
*phenoxybenzamine hcl* ..... 73, 116
*phentermine hcl* ..... 120
*phentermine-topiramate er* .....122
PHENYLADE ESSENTIAL DRINK MIX ..... 184
PHENYLADE GMP MIX DHA/FIBER .....184
PHENYLADE GMP MIX-IN .....184
PHENYLADE GMP ULTRA .... 184
PHENYLADE60 DRINK MIX ...184
*phenylephrine hcl* .....205, 207
*phenytek* ..... 104, 144
*phenytoin* ..... 104, 145
*phenytoin infatabs* .....104, 145
*phenytoin sodium extended* ..... 104, 145
PHEXX .....296
*philith* .....233, 242, 255
PHOSPHA 250 NEUTRAL .....188
PHOSPHOLINE IODIDE .....205
*phosphorous* ..... 188
*phospho-trin 250 neutral* ..... 188
PHOXILLUM B22K4/0 ..... 188
PHOXILLUM BK4/2.5 ..... 188
*phytonadione* ..... 17, 272, 345
PIFELTRO ..... 35
*pilocarpine hcl* .....74, 205
PILOT COVID-19 AT-HOME TEST .....181
*pimecrolimus* .....290, 327, 337
*pimozide* .....134, 142
*pimtrea* ..... 233, 242, 255
*pindolol* .....72, 97, 103, 105, 113
*pioglitazone hcl* ..... 260
*pioglitazone hcl-glimepiride* .....260
*pioglitazone hcl-metformin hcl* ..... 227, 260
PIP GLUCOSE CONTROL SOLUTION .....177
PIQRAY ..... 56
*pirfenidone* ..... 299, 308
*piroxicam* .....150, 159
PIVOT SUPPLY KIT ..... 177
PIVYA ..... 24
PKU COOLER 10 ..... 184
PKU COOLER 15 ..... 184
PKU COOLER 20 ..... 184
PKU EASY MICROTABS .....184
PKU EASY MICROTABS PLUS .....184
PKU EASY SHAKE & GO .....184
PKU GOLIKE 10G P.E. .....184
PKU GOLIKE PLUS 16+ .....184
PKU GOLIKE PLUS 4-16 .....184
PKU PERIFLEX EARLY YEARS .....184
PKU START .....184
*pku trio* ..... 185
PLAN B ONE-STEP 226, 233, 255
PLEGRIDY .....288
PLEGRIDY STARTER PACK. 288
*plerixafor* ..... 81
PNEUMOVAX 23 ..... 63
*pnv 27-ca/fe/fa* ..... 87, 341, 343
PODOCON-25 ..... 330, 337
*podofilox* .....330, 337
*polyethylene glycol 3350* .....211
*polymyxin b-trimethoprim* ..... 43, 196, 316
POLY-VI-FLOR/IRON ..... 87, 276, 341
*pomalidomide* .....56, 288
*portia-28* .....233, 242, 255
*posaconazole* .....29
*potassium chloride* ..... 188
*potassium chloride crys er* ..... 188
*potassium chloride er* ..... 188
*potassium citrate er* ..... 182
*potassium citrate-citric acid* .....182
*potassium iodide (expectorant)* ..... 304
PRADAXA .....80
*pramipexole dihydrochloride* ... 147
PRAMOSONE .....318, 325
PRAMOTIC ..... 197, 205
*prasugrel hcl* ..... 89
*pravastatin sodium* ..... 110
*praziquantel* ..... 24
*prazosin hcl* .....72, 92, 93, 97
PRED MILD ..... 202, 222
*prednisolone* ..... 202, 222
*prednisolone acetate* .....202, 222
*prednisolone sodium phosphate* ..... 202, 222
*prednisone* ..... 222
*prednisone intensol* .....222
*pregabalin* ..... 127, 143, 144
PREKUNIL ..... 185
PREMARIN ..... 242, 275
PREMESISRX 188, 293, 341, 343
PREMPHASE ..... 242, 255
PREMPRO .....242, 255
*prenatal* ..... 87, 341, 343
PRENATE ..... 189, 341, 343
PRENATE DHA ..... 88, 188, 293, 341, 343
PRENATE ELITE ..... 88, 341, 343
PRENATE ENHANCE ..... 88, 188, 293, 341, 343
PRENATE ESSENTIAL ..... 88, 189, 293, 341, 343
PRENATE MINI ..... 88, 189, 293, 341, 343
PRENATE PIXIE ..... 88, 189, 293, 341, 343
PRENATE RESTORE ..... 88, 189, 293, 341, 343
PREPIDIL .....297
PRETOMANID ..... 28
*prevalite* ..... 98, 99

PREVIDENT ... 165, 166, 167, 277
PREVIDENT 5000 BOOSTER PLUS ..... 166, 277
PREVIDENT 5000 DRY MOUTH ..... 165, 166, 277
PREVIDENT 5000 ENAMEL PROTECT ..... 166, 277
PREVIDENT 5000 KIDS . 166, 277
PREVIDENT 5000 ORTHO DEFENSE ..... 166, 277
PREVIDENT 5000 PLUS ..... 165, 166, 277
PREVIDENT 5000 SENSITIVE ..... 166, 277
PREVNAR 20 ..... 63
PREVYMIS ..... 28
PREZCOBIX ..... 37, 293
PREZISTA ..... 37
PRIFTIN ..... 28, 43
*primaquine phosphate* ..... 26
*primidone* ..... 136
PRIORIX ..... 63
PRISMASOL B22GK 4/0 ..... 189
PRISMASOL BGK 0/2.5 ..... 189
PRISMASOL BGK 2/0 ..... 189
PRISMASOL BGK 2/3.5 ..... 189
PRISMASOL BGK 4/0/1.2 ..... 189
PRISMASOL BGK 4/2.5 ..... 189
PRISMASOL BK 0/0/1.2 ..... 189
*probenecid* ..... 191, 273
PROCENTRA ..... 120
*prochlorperazine* ..... 156, 209
*prochlorperazine maleate* 156, 209
PROCTOFOAM HC ..... 202, 222, 318, 325
*procto-med hc* ..... 202, 222, 325
PROCTOSOL HC ... 202, 222, 326
PROCTOZONE-HC 202, 222, 326
PROCYSBI ..... 293
PROFILNINE ..... 84
*progesterone* ..... 255
PROGESTERONE MICRONIZED ..... 255
PROGLYCEM ..... 226
PROGRAF ..... 262, 291, 327
PROMACTA ..... 81
*promethazine hcl* ..... 18, 20, 134, 209, 213, 304
*promethazine-codeine* ..... 20, 300
*promethazine-dm* ..... 20, 300
*promethazine-phenylephrine* ..... 20, 67
PROMETHEGAN ..... 20, 134, 209, 213, 304
PRONAL ..... 320, 330
*propafenone hcl* ..... 105
*propafenone hcl er* ..... 105
*proparacaine hcl* ..... 205
*propranolol hcl* ..... 72, 98, 103, 106, 113, 133
*propranolol hcl er* ..... 72, 98, 103, 106, 113, 133
*propylthiouracil* ..... 226
PROQUAD ..... 64
PRO-STAT/FIBER ..... 185
*protriptyline hcl* ..... 163
PROVERA ..... 255
*prucalopride succinate* ..... 215
PRURADIK ..... 334
*pseudoephedrine-bromphen-dm* ..... 20, 21, 66, 300
PULMOSAL ..... 305
PULMOZYME ..... 193, 305
PURE COMFORT SAFETY LANCET 30G ..... 177
PURE COMFORT SAFETY PEN NEEDLE ..... 177
PURIXAN ..... 56, 265, 291
PYLERA ..... 25, 27, 45, 208, 210
*pyrazinamide* ..... 28
PYRIDIUM ..... 318
*pyridostigmine bromide* ..... 74
*pyridostigmine bromide er* ..... 74
PYRIDOSTIGMINE BROMIDE ER ..... 74
*pyrimethamine* ..... 26
PYROGALLIC ACID 297, 330, 337
PYRUKYND ..... 78
PYRUKYND TAPER PACK ..... 78
QBRELIS ..... 95
QFITLIA ..... 84
QINLOCK ..... 56
QSYMIA ..... 122
QUADRACEL ..... 61, 64
QUESTRAN ..... 99
QUESTRAN LIGHT ..... 99
*quetiapine fumarate* ..... 131, 136
*quetiapine fumarate er* .... 131, 136
QUICK TOUCH INSULIN PEN NEEDLE ..... 177
QUICKVUE AT-HOME COVID-19 TEST ..... 181
*quinapril hcl* ..... 95
*quinapril-hydrochlorothiazide* ..... 96, 190
*quinidine gluconate er* ..... 26, 104
*quinidine sulfate* ..... 26, 104
*quinine sulfate* ..... 26
QULIPTA ..... 140
QVAR REDIHALER 222, 301, 306
*rabeprazole sodium* ..... 218
RADICAVA ORS ..... 119, 141
RADICAVA ORS STARTER KIT ..... 119, 141
RADIOGARDASE ..... 18, 186, 272
RAGWITEK ..... 61
RALDESY ..... 162
*raloxifene hcl* ..... 236, 275
*ramelteon* ..... 134, 146
*ramipril* ..... 95, 96
*ranolazine er* ..... 102
*rasagiline mesylate* ..... 146
RASUVO ..... 264, 282
RAYA SURE PEN NEEDLE ... 177
REAL FOOD BLENDS ..... 185
*reclipsen* ..... 233, 242, 255
RECOMBINATE ..... 85
RECOMBIVAX HB ..... 64
RECOTHROM ..... 85
RECOTHROM SPRAY KIT ..... 85
RECTIV ..... 113, 321, 337
REFRESH AA 15 PKU ..... 185
REGLAN ..... 217
RELENZA DISKHALER ..... 39
RELION GLUCOSE TEST STRIPS ..... 180
RELISTOR ..... 153, 154, 207, 215
RELNATE DHA . 88, 293, 341, 343
RENASTART ..... 185
RENTHYROID ..... 261
*repaglinide* ..... 247
REPATHA SURECLICK ..... 114
RESTASIS ..... 197, 203, 262
RESTORIL ..... 139
RETACRIT ..... 77, 78, 81
RETEVMO ..... 56
RETROVIR ..... 36
REVUFORJ ..... 56
REXTOVY ..... 17, 154
REXULTI ..... 136
REYATAZ ..... 37
REZDIFFRA ..... 215, 261
REZENOPY ..... 17, 154
REZLIDHIA ..... 56
REZUROCK ..... 293
RHAPSIDO ..... 288, 328

RHOFADE ..... 207, 313, 337
RHOPRESSA ..... 206
*ribavirin* ..... 40
RIDAURA ..... 218, 264, 282, 288
*rifabutin* ..... 28, 43
*rifampin* ..... 28, 43
RIFAMPIN+SYRSPEND SF 28, 43
*rilpivirine hcl* ..... 35
*riluzole* ..... 119, 141
*rimantadine hcl* ..... 22
RINVOQ ..... 268, 282
RINVOQ LQ ..... 267
*risedronate sodium* ..... 275
*risperidone* ..... 131, 136
*ritonavir* ..... 37
*rivaroxaban* ..... 79
*rivastigmine* ..... 74
*rivastigmine tartrate* ..... 74
*rivelsa* ..... 233, 242, 255
RIVFLOZA ..... 294
RIVIVE ..... 18, 154
RIXUBIS ..... 85
*rizatriptan benzoate* ..... 161
ROCKLATAN ..... 206
*roflumilast* ..... 306, 329, 333
ROMVIMZA ..... 56
*ropinirole hcl* ..... 148
*ropinirole hcl er* ..... 147
*rosuvastatin calcium* ..... 110
*rosyrah* ..... 233, 242, 255
ROTARIX ..... 64
ROTATEQ ..... 64
ROWASA ..... 210
*roweepra* ..... 127
ROZLYTREK ..... 57
RUBRACA ..... 57
RUCONEST ..... 278, 279
*rufinamide* ..... 127, 145
RUKOBIA ..... 33
RYBELSUS ..... 245
RYDAPT ..... 57
*sacubitril-valsartan* ..... 93, 94, 116
SAFETY PEN NEEDLES ..... 177
SALAGEN ..... 74, 205
SALICATE ..... 330
*salicylic acid* ..... 330
*salsalate* ..... 160
SALVAX DUO PLUS ..... 320, 330
SAMSCA ..... 191
SANTYL ..... 193, 321, 337
*sapropterin dihydrochloride* ..... 191, 192, 294
SAVAYSA ..... 79
SAVELLA ..... 143, 160
SAVELLA TITRATION PACK ..... 143, 160
*saxagliptin hcl* ..... 235
*saxagliptin-metformin er* ..227, 235
SAXENDA ..... 123, 245
SCALACORT DK ..... 326, 330
SCARCIN ..... 337
SCEMBLIX ..... 57
*scopolamine* ..... 68, 209, 216
SELECT-OB ..... 88, 341, 343
*selegiline hcl* ..... 146, 147
*selenium sulfide* ..... 319, 332
SELZENTRY ..... 33
SENSILANCE SAFETY LANCETS 21G ..... 177
SENSILANCE SAFETY LANCETS 26G ..... 177
SENSILANCE SAFETY LANCETS 28G ..... 177
SEPHIENCE ..... 192
SEREVENT DISKUS ..... 76, 310
SEROSTIM ..... 248, 259
*sertraline hcl* ..... 162
*setlakin* ..... 233, 242, 255
*sevelamer carbonate* 18, 186, 272
*sevoflurane* ..... 145
*sf* ..... 165, 167, 277
*sf 5000 plus* ..... 165, 167, 277
*sharobel* ..... 233, 255
SHARPS COLLECTOR ..... 177
SHARPS CONTAINER ..... 177
*shewise* ..... 226, 233, 255
SIGNIFOR ..... 259
*sildenafil citrate* ..... 114, 115, 307, 310, 311, 339
*silodosin* ..... 74
SILVADENE ..... 319, 332
*silver nitrate* ..... 197
*silver sulfadiazine* ..... 319, 332
*simliya* ..... 233, 243, 255
*simpesse* ..... 233, 243, 255
SIMPLERA SYNC SENSOR ..177
SIMPONI . 215, 216, 271, 283, 288
*simvastatin* ..... 110
SINEMET ..... 142
SINGULAIR ..... 305
*sirolimus* ..... 268, 291, 328
SIRTURO ..... 28
SIVEXTRO ..... 42
SKYCLARYS ..... 294
SKYRIZI ..... 216, 328, 338
SKYRIZI PEN ..... 328, 337
SKYTROFA ..... 248
SLYND ..... 226, 233, 255
*smooth lax* ..... 211
*sod citrate-citric acid* ..... 182
*sod fluoride-potassium nitrate* ..... 167, 277
*sodium chloride* ..... 305
*sodium fluoride* ..... 165, 167, 277
*sodium fluoride 5000 enamel* ..... 167, 277
*sodium fluoride 5000 plus* ..... 165, 167, 277
*sodium fluoride 5000 ppm* ..... 165, 167, 277
*sodium fluoride 5000 sensitive* ..... 167, 277
*sodium oxybate* ..... 141, 164, 274
*sodium phenylbutyrate* ..... 182
*sodium polystyrene sulfonate* ..... 18, 186, 273
*sodium sulfacetamide* ..... 316
*sodium sulfacetamide wash* .... 316
SOFOSBUVIR-VELPATASVIR ..... 31, 33
SOGROYA ..... 249
SOHONOS ..... 294
*solifenacin succinate* ..... 339
SOLIQUA ..... 245, 246
SOLOSEC ..... 27
SOMAVERT ..... 259
SOOLANTRA ..... 334
*sorafenib tosylate* ..... 57
*sotalol hcl* .... 72, 98, 104, 106, 113
*sotalol hcl (af)* ..... 72, 98, 103, 106, 113
SOTYKTU ..... 329, 338
SOTYLIZE ... 72, 98, 104, 106, 113
SOVALDI ..... 32
SPEEDY SWAB COVID-19 ANTIGEN ..... 181
SPEVIGO ..... 328
SPIKEVAX ..... 64
SPIKEVAX 6M-11Y ..... 64
*spinosad* ..... 334
SPIRIVA HANDIHALER .... 69, 299
SPIRIVA RESPIMAT ..... 69, 299
*spironolactone* ..... 92, 111, 115, 116, 187
*spironolactone-hctz* ..... 92, 111, 116, 187, 190
SPORANOX ..... 29

SPRAVATO (56 MG DOSE) ..... 129, 147
SPRAVATO (84 MG DOSE) ..... 129, 147
*sprintec 28* ..... 233, 243, 255
SPRIX ..... 150, 159, 204
SPS (SODIUM POLYSTYRENE SULF) ..... 18, 187, 273
*ssd* ..... 319, 332
SSKI ..... 304
*sss 10-5* ..... 316, 330
ST JOSEPH LOW DOSE ..... 89, 90, 133, 160
STARJEMZA ..... 267
STENDRA ..... 114, 115
STEQEYMA ..... 267
STIOLTO RESPIMAT ..... 69, 76
STIVARGA ..... 57
STRENSIQ ..... 193
STRIBILD ..... 34, 36, 294
STRIVERDI RESPIMAT ... 76, 310
STROMECTOL ..... 24
SUBOXONE ..... 154, 155
SUBVENITE ..... 127, 131
*subvenite* ..... 127, 131
*subvenite starter kit-blue* . 127, 131
*subvenite starter kit-green* ..... 127, 131
*subvenite starter kit-orange* ..... 127, 131
SUCRAID ..... 193
*sucralfate* ..... 217
SUFLAVE ..... 212
SULAR ..... 108, 109
SULCONAZOLE NITRATE ..... 320
*sulfacetamide sodium* ..... 196, 316
*sulfacetamide sodium (acne)* .. 316
*sulfacetamide sodium (cleans)* 316
*sulfacetamide sodium-sulfur* ..... 316, 330
*sulfacetamide sod-sulfur wash* ..... 316, 330
*sulfacetamide-prednisolone* ..... 196, 202
*sulfacetamide-sulfur in urea* ..... 316, 330
*sulfadiazine* ..... 44
*sulfamethoxazole-trimethoprim* ..... 27, 44, 45
SULFAMYLON ..... 316, 332
*sulfasalazine* ..... 44, 210, 264, 283, 288, 289
*sulfatrim pediatric* ..... 27, 44, 45
*sulfurated lime* ..... 334
*sulindac* ..... 150, 159
*sumatriptan* ..... 161
*sumatriptan succinate* ..... 161
SUMAXIN ..... 316, 330
*sunitinib malate* ..... 57
SUNLENCA ..... 27, 33
SUNOSI ..... 164
SUPREP BOWEL PREP KIT .. 212
SUTAB ..... 212
*syeda* ..... 233, 243, 255
SYMBICORT ..... 76, 222
SYMDEKO ..... 302, 303
SYMFI ..... 35, 36
SYMPAZAN ..... 138, 139
SYMPROIC ..... 208, 216
SYMTUZA ..... 36, 37, 294
SYNAPRYN FUSEPAQ ..... 152
SYNAREL ..... 245
SYNDROS ..... 209, 216
SYNJARDY ..... 227, 258
SYNJARDY XR ..... 227, 258
TABLOID ..... 57
TABRADOL FUSEPAQ ..... 71
TABRECTA ..... 57
TACLONEX ..... 321, 326, 338
*tacrolimus* ..... 262, 291, 328, 338
*tadalafil* ..... 114, 115, 307
*tadalafil (pah)* .. 114, 115, 307, 311
TADLIQ ..... 114, 115, 307, 311
TAFINLAR ..... 57
*tafluprost (pf)* ..... 206
TAGRISSO ..... 57
*take action* ..... 226, 233, 256
TAKHZYRO ..... 91, 291
TALZENNA ..... 57
*tamoxifen citrate* ..... 57, 236
*tamsulosin hcl* ..... 74
TANLOR ..... 71
*tapentadol hcl* ..... 152
TAPERDEX 12-DAY ..... 203, 223
TAPERDEX 6-DAY ..... 203, 223
TAPERDEX 7-DAY ..... 203, 223
*tarina 24 fe* ..... 233, 243, 256
*tarina fe 1/20 eq* ..... 233, 243, 256
TARPEYO ..... 223
*tasimelteon* ..... 135, 146
*tavaborole* ..... 333
TAVALISSE ..... 79
TAVNEOS ..... 263, 278, 279
*taysofy* ..... 233, 243, 256
*tazarotene* ..... 331, 338
TAZORAC ..... 331, 338
TECHLITE LANCETS 26G ..... 177
TECHLITE PLUS PEN NEEDLES ..... 177
TEGLUTIK ..... 119, 141
TEGRETOL ..... 127, 131
TEGRETOL-XR ..... 127, 131
TEKTURNA ..... 115
*telmisartan* ..... 93, 94
*telmisartan-hctz* ..... 94, 190
*temazepam* ..... 139
TEMBEXA ..... 40
*temozolomide* ..... 57
TENCON ..... 122, 137, 148
TENIVAC ..... 61
*tenofovir disoproxil fumarate* ..... 36
TEPMETKO ..... 57
*terazosin hcl* ..... 73, 92, 93, 98
*terbinafine hcl* ..... 22
*terbutaline sulfate* ..... 76, 310
*terconazole* ..... 320
*teriflunomide* ..... 262, 289
TERIPARATIDE ..... 247, 274
*terrell* ..... 145
TESTIM ..... 224, 226
*testosterone* ..... 224, 226
*testosterone cypionate* .... 224, 226
TESTOSTERONE CYPIONATE ..... 224, 226
*testosterone enanthate* ... 224, 226
*tetrabenazine* ..... 164
*tetracaine hcl* ..... 205, 271
*tetracycline hcl* .... 26, 45, 210, 316
TEXACORT ..... 203, 223, 326
TEZRULY ..... 73, 92
TEZSPIRE ..... 304, 308
THALOMID ..... 58, 289
THEO-24 . 109, 157, 185, 312, 339
*theophylline* ..... 110, 158, 185, 312, 340
*theophylline er* ..... 109, 110, 158, 185, 312, 340
*thioridazine hcl* ..... 156
*thiothixene* ..... 162
THROMBIN-JMI ..... 85
THROMBIN-JMI EPISTAXIS .... 85
THROMBOGEN ..... 85
*thyroid* ..... 261
*tiadylt er* .... 99, 100, 101, 107, 118
*tiagabine hcl* ..... 127, 144
TIAZAC ..... 99, 100, 101, 107, 118

TIBSOVO ..... 58
*ticagrelor* ..... 89
TIGLUTIK ..... 119, 141
TIKOSYN ..... 106
*tilia fe* ..... 233, 243, 256
*timolol hemihydrate* ..... 72, 98, 106, 198
*timolol maleate* .... 72, 98, 104, 106, 113, 133, 198
*timolol maleate (once-daily)* ..... 72, 98, 106, 198
*timolol maleate ocudose* ..... 72, 98, 106, 198
*timolol maleate pf* 72, 98, 106, 198
TIMOPTIC OCUDOSE ..... 72, 98, 106, 198
*tinidazole* ..... 27
*tiopronin* ..... 294
TIROSINT-SOL ..... 261
TISSEEL ..... 321, 338
TIVICAY ..... 34
TIVICAY PD ..... 34
*tizanidine hcl* ..... 71
TOBI NEBULIZER ..... 23, 196
TOBI PODHALER ..... 23, 196
TOBRADEX ..... 23, 196, 203
*tobramycin* ..... 23, 196
TOBRAMYCIN ..... 23, 196
*tobramycin-dexamethasone* ..... 23, 196, 203
TOBREX ..... 23, 196
TODAY SPONGE ..... 296
*tofacitinib citrate* ..... 268, 283
*tofacitinib citrate er* ..... 268, 283
*tolcapone* ..... 140
*tolterodine tartrate* ..... 339
*tolvaptan* ..... 191
*tolvaptan (hyponatremia)* ..... 191
TONMYA ..... 71, 143
TOPAMAX ..... 127, 133
TOPAMAX SPRINKLE .... 127, 133
TOPFINE INSULIN PEN NEEDLE ..... 177
TOPICORT ..... 326
*topiramate* ..... 127, 128, 133
*toremifene citrate* ..... 58, 236
*torpenz* ..... 58, 265
*torsemide* ..... 91, 111, 186
TOUJEO MAX SOLOSTAR .... 246
TOUJEO SOLOSTAR ..... 247
TPOXX ..... 28
TRACLEER ..... 118, 303, 311
TRADJENTA ..... 235
*tramadol hcl* ..... 152
*tramadol hcl (er biphasic)* ..... 152
*tramadol hcl er* ..... 152
*tramadol-acetaminophen* ..... 122, 148, 153
*trandolapril* ..... 95, 96
*trandolapril-verapamil hcl er* ..... 96, 101
*tranexamic acid* ..... 85
*tranylcypromine sulfate* ..... 147
*travoprost (bak free)* ..... 206
*trazodone hcl* ..... 162
TRELEGY ELLIPTA ..... 69, 76, 203, 223, 301
TREMFYA ..... 264, 328, 338
TREMFYA ONE-PRESS ..... 264, 328, 338
TREMFYA PEN ..... 264, 328
TREMFYA-CD/UC INDUCTION ..... 264, 328
*tretinoin* ..... 58, 321
TRETTEN ..... 85
TREXALL .. 58, 264, 283, 289, 291
TREZIX ..... 122, 148, 153, 158
*triamcinolone acetonide* .. 223, 326
*triamterene* ..... 92, 115, 187
*triamterene-hctz* ..... 187, 190
*triazolam* ..... 139
TRICITRASOL ..... 78
*tricitrates* ..... 182
*triderm* ..... 223, 326
*trientine hcl* ..... 218
*tri-estarylla* ..... 233, 243, 256
*trifluoperazine hcl* ..... 156
*trifluridine* ..... 197
*trihexyphenidyl hcl* ..... 69, 124
TRIJARDY XR 227, 228, 235, 258
TRIKAFTA ..... 302, 303
*tri-legest fe* ..... 233, 243, 256
TRILEPTAL ..... 128, 145
*tri-linyah* ..... 233, 243, 256
*trilitas* ..... 331, 338
*tri-lo-estarylla* ..... 233, 243, 256
*tri-lo-marzia* ..... 233, 243, 256
*tri-lo-mili* ..... 234, 243, 256
*tri-lo-sprintec* ..... 234, 243, 256
*trimethobenzamide hcl* ..... 209
*trimethoprim* ..... 45
*tri-mili* ..... 234, 243, 256
*trimipramine maleate* ..... 163
TRINATE ..... 88, 341, 343
TRINTELLIX ..... 162
TRIPLE PMB ..... 196, 203, 204
TRIPLE PMK ..... 196, 203, 205
*tri-sprintec* ..... 234, 243, 256
TRISTART DHA ..... 88, 189, 294, 341, 344
TRIUMEQ ..... 34, 36
TRIUMEQ PD ..... 34, 36
TRI-VI-FLORO 165, 167, 277, 341, 342, 344, 345
*tri-vite/fluoride* 165, 167, 277, 341, 342, 344, 345
*tri-vylibra* ..... 234, 243, 256
*tri-vylibra lo* ..... 234, 243, 256
*trospium chloride* ..... 339
TRUE COMFORT SAFETY PEN NEEDLE ..... 178
TRUE COVER ..... 296
TRUE FOLIC ACID ..... 344
TRUE METRIX LEVEL 1 ..... 178
TRUE METRIX LEVEL 2 ..... 178
TRUE METRIX LEVEL 3 ..... 178
TRULICITY ..... 245
TRUMENBA ..... 64
TRUQAP ..... 58
TRUVADA ..... 36, 40
TRYNGOLZA ..... 96, 223, 274
TRYPTYR ..... 204
TRYVIO ..... 303
TUKYSA ..... 58
TURALIO ..... 58
*turpentine* ..... 320
*turqoz* ..... 234, 243, 256
TUXARIN ER ..... 20, 21, 300
TWIIST REFILL KIT ..... 178
TWIIST REFILL KIT/INFUSION SET ..... 178
TWIIST STARTER KIT ..... 178
TWINRIX ..... 64
TWIRLA ..... 234, 243, 256
TYBLUME ..... 234, 243, 256
*tydemy* ..... 234, 243, 256, 344
TYMLOS ..... 247, 274
TYRVAYA ..... 65, 204
TYVASO ..... 118, 307, 311
TYVASO DPI MAINTENANCE KIT ..... 118, 307, 311
TYVASO DPI TITRATION KIT ..... 118, 307, 311
TYVASO REFILL KIT ..... 118, 308, 311
TYVASO STARTER KIT ..... 119, 308, 311
UBRELVY ..... 140
UCERIS ..... 223

UDENYCA ..... 81
ULTANE ..... 145
ULTRA-CARE SAFETY LANCETS 30G ..... 178
UNIFINE OTC PEN NEEDLES ..... 178
UNIFINE PROTECT PEN NEEDLE ..... 178
UNISTRIP CONTROL ..... 178
*unithroid* ..... 261
UPNEEQ ..... 207
UPTRAVI ..... 311
UPTRAVI TITRATION .... 311, 312
*urea* ..... 91, 92, 186, 206, 331
URELLE ..... 45, 69, 122, 294
*uretron d/s* ..... 46, 69, 122, 294
UROCIT-K 10 ..... 182
UROCIT-K 15 ..... 182
UROGESIC-BLUE ..... 46, 69, 294
*ursodiol* ..... 212
URSODIOL+SYRSPEND SF .. 212
VAFSEO ..... 81
*valacyclovir hcl* ..... 40
VALCHLOR ..... 312, 338
*valganciclovir hcl* ..... 40, 41
*valproic acid* ..... 128, 131, 132, 134, 144
*valsartan* ..... 93, 94
*valsartan-hydrochlorothiazide* ..... 94, 190
VALTOCO 10 MG DOSE ..... 138
VALTOCO 15 MG DOSE ..... 138
VALTOCO 20 MG DOSE ..... 138
VALTOCO 5 MG DOSE ..... 138
*valtya 1/35* ..... 234, 243, 256
*valtya 1/50* ..... 234, 243, 256
VANCOCIN ..... 31
*vancomycin hcl* ..... 31
VANCOMYCIN+SYRSPEND SF ..... 31
VANDAZOLE ..... 22, 39, 316
VANFLYTA ..... 58
VANRAFIA ..... 283, 303
VAQTA ..... 64
*vardenafil hcl* ..... 114, 115
*varenicline tartrate* ..... 65, 70
*varenicline tartrate (starter)* . 65, 70
*varenicline tartrate(continue)* ..... 65, 70
VARIVAX ..... 64
VAXELIS ..... 61, 64
VAXNEUVANCE ..... 64
VCF VAGINAL CONTRACEPTIVE ..... 296
VECAMYL ..... 116
*velivet* ..... 234, 243, 256
VELPHORO ..... 186
VELTASSA ..... 187
VEMLIDY ..... 41
VENCLEXTA ..... 58
VENCLEXTA STARTING PACK ..... 59
VENELEX ..... 338
*venlafaxine hcl* ..... 160
*venlafaxine hcl er* ..... 160
VEOZAH ..... 141
*verapamil hcl* ... 100, 101, 107, 119
*verapamil hcl er* ..... 99, 100, 101, 107, 119
VEREGEN ..... 331, 338
VERIFINE INSULIN PEN NEEDLE ..... 178
VERIFINE INSULIN SYRINGE ..... 178
VERIFINE PLUS PEN NEEDLE ..... 178
VERIFINE SAFE LANCET MINI 21G ..... 178
VERIFINE SAFE LANCET MINI 23G ..... 178
VERIFINE SAFE LANCET MINI 28G ..... 178
VERIFINE SAFE LANCET MINI 30G ..... 178
VERIFINE SHARPS CONTAINER ..... 178
VERISAFE SAFETY STERILE NEEDLE ..... 178
VERKAZIA ..... 197, 203, 262
VERQUVO ..... 104, 119
VERSAPENN (AG) ANHYDROUS ..... 297
VERSAPENN (AL) ANHYD LIPID ..... 297
VERZENIO ..... 59
*vestura* ..... 234, 243, 256
VFEND ..... 29
VIBERZI ..... 208, 216
*vienva* ..... 234, 243, 256
*vigabatrin* ..... 128, 144
VIGADRONE ..... 128, 144
VIGAFYDE ..... 144
VIJOICE ..... 294
*vilazodone hcl* ..... 162
VILEVEV MB ..... 46, 69, 122, 295
VIMPAT ..... 128, 145
VIOKACE ..... 193, 213
*viorele* ..... 234, 243, 256
VIRACEPT ..... 37
VIREAD ..... 36
VISTOGARD ..... 18, 273
VITAFOL FE+ ..... 88, 189, 295, 341, 344
VITAFOL-OB+DHA ..... 88, 189, 295, 341, 344
VITAMIN C BRIGHTENING SERUM ..... 320
*vitamin d (ergocalciferol)* ..... 345
VITATHELY WITH GINGER ..... 88, 342, 344
VITRAKVI ..... 59
VIVAGUARD INO CONTROL SOLUTION ..... 179
VIVAGUARD LANCETS 30G . 179
VIVAGUARD LANCING DEVICE ..... 179
VIVAGUARD SAFETY LANCETS 28G ..... 179
VIVJOA ..... 29
VOCABRIA ..... 34
*volnea* ..... 234, 243, 256
VONJO ..... 59
VONVENDI ..... 85
VOQUEZNA ..... 217, 218
VOQUEZNA DUAL PAK ... 24, 217
VOQUEZNA TRIPLE PAK ..... 24, 41, 42, 217
VORANIGO ..... 59
*voriconazole* ..... 29
VORTEX VALVE CHAMBER-PEDI MASK ..... 179
VORTEX VALVED HOLDING CHAMBER ..... 179
VOSEVI ..... 32, 33
VOWST ..... 216, 295
VOXZOGO ..... 295
VOYDEYA ..... 278
VOYXACT ..... 262
VP FC KIT ..... 71, 332, 338
VP GKL KIT ..... 318, 333, 338
VRAYLAR ..... 136
VTAMA ..... 317, 321, 338
VYBRIQUE ..... 114, 307
*vyfemla* ..... 234, 244, 256
VYKAT XR ..... 122, 123
VYLEESI ..... 141, 218
*vylibra* ..... 234, 244, 256
VYNDAMAX ..... 102, 141, 295

VYSCOXA....142
VYVGART HYTRULO....268
WAINUA....274
WAKIX.... 164
*warfarin sodium*....79
WAYRILZ.... 79
WEGOVY....123, 245, 246
WEGOVY HD....123, 245
WELIREG.... 59
*wera*.... 234, 244, 256
WESCAP-PN DHA
.... 88, 189, 295, 342, 344
WESNATE DHA 88, 295, 342, 344
WESTGEL DHA
.... 88, 189, 295, 342, 344
WEZLANA....267
*wheat germ oil*....345
WIDE-SEAL DIAPHRAGM 60 296
WIDE-SEAL DIAPHRAGM 65 296
WIDE-SEAL DIAPHRAGM 70 296
WIDE-SEAL DIAPHRAGM 75 296
WIDE-SEAL DIAPHRAGM 80 296
WIDE-SEAL DIAPHRAGM 85 296
WIDE-SEAL DIAPHRAGM 90 297
WIDE-SEAL DIAPHRAGM 95 297
WILATE....85
WINREVAIR....308
*wixela inhub*..... 76, 203, 223, 301
*wymzya fe*.... 234, 244, 257
XACIATO.... 38, 316
*xarah fe*.... 234, 244, 257
XARELTO.... 79
XARELTO STARTER PACK....79
XATMEP... 59, 264, 283, 289, 291
XCOPRI.... 128, 146
XDEMVY....197
XELPROS....206
*xelria fe*.... 234, 244, 257
XELSTRYM....121
XENICAL....216
XEPI....316
XERMELO.... 208
XIFAXAN....43
XIIDRA.... 197, 203
XIRUN....320, 331
XOFLUZA (40 MG DOSE).. 29, 30
XOFLUZA (80 MG DOSE).. 29, 30
XOLAIR....266, 308
XOLREMDI.... 82
XOPENEX HFA.... 76, 310
XOSPATA.... 59
XPHOZAH....186, 187, 216
XPOVIO (100 MG ONCE
WEEKLY).... 59
XPOVIO (40 MG ONCE
WEEKLY).... 59
XPOVIO (40 MG TWICE
WEEKLY).... 59
XPOVIO (60 MG ONCE
WEEKLY).... 59
XPOVIO (60 MG TWICE
WEEKLY).... 59
XPOVIO (80 MG ONCE
WEEKLY).... 59
XPOVIO (80 MG TWICE
WEEKLY).... 60
XROMI.... 60
XTAMPZA ER.... 153
XTANDI.... 60
*xulane*.... 234, 244, 257
XYNTHA.... 85
XYNTHA SOLOFUSE....85
*xyvona*....153
XYWAV.... 142
YASMIN 28..... 234, 244, 257
YAZ.... 234, 244, 257
YESINTEK.... 267
YEZTUGO....33
YORVIPATH.... 247
*your choice*....226, 234, 257
*yulithira*....60, 265
YUPELRI....69, 299
YUTREPIA.... 119, 308
*yuvafem*.... 244, 275
ZACARE.... 320, 332
ZACLIR CLEANSING..... 332
*zafemy*.... 234, 244, 257
*zafirlukast*....305
*zaleplon*....135, 147
ZANAFLEX.... 71
ZARONTIN....162
ZARXIO....82
ZAVZPRET.... 140
ZEJULA....60
ZELAPAR....146, 147
ZELBORAF.... 60
ZELSUVMI.... 318, 338
*zelvysia*.... 192, 295
ZEMPLAR.... 345
*zenatane*.... 331, 339
ZENPEP....193, 213
ZEPBOUND.... 123, 246
ZEPOSIA.... 289
ZEPOSIA 7-DAY STARTER
PACK.... 289
ZEPOSIA STARTER KIT.... 289
ZIAGEN....36
*zidovudine*....36
ZILBRYSQ.... 263, 278
*zileuton er*.... 305
ZILXI.... 26, 45, 196, 316
ZIOPTAN.... 206
*ziprasidone hcl*.... 132, 136
ZIRGAN.... 41, 197
ZITHROMAX....41, 42
ZITHROMAX TRI-PAK....41, 42
ZITHROMAX Z-PAK..... 41, 42
ZOKINVY.... 192, 295
ZOLINZA....60
*zolmitriptan*....161
*zolpidem tartrate*..... 135, 147
*zolpidem tartrate er*.... 135, 147
ZOMIG.... 161
ZONEGRAN....128, 146
ZONISADE....128, 146
*zonisamide*....128, 146
ZONTIVITY.... 89
ZORYVE..... 306, 329, 333, 339
*zovia 1/35 (28)*..... 234, 244, 257
ZTALMY....128, 144
ZTLIDO.... 271, 318
ZUBSOLV.... 154, 155
*zumandimine*.....235, 244, 257
ZURNAI....154
ZURZUVAE....129
ZYCUBO....189
ZYDELIG....60
ZYLET....196, 203