2026 Illinois Access Large Group 3 and 4-Tier Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of March 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 All previous versions of this PDL are no longer in effect.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/member-resources/pharmacy-benefits/prescription-drug-lists**. Scroll down to Illinois section. An example of a plan coverage document may be accessed online at **2025-IL-LrgGrp-SBC**.

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:

- Charter
- Choice
- Choice Plus
- Core
- Options PPO
- Navigate
- NexusACO R
- NexusACO OAP
- Non-Differential PPO

Updated 1/1/2026

1/26 © 2026 United HealthCare Services, Inc. All Rights Reserved. WF19665903-A

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

Additional programs and details 7

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

Requesting a prior authorization 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 get updated information about my pharmacy benefit? 10

Nondiscrimination notice and access to communication services . . . 11

Prescription drug list 15

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:

Allowed Amount is the maximum amount on which the health insurance issuer bases its payment for a covered health care service. This may be called "eligible expense", "payment allowance", or "negotiated rate". If your health care provider charges more than the allowed amount and is not part of the provider network, you may have to pay the difference.

Brand-name drug is a drug that is marketed under a proprietary, trademark protected name. The brand name drug must be listed in all capital letters.

Coinsurance is a percentage of the cost of a covered health care service, which you are responsible to pay. The cost of the covered health care service is generally deemed to be the allowed amount, which may differ from the retail price that you would pay for the same service without using insurance. Typically, a coinsurance does not apply until after you have met the deductible, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

Copayment is a fixed dollar amount that you pay for a covered health care service. Typically, a copayment does not apply until after you have met the deductible, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

Covered Individual is an individual enrolled in, subscribed to, or insured under a health product, whether directly or as a dependent or beneficiary.

Deductible is the amount you pay for covered health care services before your health product begins payment for all or part of the cost of the health care service under the terms of coverage. If your health product has a deductible, it may have either one deductible or separate deductibles for medical benefits and drug benefits. For some health care services, such as preventive services, the health insurance issuer might waive or lower the deductible to pay for costs of the health care service from the first dollar of coverage, but this tends not to happen for most other covered services.

Drug Tier is a group of drugs that corresponds to a specified cost sharing tier in the health product's drug coverage. The tier in which a drug is placed determines your portion of the cost for the drug.

Exception request is a request for coverage of i) a nonformulary drug, ii) a drug being removed from the formulary, or iii) a quantity of a drug above a quantity limit. If you, your designee, or your attending or prescribing provider submits an exception request for coverage of a drug, the health insurance issuer must cover the drug when the drug is determined to be medically necessary to treat your condition.

Exigent circumstances are when you are suffering from a health 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 nonformulary drug.

Formulary or Prescription Drug List (PDL) is the complete list of drugs preferred for use and eligible for coverage under a health product, and includes all drugs covered under the outpatient or pharmacy drug benefit of the health product. Formulary is also known as a drug list or prescription drug list.

Generic drug is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters.

Non-formulary drug is a drug that is not listed on the health product's formulary as a covered drug, but may become eligible for coverage under an "exception request".

Out-of-pocket cost is copayments, coinsurance, and the applicable deductible, plus all costs for health care services that the health product does not cover.

Prescribing provider is a health care provider authorized to write a prescription to treat your health condition.

Prescription is an oral, written, or electronic order by a prescribing provider for you that contains the name of the drug, the quantity of the drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by you, the health condition or purpose for which the drug is being prescribed.

Prescription Drug Product is a drug that is prescribed by your prescribing provider and requires a prescription under applicable law.

Prior authorization is a health product's requirement that you or your prescribing provider obtain the health insurance issuer's authorization for a drug before the health product will cover the drug. The health insurance issuer must grant a prior authorization when it is medically necessary for you to obtain the drug.

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.

How do I use my PDL?

When choosing a medication, you and your provider should consult the Prescription Drug List (PDL). It will help you and your 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 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 or, if only the generic equivalent is covered under the plan, then just by its generic name, 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 bold and italicized lowercase letters;
3. If a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all bold and italicized lowercase letters; and
4. In the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with 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)***	3/4	
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. If you have a plan with 3 Tiers, Tier 3/4 drugs will be placed on Tier 3. If you have a plan with 4 Tiers, Tier 3/4 drugs will be placed on Tier 4.

Drug Tier 1	Your lowest cost medications
Drug Tier 2	Your mid-range cost medications
Drug Tier 3	Your mid-range to high-cost medications
Drug Tier 3/4	Your highest cost medications
PA	Prior authorization required
QL	Quantity limit
H	Part of health care reform
H-N	Part of health care reform preventive with confirmation 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	Cost-share cap by state mandate applies when condition appropriate

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 3/4, look to see if there is a Tier 1 option available. Discuss these options with your provider.

For orally administered anti-cancer medications, there are no separate cost-sharing requirements or treatment limitations that do not also apply to intravenously injected or administered cancer medications covered under your medical benefit.

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** **Your lowest cost**	Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
$$	**Tier 2** **Your mid-range cost**	Medications that provide good overall value. Mainly preferred brand-name drugs.	Use Tier 2 drugs instead of Tier 3 or 3/4 to help reduce your out-of-pocket costs.
$$$	**Tier 3 and 3/4** **Your highest cost**	Medications that provide the lowest overall value. Mainly non-preferred brand-name drugs.	Many Tier 3 and 3/4 drugs have lower-cost options in Tier 1 or 2. Ask your 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. Your cost-share will not exceed the lesser of the cost-sharing amount or the retail price of the medication without the drug coverage. 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 be subject to new or updated utilization management requirements at any time. This includes prior authorization or quantity limits. These changes most commonly occur upon FDA approval of a medication or its generic equivalent, or on scheduled update dates: 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.

Additional programs and details

Based on your benefit, the following may apply.

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. 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**.

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

- Abortion*
- Gender Dysphoria*
- Human Immunodeficiency Virus (HIV) Prevention
- Naloxone

This medication is mandated to have the cost-share capped:

- Insulin $35 max per one month supply
- Epinephrine injectors $60 max per twin-pack

***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

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization from us. Your prescribing provider can submit a request by phone to Optum Rx® or electronically by contacting us at **ProviderPA.com**. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your prescribing provider 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 by going online at **myuhc.com** or by calling at the toll-free phone number on the back of your member ID card.

Approvals for maintenance medications used to treat a chronic or long-term condition will be valid for at least 12 months. All other approvals, except for benzodiazepines and Schedule II narcotic drugs, will be valid for the lesser of six months, the length of treatment determined by your prescribing provider, or the renewal of your plan.

In the case of a standard prior authorization, 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 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 > 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 Pharmacy.

You can start a new prescription or refill an existing one in several ways:

- **E-prescribe:** Ask your provider to send prescriptions directly to Optum Home Delivery Pharmacy (usually up to a 90-day supply).
- **Online:** Visit **myuhc.com > Pharmacies & Prescriptions > Rx Account** to set up an account. Then choose which medication you want moved to home delivery.
- **Phone:** Call Optum Rx at **1-888-658-0539** / TTY **711,** any day, any time.

Most prescriptions arrive within about 5 business days once Optum receives the completed order.

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.

You will receive sixty days notice if one of the following changes impacts you:

- A medication is moved to a higher tier*
- A medication becomes non-formulary*
- A medication becomes subject to new or revised utilization management procedures

***Please note:** You may be able to continue coverage of the medication at the same cost-share if your prescriber provides notice of medical necessity.

Sign in to myuhc.com 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**.

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 ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملحوظة: اذا كنت تتحدث **العربية** (Arabic)، فإن خدمات المساعدة اللغوية المجانية والتواصل بتنسيقات أخرى، مثل الطباعة بالحروف الكبيرة، متاحة لك دون مقابل. اتصل بالرقم المجاني المدون على بطاقة العضو الخاصة بك.

দেখুন: আপনি যদি বাংলায় (Bengali-Bangala) কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণে ক্রমতো অনুযায়ী ফরম্যাটে যোগাযোগগুলি আপনার জন্য উপলব্ধ। আপনার সদস্য পরিচয়পত্রে মুদ্রিত টোল-ফ্রি নম্বরে কল করুন।

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Cambodian-Mon-Khmer) សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរស័ព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

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.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોમેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી વિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

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

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 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

ໝາຍເຫດ: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ໂທຫາເບີໂທຟຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

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

توجه: اگر به زبان فارسی (Persian-Farsi) صحبت می‌کنید، خدمات زبانی کمکی رایگان و مطالب به زبان‌های دیگر در قالب‌های دیگر در دسترس شما هستند. با شماره زبان مندرج روی کارت شناسایی عضویت 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.

ਵਿਆਨ ਦਿਓ ! ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿੱਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

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.

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 หากคุณพูดภาษาไทย (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) زبان بولتے ہیں تو زبان کی معاونت کی خدمات اور مدد فراہم کی جائیں گی۔

مواطن اپنے حق میں ہیں کہ ممبر سے رابطہ کرنے کے لیے مفت ترجمان کی خدمات حاصل 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.

State of Illinois

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION 1
ANTIDOTE THERAPEUTICS 15
ANTIHISTAMINE DRUGS - Drugs for Allergy 17
ANTI-INFECTIVE AGENTS - Drugs for Infections 20
ANTINEOPLASTIC AGENTS - Drugs for Cancer 45
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM 58
AUTONOMIC DRUGS 63
AUTONOMIC DRUGS - Drugs for the Nervous System 64
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood 75
CARDIOVASCULAR DRUGS 88
CARDIOVASCULAR DRUGS - Drugs for the Heart 89
CENTRAL NERVOUS SYSTEM AGENTS 117
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System 117
DENTAL AGENTS 161
DENTAL AGENTS - Oral Care 162
DEVICES - Medical Supplies and Durable Medical Equipment 164
DIAGNOSTIC AGENTS 175
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants 176
ELECTROLYTIC, CALORIC, AND WATER BALANCE 177
ENZYMES 184
EYE, EAR, NOSE AND THROAT (EENT) PREPS. 186
GASTROINTESTINAL DRUGS 201
GASTROINTESTINAL DRUGS - Drugs for the Stomach 202
GOLD COMPOUNDS 211
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron 212
HORMONES AND SYNTHETIC SUBSTITUTES 212
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones 212
IMMUNOMODULATORY AGENTS (90:00) 258
LOCAL ANESTHETICS - Drugs for Numbing 266
MISCELLANEOUS THERAPEUTIC AGENTS 267
NONHORMONAL CONTRACEPTIVES - Drugs for Women 290
OXYTOCICS - Drugs for Women 291
PHARMACEUTICAL AIDS 291
RESPIRATORY TRACT AGENTS 291
RESPIRATORY TRACT AGENTS - Drugs for the Lungs 292
SKIN AND MUCOUS MEMBRANE AGENTS 306
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin 306
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles 333
VITAMINS 334

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	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
ft naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	SM
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
penicillamine oral tablet 250 mg	1	
phytonadione oral tablet 5 mg	1	
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	1	SM
ANTIDOTES (91:04)		
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	
sevelamer carbonate oral tablet 800 mg	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		
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	PA
ANTIHISTAMINE DRUGS - Drugs for Allergy		
ANTIHISTAMINE DRUGS - Drugs for Allergy		
promethazine hcl oral tablet 25 mg	1	
ETHANOLAMINE DERIVATIVES - Drugs for Allergy		
CARBINOXAMINE MALEATE ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
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	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	
FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy		
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy		
CARBINOXAMINE MALEATE ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
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	
CORPHENA ORAL SOLUTION 2 MG/5ML	3/4	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
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	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
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
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
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	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
OTHER ANTIHISTAMINES - Drugs for Allergy		
bepotastine besilate ophthalmic solution 1.5 %	1	
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	
nizatidine oral capsule 150 mg, 300 mg	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
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
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
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	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
CORPHENA ORAL SOLUTION 2 MG/5ML	3/4	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
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	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
epinastine hcl ophthalmic solution 0.05 %	1	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	1	
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	
3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefdinir oral capsule 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefixime oral capsule 400 mg	1	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
CEFIXIME ORAL TABLET 400 MG	3/4	
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***)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	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 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (***amikacin sulfate liposome***)	3/4	PA; QL (8.4 ml per day.)
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
HUMATIN ORAL CAPSULE 250 MG (***paromomycin sulfate***)	2	
neomycin sulfate oral tablet 500 mg	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (***omadacycline tosylate***)	3/4	
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
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-potassium clavulanate er oral tablet extended release 12 hour 1000-62.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
ampicillin oral capsule 500 mg	1	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED 125-31.25 MG/5ML (***amoxicillin-pot clavulanate***)	3/4	
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
albendazole oral tablet 200 mg	1	QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (***praziquantel***)	3/4	
EGATEN ORAL TABLET 250 MG (***triclabendazole***)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (***mebendazole***)	3/4	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	1	
STROMECTOL ORAL TABLET 3 MG (***ivermectin***)	3/4	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	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
ARAKODA ORAL TABLET 100 MG (***tafenoquine succinate***)	3/4	QL (16 tablets per month.)
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	1	
AVIDOXY ORAL TABLET 100 MG	3/4	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG (***artemether-lumefantrine***)	2	
DARAPRIM ORAL TABLET 25 MG (***pyrimethamine***)	3/4	PA
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
DOXYCYCLINE HYCLATE ORAL TABLET DELAYED RELEASE 80 MG	3/4	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
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	
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (***atovaquone-proguanil hcl***)	3/4	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	1	
pyrimethamine oral tablet 25 mg	1	PA
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	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
dapsone oral tablet 100 mg, 25 mg	1	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
nitazoxanide oral tablet 500 mg	1	
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
atovaquone oral suspension 750 mg/5ml	1	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (248 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	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LAMPIT ORAL TABLET 120 MG (***nifurtimox***)	3/4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (***nifurtimox***)	3/4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (***pentamidine isethionate***)	3/4	
nitazoxanide oral tablet 500 mg	1	
pentamidine isethionate inhalation solution reconstituted 300 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (***secnidazole***)	3/4	
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	1	
ANTIPROTOZOALS,NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat		
tinidazole oral tablet 250 mg, 500 mg	1	
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; 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***)	3/4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
clarithromycin er oral tablet extended release 24 hour 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
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	1	
PRETOMANID ORAL TABLET 200 MG	3/4	
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	
SIRTURO ORAL TABLET 100 MG, 20 MG (***bedaquiline fumarate***)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (***maribavir***)	3/4	PA; QL (4 tablets per day.)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
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***)	3/4	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	QL (1800 ml per 365 days)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	1	
ketodan external foam 2 %	1	
NOXAFIL ORAL PACKET 300 MG (***posaconazole***)	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML (***posaconazole***)	3/4	QL (20 ml per day.)
posaconazole oral suspension 40 mg/ml	1	QL (20 ml per day.)
posaconazole oral tablet delayed release 100 mg	1	
SPORANOX ORAL CAPSULE 100 MG (***itraconazole***)	3/4	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***voriconazole***)	3/4	
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, 50 mg	1	
BACITRACIN ANTIBIOTICS - Antibiotics		
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
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	QL (40 tablets per 365 days. 20 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
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.)
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***)	3/4	
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	1	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	1	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	1	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (***vancomycin hcl***)	3/4	
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (***vancomycin hcl***)	3/4	
vancomycin hcl oral capsule 125 mg, 250 mg	1	
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
EPCLUSA ORAL PACKET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 packet per day and 84 packets per 720 days.)
EPCLUSA ORAL TABLET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (84 tablets per 720 days.)
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; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***)	2	PA; QL (1 tablet per day and 28 tablets per month.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; 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.)
SOVALDI ORAL PACKET 150 MG, 200 MG (***sofosbuvir***)	3/4	PA; ST; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.)
SOVALDI ORAL TABLET 200 MG, 400 MG (***sofosbuvir***)	3/4	PA; ST; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)
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.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)
ZEPATIER ORAL TABLET 50-100 MG (***elbasvir-grazoprevir***)	2	PA; QL (84 tablets per 720 days (12 weeks).)
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.)
EPCLUSA ORAL PACKET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 packet per day and 84 packets per 720 days.)
EPCLUSA ORAL TABLET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (84 tablets per 720 days.)
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; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***)	2	PA; QL (1 tablet per day and 28 tablets per month.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; 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.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)
ZEPATIER ORAL TABLET 50-100 MG (***elbasvir-grazoprevir***)	2	PA; QL (84 tablets per 720 days (12 weeks).)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	PA; QL (24 tablets per year.)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	QL (4 tablets per year.); SM
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
maraviroc oral tablet 150 mg, 300 mg	1	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (***fostemsavir tromethamine***)	3/4	PA
SELZENTRY ORAL SOLUTION 20 MG/ML (***maraviroc***)	2	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (***maraviroc***)	3/4	PA
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	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***)	3/4	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL PACKET 100 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET 400 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (***raltegravir potassium***)	2	SM
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***)	3/4	QL (1 tablet per day.); SM
TIVICAY ORAL TABLET 50 MG (***dolutegravir sodium***)	3	SM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (***dolutegravir sodium***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	SM
HIV NONNUCLEOSIDE REV.TRANSCRIP. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
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	SM
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (***rilpivirine hcl***)	2	SM
efavirenz oral tablet 600 mg	1	
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
etravirine oral tablet 100 mg, 200 mg	1	SM
INTELENCE ORAL TABLET 100 MG, 200 MG (***etravirine***)	3/4	SM
INTELENCE ORAL TABLET 25 MG (***etravirine***)	2	SM
JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***)	2	QL (1 tablet per day.)
methocarbamol oral tablet 500 mg	1	
nevirapine er oral tablet extended release 24 hour 400 mg	1	
nevirapine oral suspension 50 mg/5ml	1	
nevirapine oral tablet 200 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (***doravirine***)	3	
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	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***)	3/4	QL (1 tablet per day.); SM
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***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitabine oral capsule 200 mg	1	SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
EMTRIVA ORAL CAPSULE 200 MG (***emtricitabine***)	3/4	SM
EMTRIVA ORAL SOLUTION 10 MG/ML (***emtricitabine***)	2	SM
EPIVIR ORAL SOLUTION 10 MG/ML (***lamivudine***)	3/4	SM
EPIVIR ORAL TABLET 150 MG, 300 MG (***lamivudine***)	3/4	SM
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	3/4	QL (1 tablet per day.)
lamivudine oral solution 10 mg/ml	1	SM
lamivudine oral tablet 100 mg	1	
lamivudine oral tablet 150 mg, 300 mg	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
lamivudine-zidovudine oral tablet 150-300 mg	1	SM
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (***zidovudine***)	3/4	SM
RETROVIR ORAL SYRUP 50 MG/5ML (***zidovudine***)	3	SM
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	1	H-N
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***)	3/4	QL (1 tablet per day.); SM
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***)	3/4	
zidovudine oral capsule 100 mg	1	SM
zidovudine oral syrup 50 mg/5ml	1	SM
zidovudine oral tablet 300 mg	1	SM
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	1	SM
darunavir oral tablet 600 mg, 800 mg	1	SM
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
fosamprenavir calcium oral tablet 700 mg	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML (***lopinavir-ritonavir***)	3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (***lopinavir-ritonavir***)	3/4	
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NORVIR ORAL PACKET 100 MG (***ritonavir***)	2	SM
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (***darunavir***)	2	SM
PREZISTA ORAL TABLET 150 MG, 75 MG (***darunavir***)	2	SM
REYATAZ ORAL PACKET 50 MG (***atazanavir sulfate***)	2	SM
ritonavir oral tablet 100 mg	1	SM
VIRACEPT ORAL TABLET 250 MG, 625 MG (***nelfinavir mesylate***)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
LINCOMYCIN ANTIBIOTICS - Antibiotics		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	3/4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	3/4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	3/4	
clindamycin hcl oral capsule 150 mg, 300 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (***aztreonam lysine***)	3/4	PA; ST; QL (84 vials per 56 days.); SP; SMCS
MONOCLONAL ANTIBODIES (08:18) - Drugs for Viral Infections		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (***nirsevimab-alip***)	3	H
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	1	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	1	
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 (248 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***)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	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 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
acyclovir oral tablet 400 mg, 800 mg	1	
adefovir dipivoxil oral tablet 10 mg	1	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (***entecavir***)	2	
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
entecavir oral tablet 0.5 mg, 1 mg	1	
famciclovir oral tablet 125 mg, 250 mg, 500 mg	1	
LAGEVRIO ORAL CAPSULE 200 MG (***molnupiravir***)	2	QL (80 capsules per 365 days. 40 capsules per prescription.)
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
ribavirin inhalation solution reconstituted 6 gm	1	
ribavirin oral capsule 200 mg	1	
ribavirin oral tablet 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (***brincidofovir***)	3/4	
TEMBEXA ORAL TABLET 100 MG (***brincidofovir***)	3/4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	3/4	QL (1 tablet per day.); SM
valacyclovir hcl oral tablet 1 gm, 500 mg	1	
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
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	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
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	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
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	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
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	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
linezolid oral suspension reconstituted 100 mg/5ml	1	
linezolid oral tablet 600 mg	1	
SIVEXTRO ORAL TABLET 200 MG (***tedizolid phosphate***)	3	
ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (***linezolid***)	3/4	
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	
nyamyc external powder 100000 unit/gm	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
POLYMYXIN ANTIBIOTICS - Antibiotics		
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (***colistimethate sodium***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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 (***flucytosine***)	3/4	
ANCOBON ORAL CAPSULE 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***)	3/4	
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 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
moxifloxacin hcl oral tablet 400 mg	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin oral tablet 300 mg, 400 mg	1	
ofloxacin otic solution 0.3 %	1	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (***rifapentine***)	2	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
XIFAXAN ORAL TABLET 200 MG (***rifaximin***)	3	PA
XIFAXAN ORAL TABLET 550 MG (***rifaximin***)	3	PA; QL (62 tablets per month.)
SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
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***)	3/4	
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
demeclocycline hcl oral tablet 150 mg, 300 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
DOXYCYCLINE HYCLATE ORAL TABLET DELAYED RELEASE 80 MG	3/4	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
tetracycline hcl oral capsule 250 mg, 500 mg	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
fosfomycin tromethamine oral packet 3 gm	1	
HIPREX ORAL TABLET 1 GM (***methenamine hippurate***)	3/4	
MACROBID ORAL CAPSULE 100 MG (***nitrofurantoin monohyd macro***)	3/4	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (***nitrofurantoin macrocrystal***)	3/4	
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	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	1	QL (4 tablets per day.); CM
abirtega oral tablet 250 mg	1	QL (4 tablets per day.); CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (***niraparib-abiraterone acetate***)	3/4	PA; ST; QL (2 tablets per day.); SP; CM; SMCS
ALECENSA ORAL CAPSULE 150 MG (***alectinib hcl***)	2	PA; QL (8 capsules per day.); CM
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	3/4	PA
ALUNBRIG ORAL TABLET 180 MG, 90 MG (***brigatinib***)	2	PA; QL (1 tablet per day); CM
ALUNBRIG ORAL TABLET 30 MG (***brigatinib***)	2	PA; QL (6 tablets per day); CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (***brigatinib***)	2	PA; QL (30 packs per year); CM
anastrozole oral tablet 1 mg	1	H-N
AUGTYRO ORAL CAPSULE 160 MG (***repotrectinib***)	2	PA; QL (60 capsules per month.); CM
AUGTYRO ORAL CAPSULE 40 MG (***repotrectinib***)	2	PA; QL (8 capsules per day.); CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (***avutometinib-defactinib***)	3/4	PA; QL (66 capsules/tablets per month.); SP; CM; SMCS
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (***avapritinib***)	3/4	PA; QL (1 tablet per day.); CM
BALVERSA ORAL TABLET 3 MG (***erdafitinib***)	3/4	PA; QL (3 tablets per day.); SP; CM; SMCS
BALVERSA ORAL TABLET 4 MG (***erdafitinib***)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BALVERSA ORAL TABLET 5 MG (***erdafitinib***)	3/4	PA; QL (1 tablet per day.); SP; CM; SMCS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
bexarotene external gel 1 %	1	
bexarotene oral capsule 75 mg	1	CM
bicalutamide oral tablet 50 mg	1	CM
BOSULIF ORAL CAPSULE 100 MG (***bosutinib***)	2	PA; QL (3 Capsules per day.); SP; CM; SMCS
BOSULIF ORAL CAPSULE 50 MG (***bosutinib***)	2	PA; QL (1 Capsule per day.); SP; CM; SMCS
BOSULIF ORAL TABLET 100 MG (***bosutinib***)	2	PA; ST; QL (4 tablets per day.); SP; CM; SMCS
BOSULIF ORAL TABLET 400 MG (***bosutinib***)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
BOSULIF ORAL TABLET 500 MG (***bosutinib***)	2	PA; ST; QL (1 tablet per day.); SP; CM; SMCS
BRAFTOVI ORAL CAPSULE 75 MG (***encorafenib***)	3/4	PA; ST; QL (6 capsules per day); SP; CM; SMCS
BRUKINSA ORAL CAPSULE 80 MG (***zanubrutinib***)	3	PA; ST; CM
BRUKINSA ORAL TABLET 160 MG (***zanubrutinib***)	3	PA; ST; QL (60 capsules per month.); CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (***cabozantinib s-malate***)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
CALQUENCE ORAL TABLET 100 MG (***acalabrutinib maleate***)	2	PA; QL (2 tablets per day.); CM
capecitabine oral tablet 150 mg, 500 mg	1	CM
CAPRELSA ORAL TABLET 100 MG (***vandetanib***)	2	PA; QL (2 tablets per day.); SP; CM; SMCS
CAPRELSA ORAL TABLET 300 MG (***vandetanib***)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
COMETRIQ ORAL KIT 20 MG (***cabozantinib s-malate***)	2	PA; QL (93 capsules per month.); SP; CM; SMCS
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (***cabozantinib s-malate***)	2	PA; QL (124 capsules per month.); SP; CM; SMCS
COMETRIQ ORAL KIT 80 & 20 MG (***cabozantinib s-malate***)	2	PA; QL (62 capsules per month.); SP; CM; SMCS
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (***duvelisib***)	3/4	PA; QL (2 capsules per day.); SP; CM; SMCS
COTELLIC ORAL TABLET 20 MG (***cobimetinib fumarate***)	2	PA; QL (63 tablets per 21 days); SP; CM; SMCS
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	1	PA; QL (1 tablet per day.); CM
dasatinib oral tablet 20 mg	1	PA; QL (90 tablets per month.); CM
DAURISMO ORAL TABLET 100 MG, 25 MG (***glasdegib maleate***)	2	PA; QL (2 tablets per day.); SP; CM; SMCS
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.); CM
ERIVEDGE ORAL CAPSULE 150 MG (***vismodegib***)	2	PA; QL (1 capsule per day.); SP; CM; SMCS
ERLEADA ORAL TABLET 240 MG (***apalutamide***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ERLEADA ORAL TABLET 60 MG (***apalutamide***)	2	PA; QL (4 tablets per day.); CM
erlotinib hcl oral tablet 100 mg, 150 mg	1	PA; QL (1 tablet per day.); SP; CM; SMCS
erlotinib hcl oral tablet 25 mg	1	PA; QL (2 tablets per day.); SP; CM; SMCS
etoposide oral capsule 50 mg	1	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
exemestane oral tablet 25 mg	1	H-N
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (***tivozanib hcl***)	3/4	PA; QL (0.75 capsules per day.); SP; CM; SMCS
FRUZAQLA ORAL CAPSULE 1 MG (***fruquintinib***)	3/4	PA; ST; QL (84 capsules per 21 days.); CM
FRUZAQLA ORAL CAPSULE 5 MG (***fruquintinib***)	3/4	PA; ST; QL (21 capsules per 21 days.); CM
GAVRETO ORAL CAPSULE 100 MG (***pralsetinib***)	3/4	PA; QL (4 capsules per day.); CM
gefitinib oral tablet 250 mg	1	PA; QL (2 tablets per day.); CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (***afatinib dimaleate***)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***lomustine***)	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GOMEKLI ORAL CAPSULE 1 MG (***mirdametinib***)	3/4	PA; QL (42 capsules per 4 weeks.); SP; SMCS
GOMEKLI ORAL CAPSULE 2 MG (***mirdametinib***)	3/4	PA; QL (84 capsules per 4 weeks.); SP; SMCS
GOMEKLI ORAL TABLET SOLUBLE 1 MG (***mirdametinib***)	3/4	PA; QL (168 tablets per 4 weeks.); SP; SMCS
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***)	3/4	PA; QL (90 tablets per month.); SP; CM; SMCS
HYCAMTIN ORAL CAPSULE 0.25 MG (***topotecan hcl***)	2	PA; QL (20 capsules per three weeks.); CM
HYCAMTIN ORAL CAPSULE 1 MG (***topotecan hcl***)	2	PA; QL (30 capsules per 3 weeks.); CM
hydroxyurea oral capsule 500 mg	1	CM
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (***palbociclib***)	3/4	PA; ST; QL (21 capsules per month.); CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (***palbociclib***)	3/4	PA; ST; QL (0.75 tablets per day.); CM
IBTROZI ORAL CAPSULE 200 MG (***taletrectinib adipate***)	3/4	PA; ST; QL (90 capsules per month.); SP; CM; SMCS
ICLUSIG ORAL TABLET 15 MG, 45 MG (***ponatinib hcl***)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
IDHIFA ORAL TABLET 100 MG, 50 MG (***enasidenib mesylate***)	2	PA; QL (1 tablet per day); CM
imatinib mesylate oral tablet 100 mg	1	QL (6 tablets per day.); CM
imatinib mesylate oral tablet 400 mg	1	QL (1 tablet per day.); CM
IMBRUVICA ORAL CAPSULE 140 MG (***ibrutinib***)	2	PA; QL (4 capsules per day.); CM
IMBRUVICA ORAL CAPSULE 70 MG (***ibrutinib***)	2	PA; QL (1 capsule per day.); CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (***ibrutinib***)	2	PA; QL (7.2 ml per day.); CM
IMBRUVICA ORAL TABLET 420 MG (***ibrutinib***)	2	PA; QL (1 tablet per day.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMKELDI ORAL SOLUTION 80 MG/ML	3/4	PA; QL (280 ml (2 bottles) per month.); CM
INLYTA ORAL TABLET 1 MG (***axitinib***)	3	PA; QL (6 tablets per day.); SP; CM; SMCS
INLYTA ORAL TABLET 5 MG (***axitinib***)	3	PA; QL (124 tablets per 30 days.); SP; CM; SMCS
INQOVI ORAL TABLET 35-100 MG (***decitabine-cedazuridine***)	3/4	PA; QL (5 tablets per month.); SP; CM; SMCS
IRESSA ORAL TABLET 250 MG (***gefitinib***)	3/4	PA; QL (2 tablets per day.); CM
ITOVEBI ORAL TABLET 3 MG (***inavolisib***)	2	PA; QL (56 tablets per month.); CM
ITOVEBI ORAL TABLET 9 MG (***inavolisib***)	2	PA; QL (28 tablets per month.); CM
IWILFIN ORAL TABLET 192 MG (***eflornithine hcl***)	2	PA; QL (8 tablets per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
JAYPIRCA ORAL TABLET 100 MG (***pirtobrutinib***)	3/4	PA; QL (3 tablets per day.); CM
JAYPIRCA ORAL TABLET 50 MG (***pirtobrutinib***)	3/4	PA; QL (1 tablet per day.); CM
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (21 tablets per month); CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (42 tablets per 21 days.); CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (42 tablets per month); CM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (63 tablets per 21 days.); CM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (63 tablets per month); CM
KOSELUGO ORAL CAPSULE 10 MG (***selumetinib sulfate***)	3	PA; QL (8 capsules per day.); CM
KOSELUGO ORAL CAPSULE 25 MG (***selumetinib sulfate***)	3	PA; QL (4 capsules per day.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (***selumetinib sulfate***)	3	PA
KRAZATI ORAL TABLET 200 MG (***adagrasib***)	3/4	PA; QL (6 tablets per day.); CM
lapatinib ditosylate oral tablet 250 mg	1	PA; QL (186 tablets per month.); CM
LAZCLUZE ORAL TABLET 240 MG (***lazertinib mesylate***)	3	PA; QL (30 tablets per month.); CM
LAZCLUZE ORAL TABLET 80 MG (***lazertinib mesylate***)	3	PA; QL (60 tablets per month.); CM
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
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; SMCS
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; SMCS
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (***lenvatinib mesylate***)	2	PA; QL (1 capsule per day.); SP; CM; SMCS
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; SM
lomustine oral capsule 10 mg, 100 mg, 40 mg	1	CM
LONSURF ORAL TABLET 15-6.14 MG (***trifluridine-tipiracil***)	3/4	PA; QL (100 tablets per month.); SP; CM; SMCS
LONSURF ORAL TABLET 20-8.19 MG (***trifluridine-tipiracil***)	3/4	PA; QL (80 tablets per 21 days.); SP; CM; SMCS
LORBRENA ORAL TABLET 100 MG (***lorlatinib***)	3	PA; ST; QL (30 tablets per month.); CM
LORBRENA ORAL TABLET 25 MG (***lorlatinib***)	3	PA; ST; QL (90 tablets per month.); CM
LUMAKRAS ORAL TABLET 120 MG (***sotorasib***)	3/4	PA; QL (240 tablets per month.); CM
LUMAKRAS ORAL TABLET 240 MG (***sotorasib***)	3/4	PA; QL (120 tablets per month.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LUMAKRAS ORAL TABLET 320 MG (***sotorasib***)	3/4	PA; QL (3 tablets per day.); CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (***olaparib***)	2	PA; QL (4 tablets per day); SP; CM; SMCS
LYSODREN ORAL TABLET 500 MG (***mitotane***)	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (84 tablets per month.); CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (112 tablets per month.); CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (140 tablets per month.); CM
MATULANE ORAL CAPSULE 50 MG (***procarbazine hcl***)	2	SP; CM; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	1	
megestrol acetate oral tablet 20 mg, 40 mg	1	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (***trametinib dimethyl sulfoxide***)	3/4	ST; QL (17.4 ml per day.); CM
MEKINIST ORAL TABLET 0.5 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; ST; QL (2 tablets per day.); CM
MEKINIST ORAL TABLET 2 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; ST; QL (1 tablet per day.); CM
MEKTOVI ORAL TABLET 15 MG (***binimetinib***)	3/4	PA; ST; QL (6 tablets per day); SP; CM; SMCS
mercaptopurine oral suspension 2000 mg/100ml	1	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
MODEYSO ORAL CAPSULE 125 MG (***dordaviprone hcl***)	3/4	PA; QL (20 capsules per month.); SP; CM; SMCS
MYLERAN ORAL TABLET 2 MG (***busulfan***)	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NERLYNX ORAL TABLET 40 MG (***neratinib maleate***)	2	PA; QL (6 tablets per day.); CM
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	1	PA; ST; QL (4 capsules per day.); SP; CM; SMCS
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (***ixazomib citrate***)	2	PA; SP; CM; SMCS
NUBEQA ORAL TABLET 300 MG (***darolutamide***)	2	PA; QL (4 tablets per day.); CM
ODOMZO ORAL CAPSULE 200 MG (***sonidegib phosphate***)	2	PA; QL (1 capsule per day.); CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (***nirogacestat hydrobromide***)	2	PA; CM
OGSIVEO ORAL TABLET 50 MG (***nirogacestat hydrobromide***)	2	PA; QL (6 tablets per day.); CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (***tovorafenib***)	3/4	PA; QL (96 ml per month.); CM
OJEMDA ORAL TABLET 100 MG (***tovorafenib***)	3/4	PA; QL (24 tablets per month.); CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (***momelotinib dihydrochloride***)	3/4	PA; ST; QL (1 tablet per day.); CM
ONUREG ORAL TABLET 200 MG, 300 MG (***azacitidine***)	2	PA; QL (14 tablets per 24 days.); CM
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
ORGOVYX ORAL TABLET 120 MG (***relugolix***)	3	PA; QL (1 tablet per day); CM
ORSERDU ORAL TABLET 86 MG (***elacestrant hydrochloride***)	2	PA; QL (3 tablets per day.); CM
pazopanib hcl oral tablet 200 mg	1	PA; QL (4 tablets per day.); SP; CM; SMCS
pazopanib hcl oral tablet 400 mg	1	PA; SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (***pemigatinib***)	3/4	PA; QL (31 tablets per month.); CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (***alpelisib***)	2	PA; QL (2 tablets per day.); CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (***alpelisib***)	2	PA; QL (1 tablet per day.); CM
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (***pomalidomide***)	3	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
QINLOCK ORAL TABLET 50 MG (***ripretinib***)	3/4	PA; QL (3 tablets per day.); SP; CM; SMCS
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (***selpercatinib***)	3/4	PA; QL (60 tablets per month.); CM
RETEVMO ORAL TABLET 40 MG (***selpercatinib***)	3/4	PA; QL (90 tablets per month.); CM
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	3/4	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***lenalidomide***)	2	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
REVLIMID ORAL CAPSULE 20 MG, 25 MG (***lenalidomide***)	2	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
REVUFORJ ORAL TABLET 110 MG (***revumenib citrate***)	3/4	PA; QL (120 tablets per month.); SP; CM; SMCS
REVUFORJ ORAL TABLET 160 MG (***revumenib citrate***)	3/4	PA; QL (60 tablets per month.); SP; CM; SMCS
REVUFORJ ORAL TABLET 25 MG (***revumenib citrate***)	3/4	PA; QL (240 tablets per month.); SP; CM; SMCS
REZLIDHIA ORAL CAPSULE 150 MG (***olutasidenib***)	2	PA; QL (2 capsules per day.); CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (***vimseltinib***)	2	PA; QL (8 capsules per 4 weeks.); SP; CM; SMCS
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (***entrectinib***)	2	PA; QL (3 capsules per day.); CM
ROZLYTREK ORAL PACKET 50 MG (***entrectinib***)	2	PA; QL (84 packets (2 boxes) per month.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (***rucaparib camsylate***)	3	PA; ST; QL (4 tablets per day.); SP; CM; SMCS
RYDAPT ORAL CAPSULE 25 MG (***midostaurin***)	2	PA; QL (8 capsules per day); CM
SCEMBLIX ORAL TABLET 100 MG (***asciminib hcl***)	3/4	PA; QL (120 tablets per month.); SP; CM; SMCS
SCEMBLIX ORAL TABLET 20 MG, 40 MG (***asciminib hcl***)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
sorafenib tosylate oral tablet 200 mg	1	PA; QL (4 tablets per day.); SP; CM; SMCS
STIVARGA ORAL TABLET 40 MG (***regorafenib***)	2	PA; QL (84 tablets per 21 days.); SP; CM; SMCS
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA; QL (1 capsule per day.); SP; CM; SMCS
TABLOID ORAL TABLET 40 MG (***thioguanine***)	2	CM
TABRECTA ORAL TABLET 150 MG, 200 MG (***capmatinib hcl***)	3/4	PA; QL (4 tablets per day.); CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (***dabrafenib mesylate***)	3/4	PA; ST; QL (4 capsules per day.); CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (***dabrafenib mesylate***)	3/4	ST; QL (420 tablets per month.); CM
TAGRISSO ORAL TABLET 40 MG, 80 MG (***osimertinib mesylate***)	3	PA; QL (1 tablet per day.); CM
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (***talazoparib tosylate***)	3/4	PA; ST; QL (1 capsule per day.); SP; CM; SMCS
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
TAZVERIK ORAL TABLET 200 MG (***tazemetostat hbr***)	3/4	PA; QL (8 tablets per day.); SP; CM; SMCS
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	CM
TEPMETKO ORAL TABLET 225 MG (***tepotinib hcl***)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; SP; CM; SMCS
TIBSOVO ORAL TABLET 250 MG (***ivosidenib***)	2	PA; QL (2 tablets per day.); SP; CM; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
toremifene citrate oral tablet 60 mg	1	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %, 0.025 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	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.)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (***capivasertib***)	2	PA; QL (64 tablets every month.); CM
TUKYSA ORAL TABLET 150 MG (***tucatinib***)	2	PA; QL (4 tablets per day.); CM
TUKYSA ORAL TABLET 50 MG (***tucatinib***)	2	PA; QL (10 tablets per day.); CM
TURALIO ORAL CAPSULE 125 MG (***pexidartinib hcl***)	2	PA; QL (4 capsules per day.); SP; CM; SMCS
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (***quizartinib dihydrochloride***)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
VENCLEXTA ORAL TABLET 10 MG (***venetoclax***)	2	PA; QL (14 tablets per month.); CM
VENCLEXTA ORAL TABLET 100 MG (***venetoclax***)	2	PA; QL (4 tablets per day.); CM
VENCLEXTA ORAL TABLET 50 MG (***venetoclax***)	2	PA; QL (1 tablet per day.); CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (***venetoclax***)	2	PA; QL (42 tablets per year.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***abemaciclib***)	2	PA; QL (2 tablets per day); CM
VITRAKVI ORAL CAPSULE 100 MG (***larotrectinib sulfate***)	2	PA; QL (2 capsules per day.); CM
VITRAKVI ORAL CAPSULE 25 MG (***larotrectinib sulfate***)	2	PA; QL (6 capsules per day.); CM
VITRAKVI ORAL SOLUTION 20 MG/ML (***larotrectinib sulfate***)	2	PA; QL (10 mL per day.); CM
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (***dacomitinib***)	3	PA; QL (1 tablet per day.); CM
VORANIGO ORAL TABLET 10 MG (***vorasidenib***)	2	PA; QL (62 tablets per month.); SP; CM; SMCS
VORANIGO ORAL TABLET 40 MG (***vorasidenib***)	2	PA; QL (31 tablets per month.); SP; CM; SMCS
WELIREG ORAL TABLET 40 MG (***belzutifan***)	3/4	PA; QL (3 tablets day.); SP; CM; SMCS
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
XOSPATA ORAL TABLET 40 MG (***gilteritinib fumarate***)	3	PA; QL (3 tablets per day.); CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (***selinexor***)	3/4	PA; QL (0.26 tablet per day.); CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (***selinexor***)	3/4	PA; QL (16 tablets per month.); CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (***selinexor***)	3/4	PA; QL (1 therapy pack per month.); CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (0.86 tablets per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (***selinexor***)	3/4	PA; CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (1.15 tablets per day.); CM
XROMI ORAL SOLUTION 100 MG/ML (***hydroxyurea***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XTANDI ORAL CAPSULE 40 MG (***enzalutamide***)	2	PA; QL (4 capsules per day.); SP; CM; SMCS
ZELBORAF ORAL TABLET 240 MG (***vemurafenib***)	2	PA; QL (8 tablets per day.); SP; CM; SMCS
ZOLINZA ORAL CAPSULE 100 MG (***vorinostat***)	2	PA; QL (4 capsules per day.); CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (***idelalisib***)	3/4	PA; QL (60 tablets per month.); SP; CM; SMCS
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***)	3/4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (***dust mite mixed allergen ext***)	3/4	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (1 tablet per day.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (1 tablet per day.)
PALFORZIA (1 MG DAILY DOSE) ORAL 1 X 1 MG (***peanut powder-dnfp***)	3	PA
PALFORZIA INITIAL DOSE 1-3YRS ORAL 0.5 & 1 & 1.5 & 3 MG (***peanut powder-dnfp***)	3	PA; QL (7 capsules (1 pack) per 365 days.)
PALFORZIA INITIAL DOSE 4-17YRS ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (***peanut powder-dnfp***)	3	PA; QL (13 capsules per year.)
PALFORZIA ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (***peanut powder-dnfp***)	3	PA; QL (13 capsules per year.)
PALFORZIA ORAL 2 X 1 MG & 10 MG, 3 X 1 MG (***peanut powder-dnfp***)	3	PA; QL (45 capsules per 13 days.)
PALFORZIA ORAL 2 X 100 MG, 2 X 20 MG, 20 MG & 100 MG (***peanut powder-dnfp***)	3	PA; QL (30 capsules per 13 days.)
PALFORZIA ORAL 2 X 20 MG & 2 X 100 MG, 4 X 20 MG (***peanut powder-dnfp***)	3	PA; QL (60 capsules per 13 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PALFORZIA ORAL 20 MG (***peanut powder-dnfp***)	3	PA; QL (15 capsules per 13 days.)
PALFORZIA ORAL 3 X 20 MG & 100 MG (***peanut powder-dnfp***)	3	PA; QL (60 capsule per 13 days.)
PALFORZIA ORAL 6 X 1 MG (***peanut powder-dnfp***)	3	PA; QL (90 capsules per 13 days.)
PALFORZIA ORAL PACKET 300 MG (***peanut powder-dnfp***)	3	PA; QL (1 capsule per day.)
PALFORZIA ORAL PACKET 300 MG (***peanut powder-dnfp***)	3	PA; QL (15 capsules per 13 days.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***)	3/4	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 (***dtap-ipv-hib-hepatitis b recmb***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
AFLURIA INTRAMUSCULAR SUSPENSION (***influenza virus vaccine split***)	3	H
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
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
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (***covid-19 mrna virus vaccine***)	3	H
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (***covid-19 mrna virus vaccine***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
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 (***meningococcal a c y&w-135 olig***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
PEDVAX HIB 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
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
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (***zoster vac recomb adjuvanted***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 (***dtap-ipv-hib-hepatitis b recmb***)	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
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	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***)	1	H
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	3/4	PA; QL (0.28 ml per day.)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	H
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	SM
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
droxidopa oral capsule 100 mg	1	PA; QL (90 tablets per month.)
droxidopa oral capsule 200 mg, 300 mg	1	PA; QL (180 tablets per month.)
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (***epinephrine***)	3/4	
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	1	
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	1	
lofexidine hcl oral tablet 0.18 mg	1	
LUCEMYRA ORAL TABLET 0.18 MG (***lofexidine hcl***)	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
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	SM
atropine sulfate ophthalmic solution 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (***ipratropium bromide hfa***)	2	QL (0.87 grams per day.); SM
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.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	3/4	
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	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	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 inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***)	3/4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
MOTOFEN ORAL TABLET 1-0.025 MG (***difenoxin-atropine***)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
YUPELRI INHALATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
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		
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
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
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***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	1	H
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles		
carisoprodol oral tablet 250 mg, 350 mg	1	
chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
metaxalone oral tablet 400 mg, 800 mg	1	
methocarbamol oral tablet 1000 mg, 500 mg, 750 mg	1	
TANLOR ORAL TABLET 1000 MG (***methocarbamol***)	3	
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
ZANAFLEX ORAL TABLET 4 MG (***tizanidine hcl***)	3/4	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (***dantrolene sodium***)	3/4	
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, 5 mg/5ml	1	
baclofen oral suspension 25 mg/5ml	1	
baclofen oral tablet 10 mg, 15 mg, 20 mg, 5 mg	1	
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (***baclofen***)	3/4	
OZOBAX DS ORAL SOLUTION 10 MG/5ML (***baclofen***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
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	1	
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	1	
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***)	3/4	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
TEZRULY ORAL SOLUTION 1 MG/ML (***terazosin hcl***)	3/4	PA
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	3/4	
ergotamine-caffeine oral tablet 1-100 mg	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
phenoxybenzamine hcl oral capsule 10 mg	1	
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, 23 mg, 5 mg	1	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	1	
MESTINON ORAL SOLUTION 60 MG/5ML (***pyridostigmine bromide***)	3/4	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	3/4	
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	1	
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	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
silodosin oral capsule 4 mg, 8 mg	1	
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***)	2	QL (0.4 grams per day.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	SM
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	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	SM
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 grams per day.); SM
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 mcg per day.); SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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.); SM
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.); SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	SM
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	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (***betaxolol hcl***)	3	
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***)	3/4	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 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	1	
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)
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)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
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)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
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, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	
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; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (***mitapivat sulfate***)	3	PA; QL (56 tablets per 28 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (***mitapivat sulfate***)	3	PA; QL (7 tablets per 365 days.); 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.); CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (***fostamatinib disodium***)	3/4	PA; QL (2 tablets per day); SP; SMCS
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
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	1	QL (20 ml per day.)
rivaroxaban oral tablet 2.5 mg	1	QL (2 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (***edoxaban tosylate***)	3/4	QL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (***rivaroxaban***)	2	QL (20 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
dabigatran etexilate mesylate oral capsule 110 mg	1	QL (2 tablets per day.)
dabigatran etexilate mesylate oral capsule 150 mg, 75 mg	1	QL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (***dabigatran etexilate mesylate***)	3/4	QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (***dabigatran etexilate mesylate***)	3/4	QL (2 packets per day.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (***eltrombopag choline***)	3/4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
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)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
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)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
DOPTELET ORAL TABLET 20 MG (***avatrombopag maleate***)	3/4	PA; QL (60 tablets per month.)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (***avatrombopag maleate***)	3/4	PA; QL (60 capsules per month.)
eltrombopag olamine oral packet 12.5 mg, 25 mg	1	PA; QL (6 packets per day.)
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (***sargramostim***)	2	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (***plerixafor***)	3/4	
MULPLETA ORAL TABLET 3 MG (***lusutrombopag***)	3/4	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim***)	2	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (***filgrastim-aafi***)	2	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-aafi***)	2	
plerixafor subcutaneous solution 24 mg/1.2ml	1	
PROMACTA ORAL PACKET 12.5 MG, 25 MG (***eltrombopag olamine***)	3/4	PA; QL (6 packets per day.)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
VAFSEO ORAL TABLET 150 MG, 300 MG (***vadadustat***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOLREMDI ORAL CAPSULE 100 MG (***mavorixafor***)	2	PA; QL (120 capsules per month.); SP; SMCS
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-sndz***)	2	
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	
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	3/4	
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact single chain***)	3/4	
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor-vwf***)	2	
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***coagulation factor ix***)	2	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***coagulation factor ix (rfixfc)***)	3	
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact fc-vwf-xten-ehtl***)	3/4	
aminocaproic acid oral solution 0.25 gm/ml	1	
aminocaproic acid oral tablet 1000 mg, 500 mg	1	
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	
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (***coagulation factor x (human)***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (***factor xiii concentrate human***)	2	
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
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)***)	3/4	
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (***antiinhibitor coagulant cmplx***)	2	
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; SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (***antihemophilic factor-vwf***)	2	
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***marstacimab-hncq***)	2	PA; QL (4 mL (4 Auto-injectors) per month.)
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (***coagulation factor ix (rix-fp)***)	3	
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***ahf (bdd-rfviii peg-aucl)***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
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	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (***coagulation factor viia recomb***)	2	
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	
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	
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	3	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***factor ix complex***)	2	
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (***fitusiran sodium***)	3/4	PA; ST; QL (0.2 mL (1 vial) per month.)
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***fitusiran sodium***)	3/4	PA; ST; QL (0.5 mL (1 pen) per month.)
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (***antihem factor recomb (rfviii)***)	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG (***coagulation factor viia-jncw***)	3/4	
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	1	QL (Benefit maximum quantity 1 per day.)
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (***coagulation factor xiii a-sub***)	3	SP; SMCS
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (***von willebrand factor (recomb)***)	2	
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (***antihemophilic factor-vwf***)	2	
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA; ST
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA; ST
HEPARINS - Drugs to Prevent Blood Clots		
enoxaparin sodium injection solution 300 mg/3ml	1	
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	1	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (***dalteparin sodium***)	3/4	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (***dalteparin sodium***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
INDIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	
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	3/4	
MATRONEX ORAL TABLET 27-1 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral 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 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***)	3/4	
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	3/4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***)	3	
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	1	
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 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	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (***aspirin***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (***aspirin***)	E	H
ticagrelor oral tablet 60 mg, 90 mg	1	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (***vorapaxar sulfate***)	3/4	QL (1 tablet per day.)
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 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; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CARDIOVASCULAR DRUGS		
BRADYKININ RECEPTORS ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.); SMCS
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	1	PA; QL (4 tablets per day.)
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.)
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
LOOP DIURETICS (24:36)		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ethacrynic acid oral tablet 25 mg	1	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (***furosemide***)	3/4	PA
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***)	3/4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (2 tablets per day.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (24:36)		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
POTASSIUM-SPARING DIURETICS (24:36)		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
THIAZIDE DIURETICS (24:36)		
DIURIL ORAL SUSPENSION 250 MG/5ML (***chlorothiazide***)	2	
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***)	3/4	
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	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ACL INHIBITORS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALPHA-ADRENERGIC BLOCKING AGENTS (24:16) - Drugs for Varicose Veins		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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***)	3/4	PA
ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 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***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EDARBI ORAL TABLET 40 MG, 80 MG (***azilsartan medoxomil***)	3/4	
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	1	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral solution 4 mg/ml	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	1	
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	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	
ARBLI ORAL SUSPENSION 10 MG/ML (***losartan potassium***)	3/4	PA
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	
EDARBI ORAL TABLET 40 MG, 80 MG (***azilsartan medoxomil***)	3/4	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	3/4	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
valsartan oral solution 4 mg/ml	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 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	
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	1	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
EPANED ORAL SOLUTION 1 MG/ML (***enalapril maleate***)	3/4	
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	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***)	3/4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
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	
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
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	
EPANED ORAL SOLUTION 1 MG/ML (***enalapril maleate***)	3/4	
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***)	3/4	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***)	3/4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
QBRELIS ORAL SOLUTION 1 MG/ML (***lisinopril***)	3/4	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 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	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	3/4	
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 (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	3/4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; ST; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; ST; QL (62 capsules per month.)
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
omega-3-acid ethyl esters oral capsule 1 gm	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
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-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 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***)	3/4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 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	1	
pindolol oral tablet 10 mg, 5 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
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 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
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	
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
COLESTID ORAL GRANULES 5 GM (***colestipol hcl***)	3	
COLESTID ORAL TABLET 1 GM (***colestipol hcl***)	3/4	
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	
prevalite oral powder 4 gm/dose	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (***cholestyramine light***)	3/4	
QUESTRAN ORAL PACKET 4 GM (***cholestyramine***)	3/4	
QUESTRAN ORAL POWDER 4 GM/DOSE (***cholestyramine***)	3/4	
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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
CALCIUM-CHANNEL BLOCKING AGENTS - Drugs for High Blood Pressure & Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
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	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
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.)
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***mavacamten***)	3/4	PA; QL (1 capsule per day.)
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	1	PA; QL (2 tablets per day.)
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	1	
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
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	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	3/4	
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-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
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	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***)	3/4	
methyldopa oral tablet 250 mg, 500 mg	1	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
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	1	
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***)	3/4	
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***)	3/4	PA; QL (1 tablet per day.)
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
ezetimibe oral tablet 10 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
disopyramide phosphate oral capsule 100 mg, 150 mg	1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (***disopyramide phosphate***)	2	
NORPACE ORAL CAPSULE 100 MG, 150 MG (***disopyramide phosphate***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
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	1	
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	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (***betaxolol hcl***)	3	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 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	1	
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	1	
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***)	3/4	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
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 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	1	
MULTAQ ORAL TABLET 400 MG (***dronedarone hcl***)	3/4	PA
PACERONE ORAL TABLET 100 MG (***amiodarone hcl***)	3	
PACERONE ORAL TABLET 200 MG (***amiodarone hcl***)	3/4	
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***)	3/4	
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (***dofetilide***)	3/4	
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina		
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	1	
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 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	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	
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	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SDAMLO ORAL SOLUTION RECONSTITUTED 10 MG, 2.5 MG, 5 MG (***amlodipine besylate***)	3	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
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	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	
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	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	
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)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	
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	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)
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	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
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	
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	1	
fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg	1	
fenofibrate oral tablet 120 mg, 145 mg, 160 mg, 40 mg, 48 mg, 54 mg	1	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	1	
fenofibric acid oral tablet 105 mg, 35 mg	1	
gemfibrozil oral tablet 600 mg	1	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (***fenofibrate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LOPID ORAL TABLET 600 MG (***gemfibrozil***)	3/4	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (***atorvastatin calcium***)	3/4	
atorvastatin calcium oral tablet 10 mg, 20 mg	1	H-N
atorvastatin calcium oral tablet 40 mg, 80 mg	1	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (***rosuvastatin calcium***)	3	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3/4	
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	1	
fluvastatin sodium oral capsule 20 mg, 40 mg	1	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (***pitavastatin calcium***)	3/4	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	H
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	1	
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	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	H-N
simvastatin oral tablet 80 mg	1	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (***pitavastatin magnesium***)	3/4	
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	
ethacrynic acid oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (***furosemide***)	3/4	PA
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***)	3/4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (2 tablets per day.)
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***)	3/4	SM
eplerenone oral tablet 25 mg, 50 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG (***finerenone***)	3/4	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (***finerenone***)	3/4	PA; QL (30 tablets per month.)
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
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***)	3/4	SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; ST; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; ST; QL (62 capsules per month.)
NITRATES AND NITRITES - Drugs for High Blood Pressure & Angina		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
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***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 % (***nitroglycerin***)	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 %	1	QL (30 grams per month.)
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin translingual solution 0.4 mg/spray	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	
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	1	
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***)	3/4	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***)	3/4	
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	1	
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 % (***nitroglycerin***)	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 patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin translingual solution 0.4 mg/spray	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
omega-3-acid ethyl esters oral capsule 1 gm	1	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (***evolocumab***)	2	QL (2 syringes per 28 days.)
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	1	PA; QL (2 tablets per day)
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 mg, 50 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	QL (1 capsule per day.)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 tablets per month)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day)
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 mg, 50 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	QL (1 capsule per day.)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 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***)	3/4	SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
triamterene oral capsule 100 mg, 50 mg	1	
RENIN INHIBITORS - Drugs for the Heart		
aliskiren fumarate oral tablet 150 mg, 300 mg	1	
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***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (1 tablet per day.)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	SM
eplerenone oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
DIURIL ORAL SUSPENSION 250 MG/5ML (***chlorothiazide***)	2	
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	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina		
phenoxybenzamine hcl oral capsule 10 mg	1	
VECAMYL ORAL TABLET 2.5 MG (***mecamylamine hcl***)	3/4	
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SP; SMCS
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.); SP; SMCS
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SP; SMCS
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	PA; QL (2 tablets per day.)
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 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	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OPSUMIT ORAL TABLET 10 MG (***macitentan***)	2	PA; QL (1 tablet per day.); SP; SMCS
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day)
SDAMLO ORAL SOLUTION RECONSTITUTED 10 MG, 2.5 MG, 5 MG (***amlodipine besylate***)	3	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
TRACLEER ORAL TABLET 125 MG, 62.5 MG (***bosentan***)	2	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (***treprostinil***)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 80 MCG (***treprostinil***)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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***)	3/4	PA; QL (1 tablet per day.)
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
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.)
AMPHETAMINES - Drugs for the Nervous System		
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (***amphetamine***)	3/4	QL (1 tablet per day.)
amphetamine er oral tablet extended release dispersible 12.5 mg, 15.7 mg, 18.8 mg, 3.1 mg, 6.3 mg, 9.4 mg	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
amphetamine sulfate oral tablet 10 mg, 5 mg	1	
amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	1	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	1	QL (1 capsule per day)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	QL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	QL (10 capsules per day.)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (***amphetamine***)	3/4	QL (15 mL per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 10 MG, 15 MG, 5 MG (***amphetamine***)	3/4	QL (1 tablet per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 20 MG (***amphetamine***)	3/4	QL (31 chewable tablets per month.)
EVEKEO ORAL TABLET 10 MG, 5 MG (***amphetamine sulfate***)	3/4	
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	1	QL (2 capsules per day.)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	1	QL (1 capsule per day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	1	QL (2 tablets per day.)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	1	QL (1 tablet per day)
methamphetamine hcl oral tablet 5 mg	1	
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (***amphetamine-dextroamphetamine***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROCENTRA ORAL SOLUTION 5 MG/5ML (***dextroamphetamine sulfate***)	3	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (***dextroamphetamine***)	3	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
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	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 50-300-40-30 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, 50-325-40 mg	1	QL (6 capsules per day)
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***)	3/4	QL (6 capsules per day)
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	
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	1	
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
JOURNAVX ORAL TABLET 50 MG (***suzetrigine***)	3/4	QL (30 tablets per 90 Days.)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
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, MISCELLANEOUS - Drugs for the Nervous System		
liraglutide subcutaneous solution pen-injector 18 mg/3ml	1	PA; QL (2 pens (6 mL) per month.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
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***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (***brivaracetam***)	3/4	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	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
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***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (***cannabidiol***)	3	PA
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	3/4	
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
felbamate oral suspension 600 mg/5ml	1	
felbamate oral tablet 400 mg, 600 mg	1	
FELBATOL ORAL TABLET 400 MG, 600 MG (***felbamate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FINTEPLA ORAL SOLUTION 2.2 MG/ML (***fenfluramine hcl***)	3/4	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (***perampanel***)	3/4	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***)	3/4	
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (***levetiracetam***)	3/4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (***levetiracetam***)	3/4	
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
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	1	
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
LEVETIRACETAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG	3/4	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
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***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
perampanel oral suspension 0.5 mg/ml	1	PA
perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
roweepra oral tablet 500 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG (***levetiracetam***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
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***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	1	PA; QL (6 packets per day.); SP; SMCS
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.); SP; SMCS
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SP; SMCS
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	3/4	PA
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (***dextromethorphan-bupropion***)	3/4	QL (2 tablets per day.)
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
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 ER (XL) ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG	3/4	QL (1 tablet per day.)
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***)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (12 devices (4 kits) per month.)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (***zuranolone***)	2	PA; QL (28 capsules per year.)
ZURZUVAE ORAL CAPSULE 30 MG (***zuranolone***)	2	PA; QL (14 capsules per year.)
ANTIMANIC AGENTS - Drugs for Personality Disorder		
aripiprazole oral solution 1 mg/ml	1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
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***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
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)***)	3/4	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	
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	1	
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***)	3/4	
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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg	1	QL (1 capsule per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 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***)	3/4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
butorphanol tartrate nasal solution 10 mg/ml	1	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
diclofenac potassium(migraine) oral packet 50 mg	1	
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	3/4	
ergotamine-caffeine oral tablet 1-100 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
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***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
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***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	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	1	
pimozide oral tablet 1 mg, 2 mg	1	
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	3/4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
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	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	3/4	QL (1 capsule per day.)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
aripiprazole oral solution 1 mg/ml	1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (***lumateperone tosylate***)	3/4	PA; 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***)	3/4	
FANAPT ORAL TABLET 1 MG (***iloperidone***)	3/4	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (***iloperidone***)	3/4	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (***iloperidone***)	3/4	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***)	3/4	QL (1 pack (12 tablets) per 365 days.)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (***iloperidone***)	3/4	QL (2 pack (8 tablets) per 365 days.)
lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg	1	QL (1 tablet per day.)
lurasidone hcl oral tablet 40 mg	1	QL (1 tablet per day)
lurasidone hcl oral tablet 80 mg	1	QL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (***pimavanserin tartrate***)	3/4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (***pimavanserin tartrate***)	3/4	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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	1	QL (1 tablet per day)
paliperidone er oral tablet extended release 24 hour 6 mg	1	QL (2 tablets per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	1	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (***brexpiprazole***)	3/4	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	
VERSACLOZ ORAL SUSPENSION 50 MG/ML (***clozapine***)	3/4	
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG (***cariprazine hcl***)	3/4	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (***cariprazine hcl***)	3/4	QL (1 capsule per day.)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
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	1	PA
primidone oral tablet 250 mg, 50 mg	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
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 50-300-40-30 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, 50-325-40 mg	1	QL (6 capsules per day)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	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	1	PA
clobazam oral tablet 10 mg, 20 mg	1	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	
diazepam rectal gel 10 mg, 2.5 mg, 20 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	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	3/4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	3/4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	3/4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	3/4	PA
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	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	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
HALCION ORAL TABLET 0.25 MG (***triazolam***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	3/4	
midazolam hcl oral syrup 2 mg/ml	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	3/4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	3/4	
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (***temazepam***)	3/4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	3/4	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	
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***)	2	PA; QL (0.27 tablets per day.)
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; QL (0.27 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZAVZPRET NASAL SOLUTION 10 MG/ACT (***zavegepant hcl***)	3/4	PA
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	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG (***opicapone***)	3/4	QL (1 capsule per day.)
tolcapone oral tablet 100 mg	1	
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***)	3/4	PA; QL (1 tablet per day.)
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (***trofinetide***)	2	PA; QL (120 ml per day.)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	1	
memantine hcl oral solution 2 mg/ml	1	
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	1	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	3/4	
NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3/4	PA; QL (18 ml per day.); SP; SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
VEOZAH ORAL TABLET 45 MG (***fezolinetant***)	3/4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
XYWAV ORAL SOLUTION 500 MG/ML (***ca, mg, k, and na oxybates***)	3/4	PA; QL (18 mL per day.); SP; SMCS
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	1	
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	1	
DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis		
pimozide oral tablet 1 mg, 2 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (***carbidopa-levodopa***)	3/4	PA
INBRIJA INHALATION CAPSULE 42 MG (***levodopa***)	3	PA; QL (10 tablets per day.)
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (***carbidopa-levodopa***)	3/4	
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	1	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***)	3/4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***)	3/4	QL (1 pack per 365 days.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
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	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
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	1	PA; QL (6 packets per day.); SP; SMCS
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.); SP; SMCS
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SP; SMCS
VIGAFYDE ORAL SOLUTION 100 MG/ML (***vigabatrin***)	1	PA; QL (900 mL per month.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	3/4	PA
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	
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***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
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	1	
rufinamide oral tablet 200 mg, 400 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	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***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	
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***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
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	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NARDIL ORAL TABLET 15 MG (***phenelzine sulfate***)	3/4	
PARNATE ORAL TABLET 10 MG (***tranylcypromine sulfate***)	3/4	
phenelzine sulfate oral tablet 15 mg	1	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	1	
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***)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	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	
meprobamate oral tablet 200 mg, 400 mg	1	
NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder		
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	3/4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	3/4	QL (1 capsule per day.)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (***apomorphine hcl***)	3/4	PA; QL (3 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	1	PA; QL (3 ml per day.)
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	1	
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
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	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 50-300-40-30 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, 50-325-40 mg	1	QL (6 capsules per day)
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***)	3/4	QL (6 capsules per day)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	1	
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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		
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	3/4	
diclofenac potassium oral capsule 25 mg	1	QL (4 capsules per day.)
diclofenac potassium oral tablet 50 mg	1	
diclofenac potassium(migraine) oral packet 50 mg	1	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
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	1	
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
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	
INDOCIN ORAL SUSPENSION 25 MG/5ML (***indomethacin***)	3/4	
INDOCIN RECTAL SUPPOSITORY 50 MG (***indomethacin***)	3/4	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	
indomethacin rectal suppository 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
mefenamic acid oral capsule 250 mg	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	
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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
sulindac oral tablet 150 mg, 200 mg	1	
ZIPSOR ORAL CAPSULE 25 MG (***diclofenac potassium***)	3/4	QL (4 capsules per day.)
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	1	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 50-300-40-30 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
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***tramadol hcl***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	1	PA; QL (0.34 patches per day)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	1	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	1	PA; QL (2 capsules per day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	1	PA; QL (0 tablet per 0 days)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	1	PA; QL (1 tablet per day)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	1	
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
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	1	PA; QL (2 tablets per day)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg	1	PA; QL (1 tablet per day)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	1	PA; QL (0 tablet per 0 days)
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	1	ST; QL (4 tablets per day); NTT
levorphanol tartrate oral tablet 3 mg	1	ST; QL (4 tablets per day.); 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	PA; QL (0 capsule per 100 days)
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	1	PA; QL (1 capsule per day)
morphine sulfate er oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg	1	PA; QL (62 capsules per 31 days)
morphine sulfate er oral capsule extended release 24 hour 100 mg	1	PA; QL (0 capsule per 100 days)
morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg, 80 mg	1	PA; QL (1 capsule per day)
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	1	PA; QL (0 capsule per 100 days)
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 capsule per 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (***tapentadol hcl***)	2	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	1	PA; QL (2 tablets per day.)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg	1	PA; QL (0 tablet per 100 days.)
oxymorphone hcl er oral tablet extended release 12 hour 30 mg, 40 mg	1	PA; QL (0 capsule per 100 days)
oxymorphone hcl oral tablet 10 mg, 5 mg	1	QL (6 tablets per day); NTT
TRAMADOL HCL (ER BIPHASIC) ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG	3/4	QL (1 capsule per day)
tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	1	QL (1 tablet per day)
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	1	QL (1 tablet per day)
tramadol hcl oral tablet 100 mg, 50 mg	1	NTT
tramadol hcl oral tablet 25 mg	1	
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***)	3/4	PA; QL (2 tablets per day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (***oxycodone***)	3/4	PA; QL (0 capsule per 100 days)
OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	SM
KLOXXADO NASAL LIQUID 8 MG/0.1ML (***naloxone hcl***)	1	SM
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	SM
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (***nalmefene hcl***)	1	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	1	SM
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (***nalmefene hcl***)	1	
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (***buprenorphine hcl***)	3	PA; QL (2 films per day)
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	1	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	1	PA; QL (4 patches per 28 days)
buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr	1	PA; QL (4 patches per month)
butorphanol tartrate nasal solution 10 mg/ml	1	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)
PHENOTHIAZINES - Drugs for Depression & Psychosis		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	1	
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.)
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	
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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (***methylphenidate hcl***)	3/4	QL (1 capsule per day.)
ascomp-codeine oral capsule 50-325-40-30 mg	1	
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	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***)	2	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 50-300-40-30 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, 50-325-40 mg	1	QL (6 capsules per day)
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	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (***methylphenidate***)	3/4	QL (1 tablet per day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	1	QL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	1	QL (31 capsules per 31 days.)
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	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	QL (6 capsules per day)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (***dexmethylphenidate hcl***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (***methylphenidate hcl***)	2	QL (1 capsule per day.)
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (***methylphenidate hcl***)	3/4	
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg	1	QL (2 tablets per day.)
methylphenidate hcl er (cd) oral capsule extended release 60 mg	1	QL (31 capsules per 31 days.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg	1	QL (5capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	1	QL (3 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg	1	QL (2 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg	1	QL (31 capsules per month.)
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 36 mg, 54 mg	1	QL (2 tablets per day.)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (1 capsule per day.)
methylphenidate hcl er oral tablet extended release 10 mg	1	QL (10 tablets per day.)
methylphenidate hcl er oral tablet extended release 20 mg	1	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	1	
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr	1	QL (1 patch per day)
methylphenidate transdermal patch 30 mg/9hr	1	QL (1 patch per day.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (***methylphenidate hcl***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (***methylphenidate hcl***)	3/4	QL (360 mL per month.)
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	
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***)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	3/4	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	3/4	
diclofenac sodium external gel 3 %	1	PA
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
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	
INDOCIN ORAL SUSPENSION 25 MG/5ML (***indomethacin***)	3/4	
INDOCIN RECTAL SUPPOSITORY 50 MG (***indomethacin***)	3/4	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
indomethacin rectal suppository 50 mg	1	
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	1	
mefenamic acid oral capsule 250 mg	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	
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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
aspirin regimen oral tablet delayed release 81 mg	E	H
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
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 ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG	3/4	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***)	3/4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***)	3/4	QL (1 capsule per day.)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (***levomilnacipran hcl***)	3/4	QL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (***levomilnacipran hcl***)	3/4	QL (28 capsules per year.)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***)	3/4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***)	3/4	QL (1 pack 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VENLAFAXINE BESYLATE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 112.5 MG	3/4	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 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	1	
eletriptan hydrobromide oral tablet 20 mg, 40 mg	1	
frovatriptan succinate oral tablet 2.5 mg	1	
naratriptan hcl oral tablet 1 mg, 2.5 mg	1	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC (***sumatriptan succinate***)	3/4	
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	
sumatriptan nasal solution 20 mg/act, 5 mg/act	1	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	1	
TOSYMRA NASAL SOLUTION 10 MG/ACT (***sumatriptan***)	3/4	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (***sumatriptan succinate***)	3/4	
zolmitriptan oral tablet 2.5 mg, 5 mg	1	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	1	
ZOMIG NASAL SOLUTION 2.5 MG (***zolmitriptan***)	2	
ZOMIG NASAL SOLUTION 5 MG (***zolmitriptan***)	1	
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
CITALOPRAM HYDROBROMIDE ORAL CAPSULE 30 MG	3/4	
citalopram hydrobromide oral solution 10 mg/5ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
escitalopram oxalate oral solution 5 mg/5ml	1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	1	QL (4 capsules per 28 days.)
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	1	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	1	
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	1	QL (1 capsule per day)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	1	
paroxetine hcl oral suspension 10 mg/5ml	1	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
paroxetine mesylate oral capsule 7.5 mg	1	QL (1 capsule per day.)
sertraline hcl oral capsule 150 mg, 200 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		
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***)	3/4	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***)	3/4	QL (1 tablet per day.)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	1	
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (***methsuximide***)	3/4	
ethosuximide 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ethosuximide oral solution 250 mg/5ml	1	
methsuximide oral capsule 300 mg	1	
ZARONTIN ORAL CAPSULE 250 MG (***ethosuximide***)	3/4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (***ethosuximide***)	3/4	
THIOXANTHENES - Drugs for Depression & Psychosis		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
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	1	
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl external cream 5 %	1	PA
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	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (1 tablet per day)
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***)	3/4	
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	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	3/4	QL (1 tablet per day)
trimipramine maleate oral capsule 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (***deutetrabenazine***)	2	PA; QL (4 tablets per day)
AUSTEDO ORAL TABLET 6 MG (***deutetrabenazine***)	2	PA; QL (2 tablets per day)
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.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (***deutetrabenazine***)	2	PA; QL (30 Tablets per month.)
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.)
INGREZZA ORAL CAPSULE 40 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day)
INGREZZA ORAL CAPSULE 60 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day.)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (***valbenazine tosylate***)	2	PA; QL (30 tablets per month.)
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (30 capsules per month.)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (***valbenazine tosylate***)	2	PA; QL (1 kit (28 tablets) per year.)
tetrabenazine oral tablet 12.5 mg, 25 mg	1	PA; SP; SMCS
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
armodafinil oral tablet 150 mg, 250 mg	1	QL (1 tablet per day)
armodafinil oral tablet 200 mg	1	QL (1 tablet per day.)
armodafinil oral tablet 50 mg	1	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***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
modafinil oral tablet 100 mg, 200 mg	1	QL (3 tablets per day.)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3/4	PA; QL (18 ml per day.); SP; SMCS
SUNOSI ORAL TABLET 150 MG, 75 MG (***solriamfetol hcl***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (***pitolisant hcl***)	3/4	PA; QL (2 tablets per day.)
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
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	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
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-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
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	
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
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-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID (***blood glucose calibration***)	3	
ACCU-CHEK GUIDE KIT W/DEVICE (***blood glucose monitoring suppl***)	2	
ACCU-CHEK GUIDE ME KIT W/DEVICE (***blood glucose monitoring suppl***)	2	
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (***blood glucose calibration***)	1	
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***)	2	SM
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER2GO ANTI-STATIC DEVICE (***spacer/aero-holding chambers***)	2	SM
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
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.)
AUTOLET LANCING DEVICE (***lancet devices***)	3	
AUTOLET LITE LANCING DEVICE (***lancet devices***)	3	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)
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	
BREATHE COMFORT CHAMBER/ADULT DEVICE	2	SM
BREATHE COMFORT CHAMBER/CHILD DEVICE	2	SM
CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 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 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	
CEQUR SIMPLICITY 2U DEVICE (***injection device for insulin***)	3	
CHEMSTRIP BG LOG BOOK (***blood glucose monitoring suppl***)	1	
CHOSEN LANCETS 30G (***lancets***)	3	
CHOSEN LANCING DEVICE (***lancet devices***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
CONTOUR NEXT GEN MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	
CONTOUR NEXT MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	
CONTOUR NEXT ONE KIT (***blood glucose monitoring suppl***)	1	
CONTOUR NEXT ONE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	SM
CONTOUR PLUS BLUE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	
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.); SM
DEXCOM G6 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DEXCOM G6 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.); SM
DEXCOM G7 15 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
DEXCOM G7 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DEXCOM G7 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DIABETES MONITOR DIGIT ADD-ON KIT	3	
DIABETES MONITOR DIGIT SOLN KIT	3	
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***)	2	SM
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.)
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, 28G X 1/2" 1 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML, 28G X 1/2" 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.)
ENLITE GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; SM
FLEXICHAMBER ADULT MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/LARGE (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	
FONDCIRCLE SINGLE USE LANCETS	3	
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.); SM
FREESTYLE LIBRE 14 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 2 PLUS SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 2 READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 2 SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FREESTYLE LIBRE 3 PLUS SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 3 READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 reader per 999 days.); SM
FREESTYLE LIBRE 3 SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); SM
GUARDIAN 4 GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; QL (5 sensors per month.); SM
GUARDIAN 4 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (1 transmitter kit per year.); SM
GUARDIAN LINK 3 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (1 transmitter kit per 365 days.); SM
GUARDIAN REAL-TIME CHARGER (***continuous glucose monitor sup***)	3	SM
GUARDIAN REAL-TIME TEST PLUG (***continuous glucose monitor sup***)	3	SM
GUARDIAN SENSOR 3	3	PA; QL (5 sensors per 24 days.); SM
HAN-EASE (***injection device***)	3	
IHEALTH CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	3	
IHEALTH LANCING DEVICE (***lancet devices***)	3	
INPEN 100-BLUE-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	
INPEN 100-PINK-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INSPIREASE RESERVOIR BAGS (***spacer/aero-hold chamber bags***)	2	SM
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G 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 (***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 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 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, 32G X 5/16" 1 ML	2	QL (10 syringes per day.)
INSULIN SYRINGES 28G X 1/2" 0.5 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, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
INSUL-TOTE ULTIMATE SUPPLIES (***blood glucose monitoring suppl***)	3	
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	SM
LANCETS (***lancets***)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (***lancets***)	3	
MICROLET NEXT LANCING DEVICE (***lancet devices***)	3	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OMNIPOD 5 DEXG7G6 PODS GEN 5 (***insulin disposable pump***)	2	PA
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 KIT (***insulin disposable pump***)	2	PA
OMNIPOD 5 LIBRE2 PLUS G6 PODS (***insulin disposable pump***)	2	PA
ONETOUCH DELICA PLUS LANCING (***lancet devices***)	1	
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	SM
PARI VORTEX PEDIATRIC MASK (***spacer/aero-hold chamber mask***)	2	SM
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TECHLITE LANCETS 26G (***lancets***)	3	
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
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
TWIIST REFILL KIT/INFUSION SET KIT (***insulin disposable pump***)	2	PA
TWIIST STARTER KIT KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 730 days.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (***needle (disp)***)	2	
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	
VIVAGUARD SAFETY LANCETS 28G (***lancets***)	3	
VORTEX VALVE CHAMBER-PEDI MASK DEVICE (***spacer/aero-holding chambers***)	2	SM
VORTEX VALVED HOLDING CHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; SP; SMCS
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (20 ml per 24 days.); SP; SMCS
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (***cosyntropin***)	3/4	
cosyntropin injection solution reconstituted 0.25 mg	1	
CARDIAC FUNCTION		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
KETONES		
CHEMSTRIP K IN VITRO STRIP (***acetone (urine) test***)	2	
KETOSTIX IN VITRO STRIP (***acetone (urine) test***)	2	
PHEOCHROMOCYTOMA		
DEMSER ORAL CAPSULE 250 MG (***metyrosine***)	3/4	PA
metyrosine oral capsule 250 mg	1	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 10 %, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
ORAL CITRATE ORAL SOLUTION 490-640 MG/5ML	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***)	3/4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (***potassium citrate***)	3/4	
AMMONIA DETOXICANTS		
carglumic acid oral tablet soluble 200 mg	1	PA; SP; SMCS
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	1	PA; QL (17.5 ml per day.)
KRISTALOSE ORAL PACKET 10 GM, 20 GM (***lactulose***)	3	
lactulose encephalopathy oral solution 10 gm/15ml	1	
lactulose oral packet 20 gm	1	
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	1	PA
CALORIC AGENTS - Drugs for Nutrition		
DOJOLVI ORAL LIQUID 100 % (***triheptanoin***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
ethacrynic acid oral tablet 25 mg	1	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (***furosemide***)	3/4	PA
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***)	3/4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (2 tablets per day.)
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***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	
sevelamer carbonate oral tablet 800 mg	1	
VELPHORO ORAL TABLET CHEWABLE 500 MG (***sucroferric oxyhydroxide***)	3/4	
XPHOZAH ORAL TABLET 20 MG, 30 MG (***tenapanor hcl (ckd)***)	3/4	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 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	
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)***)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance		
amiloride hcl oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
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	
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	SM
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
POKONZA ORAL PACKET 15 MEQ (***potassium chloride***)	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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	3/4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	
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	1	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
DIURIL ORAL SUSPENSION 250 MG/5ML (***chlorothiazide***)	2	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
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***)	3/4	
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	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
URICOSURIC AGENTS		
colchicine-probenecid oral tablet 0.5-500 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
probenecid oral tablet 500 mg	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (***tolvaptan***)	3/4	PA; QL (90 tablets per 365 days.); SP; SMCS
SAMSCA ORAL TABLET 30 MG (***tolvaptan***)	3/4	PA; QL (60 tablets per 365 days.); SP; SMCS
tolvaptan oral tablet 15 mg	1	PA; SMCS
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg	1	PA; QL (2 tablets per day.)
tolvaptan oral tablet therapy pack 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	1	PA; QL (2 tablets per day)
tolvaptan tablet 30 mg oral	1	PA; SMCS
tolvaptan tablet 30 mg oral	1	PA; QL (2 tablets per day.); SMCS
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 packets per day.)
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (4 packets per day.)
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 tablets per day)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (***arimoclomol citrate***)	3/4	PA; QL (90 capsules per month.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SEPHIENCE ORAL PACKET 1000 MG (***sepiapterin***)	3/4	PA; ST; QL (186 packets per month.)
SEPHIENCE ORAL PACKET 250 MG (***sepiapterin***)	3/4	PA; ST; QL (682 packets per month.)
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
miglustat oral capsule 100 mg	1	
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
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; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; ST; QL (6 syringes per 365 days.); SP; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (***pegvaliase-pqpz***)	3	PA; ST; QL (1 ml per day.); SP; SMCS
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	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***dornase alfa***)	2	PA; QL (5 ml per day.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML (***asfotase alfa***)	2	PA; QL (5.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (***asfotase alfa***)	2	PA; QL (8.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (***asfotase alfa***)	2	PA; QL (12 ml tablets per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (***asfotase alfa***)	2	PA; QL (9.6 ml (12 vials) per month.); SP; SMCS
SUCRAID ORAL SOLUTION 8500 UNIT/ML (***sacrosidase***)	2	PA; SP; SMCS
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
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***)	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	3/4	
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate external gel 0.33 %	1	PA
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***)	3	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIALLERGIC AGENTS - Drugs for Allergy		
ALOCRIL OPHTHALMIC SOLUTION 2 % (***nedocromil sodium***)	3	
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
bepotastine besilate ophthalmic solution 1.5 %	1	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
epinastine hcl ophthalmic solution 0.05 %	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
ANTIBACTERIALS (52:04) - Drugs for Infections		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
AZASITE OPHTHALMIC SOLUTION 1 % (***azithromycin***)	3	
bacitracin ophthalmic ointment 500 unit/gm	1	
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***)	3/4	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
ciprofloxacin hcl otic solution 0.2 %	1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (***neomycin-colist-hc-thonzonium***)	3	
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin ophthalmic ointment 5 mg/gm	1	H-N
gatifloxacin ophthalmic solution 0.5 %	1	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
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	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
MITOSOL OPHTHALMIC KIT 0.2 MG (***mitomycin***)	3	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin otic solution 0.3 %	1	
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***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
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	
chlorhexidine gluconate mouth/throat solution 0.12 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
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***)	3/4	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	
gengraf oral solution 100 mg/ml	1	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (***perfluorohexyloctane***)	3/4	PA; QL (3 ml per 23 days.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (5.5 mL (1 bottle) per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	PA
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***)	3/4	
periogard mouth/throat solution 0.12 %	1	
BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye		
betaxolol hcl ophthalmic solution 0.5 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (***betaxolol hcl***)	3	
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
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 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
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 %	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	3/4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
methazolamide oral tablet 25 mg, 50 mg	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	3/4	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ALA SCALP EXTERNAL LOTION 2 % (***hydrocortisone***)	3/4	
ALREX OPHTHALMIC SUSPENSION 0.2 % (***loteprednol etabonate***)	3/4	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
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***)	3/4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	3/4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CLOBETASOL PROPIONATE OPHTHALMIC SUSPENSION 0.05 %	3/4	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
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***)	3/4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
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)	1	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	1	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (***loteprednol etabonate***)	2	
FLAREX OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone acetate***)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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.); SM
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (***fluorometholone***)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone***)	3/4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2 %, 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 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
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***)	3/4	PA
LOTEMAX OPHTHALMIC GEL 0.5 % (***loteprednol etabonate***)	3/4	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (***loteprednol etabonate***)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (***loteprednol etabonate***)	3	
loteprednol etabonate ophthalmic gel 0.5 %	1	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (***dexamethasone***)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
MICORT HC EXTERNAL CREAM 2.5 % (***hydrocortisone acetate***)	3/4	
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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	
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	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
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***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	3/4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	3/4	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 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	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***)	3	
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (5.5 mL (1 bottle) per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	PA
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	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
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***)	3/4	PA; QL (3 ml per 23 days.)
MUCOSITISRX MOUTH/THROAT PACKET (***artificial saliva***)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
TRYPTYR OPHTHALMIC SOLUTION 0.003 % (***acoltremon***)	3/4	PA; QL (60 vials per month.)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	3/4	PA; QL (0.28 ml per day.)
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	3/4	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	3/4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	1	
BROMSITE OPHTHALMIC SOLUTION 0.075 % (***bromfenac sodium***)	3/4	
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (***nepafenac***)	3/4	
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***)	3/4	
PROLENSA OPHTHALMIC SOLUTION 0.07 % (***bromfenac sodium***)	3/4	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
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	
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***)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	3/4	
MYDRIATICS - Drugs for the Eye		
altafrin ophthalmic solution 10 %, 2.5 %	1	
atropine sulfate ophthalmic solution 1 %	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (***cyclopentolate hcl***)	3/4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
cyclopentolate hcl ophthalmic solution 1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
OSMOTIC AGENTS - Drugs for the Eye		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
bimatoprost ophthalmic solution 0.03 %	1	
IYUZEH OPHTHALMIC SOLUTION 0.005 % (***latanoprost***)	3/4	
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (***bimatoprost***)	2	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	
tafluprost (pf) ophthalmic solution 0.0015 %	1	
travoprost (bak free) ophthalmic solution 0.004 %	1	
VYZULTA OPHTHALMIC SOLUTION 0.024 % (***latanoprostene bunod***)	3/4	
XELPROS OPHTHALMIC EMULSION 0.005 % (***latanoprost***)	3	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (***tafluprost***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***)	3	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
altafrin ophthalmic solution 10 %, 2.5 %	1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
UPNEEQ OPHTHALMIC SOLUTION 0.1 % (***oxymetazoline hcl***)	3/4	PA
GASTROINTESTINAL DRUGS		
CHLORIDE CHANNEL ACTIVATORS		
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	3/4	PA; QL (2 capsules per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	1	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.)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	3/4	QL (1 tablet 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.)
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.)
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.)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mirikizumab-mrkz***)	2	PA; QL (0.072 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 auto-injector) per month.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***mirikizumab-mrkz***)	2	PA; QL (2 prefilled syringe per month.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 prefilled syringe) per month.)
OPIOID ANTAGONISTS (56:18)		
alvimopan oral capsule 12 mg	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
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***)	3/4	
ANZEMET ORAL TABLET 50 MG (***dolasetron mesylate***)	3	
granisetron hcl oral tablet 1 mg	1	
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	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	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***)	3/4	
MOTOFEN ORAL TABLET 1-0.025 MG (***difenoxin-atropine***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (***crofelemer***)	3/4	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***)	3/4	QL (120 capsules per 180 days.)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
XERMELO ORAL TABLET 250 MG (***telotristat etiprate***)	3	PA; QL (3 tablets per day)
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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	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	1	
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	QL (4 ml per day)
ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
BONJESTA ORAL TABLET EXTENDED RELEASE 20-20 MG (***doxylamine-pyridoxine***)	2	
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	1	PA
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	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (***mesalamine***)	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
balsalazide disodium oral capsule 750 mg	1	
DIPENTUM ORAL CAPSULE 250 MG (***olsalazine sodium***)	3	
mesalamine oral capsule delayed release 400 mg	1	
mesalamine oral tablet delayed release 1.2 gm	1	
mesalamine rectal enema 4 gm	1	QL (28 bottles per month.)
mesalamine rectal suppository 1000 mg	1	QL (1 suppository per day.)
mesalamine-cleanser rectal kit 4 gm	1	QL (4 kits per month.)
ROWASA RECTAL KIT 4 GM (***mesalamine-cleanser***)	3/4	QL (4 kits per month.)
SFROWASA RECTAL ENEMA 4 GM/60ML (***mesalamine***)	3/4	
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	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	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	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clarithromycin oral tablet 250 mg, 500 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
CATHARTICS AND LAXATIVES - Drugs for Constipation		
bisacodyl ec oral tablet delayed release 5 mg	E	H
citroma oral solution 1.745 gm/30ml	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***)	2	
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	H
gavilyte-n with flavor pack oral solution reconstituted 420 gm	1	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	H
magnesium citrate oral solution 1.745 gm/30ml	E	H
mineral oil heavy oral oil	1	
mm clearlax oral powder 17 gm/scoop	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (***peg-kcl-nacl-nasulf-na asc-c***)	3/4	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	1	
peg 3350 oral powder 17 gm/scoop	E	H
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	H
peg-3350/electrolytes oral solution reconstituted 236 gm	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	
PEG-PREP ORAL KIT 5-210 MG-GM (***bisacodyl-peg-kcl-nabicar-nacl***)	3/4	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (***peg-kcl-nacl-nasulf-na asc-c***)	2	
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
smooth lax oral powder 17 gm/scoop	E	H
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (***peg 3350-kcl-nacl-nasulf-mgsul***)	3	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (***na sulfate-k sulfate-mg sulf***)	3	
SUTAB ORAL TABLET 1479-225-188 MG (***sodium sulfate-mag sulfate-kcl***)	2	
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.)
CTEXLI ORAL TABLET 250 MG (***chenodiol (basds)***)	3/4	PA; ST; QL (93 tablets per month.)
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	3/4	PA; ST; QL (31 tablets per month.)
LIVDELZI ORAL CAPSULE 10 MG (***seladelpar lysine***)	3/4	PA; ST; QL (30 capsules per month.)
LIVMARLI ORAL SOLUTION 19 MG/ML (***maralixibat chloride***)	3/4	PA; QL (60 mL (1140 mg) per month.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	3/4	PA; QL (4 mL per day.)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (***maralixibat chloride***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LIVMARLI ORAL TABLET 30 MG (***maralixibat chloride***)	3/4	PA; QL (30 tablets per month.)
OCALIVA ORAL TABLET 10 MG, 5 MG (***obeticholic acid***)	3/4	PA; ST; QL (1 tablet per day.)
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
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; SMCS
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	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
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-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
alvimopan oral capsule 12 mg	1	
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	3/4	PA; QL (2 capsules per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA
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.)
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; QL (1 vial per day.); SP; SMCS
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	3/4	PA; ST; QL (31 tablets per month.)
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***)	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	3/4	PA; QL (4 mL per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	1	PA; QL (2 capsules per day.)
OCALIVA ORAL TABLET 10 MG, 5 MG (***obeticholic acid***)	3/4	PA; ST; QL (1 tablet per day.)
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mirikizumab-mrkz***)	2	PA; QL (0.072 ml per day.)
prucalopride succinate oral tablet 1 mg, 2 mg	1	PA; QL (1 tablet per day.)
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (***risankizumab-rzaa***)	2	PA; QL (1.2 ml per 42 days.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (***risankizumab-rzaa***)	2	PA; QL (2.4 mL per 42 days.)
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day)
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	QL (4 ml per day)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	3/4	QL (1 tablet per day)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	3/4	PA; QL (12 capsules 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	3/4	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	
nizatidine oral capsule 150 mg, 300 mg	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
scopolamine transdermal patch 72 hour 1 mg/3days	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	3/4	
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg	1	
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (***aprepitant***)	2	
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 62 tablets per 365 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	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	
metoclopramide hcl oral tablet dispersible 5 mg	1	
REGLAN ORAL TABLET 10 MG, 5 MG (***metoclopramide hcl***)	3/4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (***misoprostol***)	3/4	SM
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
misoprostol oral tablet 100 mcg, 200 mcg	1	SM
PROTECTANTS - Drugs for Ulcers and Stomach Acid		
sucralfate oral suspension 1 gm/10ml	1	
sucralfate oral tablet 1 gm	1	
PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (1 packet per day.)
esomeprazole magnesium oral packet 40 mg	1	QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (***lansoprazole***)	3	PA
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	1	QL (1 tablet per day.)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 5 MG (***esomeprazole magnesium***)	3/4	QL (1 packet per day.)
NEXIUM ORAL PACKET 40 MG (***esomeprazole magnesium***)	3/4	QL (1 packet per day)
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
pantoprazole sodium oral packet 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (***omeprazole magnesium***)	3/4	
PROTONIX ORAL PACKET 40 MG (***pantoprazole sodium***)	3/4	
RABEPRAZOLE SODIUM ORAL CAPSULE SPRINKLE 10 MG	3/4	
rabeprazole sodium oral tablet delayed release 20 mg	1	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 62 tablets per 365 days.)
GOLD COMPOUNDS		
GOLD COMPOUNDS		
AURANOFIN ORAL CAPSULE 3 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
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	1	PA
deferasirox oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	1	PA
deferiprone oral tablet 1000 mg, 500 mg	1	PA
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
FERRIPROX ORAL SOLUTION 100 MG/ML (***deferiprone***)	2	PA
FERRIPROX ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
penicillamine oral tablet 250 mg	1	
trientine hcl oral capsule 250 mg, 500 mg	1	PA
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
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***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ALA SCALP EXTERNAL LOTION 2 % (***hydrocortisone***)	3/4	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	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 (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
budesonide oral capsule delayed release particles 3 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
CORTISONE ACETATE ORAL TABLET 25 MG	3/4	
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)	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 grams per day.); SM
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 mcg per day.); SM
fludrocortisone acetate oral tablet 0.1 mg	1	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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.); SM
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
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 %, 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 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INTRAROSA VAGINAL INSERT 6.5 MG (***prasterone***)	3/4	PA; QL (1 insert per day)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (***methylprednisolone***)	3/4	
MEDROL ORAL TABLET 2 MG (***methylprednisolone***)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (***methylprednisolone***)	3/4	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
MICORT HC EXTERNAL CREAM 2.5 % (***hydrocortisone acetate***)	3/4	
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	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	
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	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
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	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	3/4	
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 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***)	3/4	PA; QL (4 capsules per day.)
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
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	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (***budesonide***)	1	
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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	1	
ANDROGENS - Hormones		
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	
danazol oral capsule 100 mg, 200 mg, 50 mg	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	QL (4 capsules per day.); SM
METHITEST ORAL TABLET 10 MG	2	SM
methyltestosterone oral capsule 10 mg	1	SM
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone gel 12.5 mg/act (1%) transdermal	1	PA; QL (300 grams (4 pumps) per month); SM
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
CYCLOSET ORAL TABLET 0.8 MG (***bromocriptine mesylate***)	3	
mifepristone oral tablet 300 mg	1	PA; QL (4 tablets per day.); SP; SMCS
ANTIESTROGENS - Drugs for Women		
anastrozole oral tablet 1 mg	1	H-N
exemestane oral tablet 25 mg	1	H-N
letrozole oral tablet 2.5 mg	1	H-N
ANTIGONADTROPINS - Hormones		
aftera oral tablet 1.5 mg	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (***cetrorelix acetate***)	3/4	PA; QL (14 cartons per 21 days.)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
econtra one-step oral tablet 1.5 mg	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***ganirelix acetate***)	3	QL (7 ml per 21 days.)
ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml	1	QL (7 ml per 21 days.)
her style oral tablet 1.5 mg	1	H
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	3/4	QL (4 capsules per day.); SM
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); 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.)
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
react oral tablet 1.5 mg	1	H
shewise oral tablet 1.5 mg	1	H
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
take action oral tablet 1.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone gel 12.5 mg/act (1%) transdermal	1	PA; QL (300 grams (4 pumps) per month); SM
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (***diazoxide***)	3/4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
calcitonin (salmon) injection solution 200 unit/ml	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
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	
BIGUANIDES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	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	1	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3/4	QL (31 Tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3/4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	3/4	QL (62 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	3/4	QL (31 Tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 Tablets per month.)
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
AVERI ORAL TABLET 0.15-0.03 MG (***desogestrel-eth estrad-fe***)	3/4	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
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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
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***)	3/4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
econtra one-step oral tablet 1.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 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
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	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)	1	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
haloette vaginal ring 0.12-0.015 mg/24hr	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	1	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	1	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	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
jencycla oral tablet 0.35 mg	1	H
jolessa oral tablet 0.15-0.03 mg	1	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 est & eth est oral tablet 42-21-21-7 days	1	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg	1	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, 0.15-30 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
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; SM
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
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
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***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	1	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, 1.5-30 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	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, 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
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
react oral tablet 1.5 mg	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	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***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	1	H
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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	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	1	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***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	H
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	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
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***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	QL (1 tablet per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3/4	QL (31 Tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3/4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	3/4	QL (62 tablets per month.)
SITAGLIPTIN ORAL TABLET 100 MG, 25 MG, 50 MG	3/4	QL (1 tablet per day.)
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.)
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	3/4	QL (31 Tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 Tablets per month.)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (***sitagliptin***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
clomid oral tablet 50 mg	1	
clomiphene citrate oral tablet 50 mg	1	
DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***)	3	QL (1 tablet per day)
milophene oral tablet 50 mg	1	
OSPHENA ORAL TABLET 60 MG (***ospemifene***)	2	PA; QL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	1	H-N
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
toremifene citrate oral tablet 60 mg	1	CM
ESTROGENS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
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.); SM
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
AVERI ORAL TABLET 0.15-0.03 MG (***desogestrel-eth estrad-fe***)	3/4	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
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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***)	2	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***)	2	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	SM
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	SM
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
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	SM
dolishale oral tablet 90-20 mcg	1	H
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	1	QL (8 patches (1 box) per 28 days.); SM
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***)	3	QL (1 tablet per day)
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	SM
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
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	1	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (50 grams (1 box) per month.); SM
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	1	QL (8 patches (1 box) per 28 days.); SM
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.); SM
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 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.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (***estradiol***)	3	QL (50 grams (1 box) per month.); SM
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	1	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***)	2	SM
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***)	3/4	H
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (***estradiol acetate***)	3	QL (1 ring per 3 months.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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)	1	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
haloette vaginal ring 0.12-0.015 mg/24hr	1	H
iclevia oral tablet 0.15-0.03 mg	1	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***)	2	QL (0.29 vaginal insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***)	2	QL (18 inserts per year.)
introvale oral tablet 0.15-0.03 mg	1	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	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 est & eth est oral tablet 42-21-21-7 days	1	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg	1	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, 0.15-30 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	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
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	1	QL (8 patches (1 box) per 28 days.); SM
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.); SM
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	1	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, 1.5-30 mg-mcg	1	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	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, 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	2	
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***)	2	
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
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 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
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
syeda oral tablet 3-0.03 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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	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***)	3/4	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	1	H
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	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
yuvafem vaginal tablet 10 mcg	1	
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GLYCOGENOLYTIC AGENTS - Hormones		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (***follitropin beta***)	2	PA; QL (5.4 mL per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML, 900 UNT/1.08ML (***follitropin beta***)	2	PA; QL (8.64 mL per 21 days.)
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***follitropin alfa***)	3/4	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (***follitropin alfa***)	3/4	PA
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; SM
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (***menotropins***)	3/4	PA; QL (6 vials per day.)
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***chorionic gonadotropin***)	3	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***choriogonadotropin alfa***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (***chorionic gonadotropin***)	3	
SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***)	2	SM
INCRETIN MIMETICS - Drugs for Diabetes		
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	2	PA; QL (2.4 ml (one pen) per month.)
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	2	PA; QL (1.2 ml (one pen) per month.)
liraglutide subcutaneous solution pen-injector 18 mg/3ml	1	PA; QL (2 pens (6 mL) per month.)
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 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.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
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.)
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	SM
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***)	2	SM
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***)	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (***metreleptin***)	3	PA; QL (0.9 vial per day.); SP; SMCS
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***)	1	SM
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***)	1	SM
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	SM
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	SM
MEGLITINIDES - Drugs for Diabetes		
nateglinide oral tablet 120 mg, 60 mg	1	QL (3 tablets per day)
repaglinide oral tablet 0.5 mg, 1 mg	1	QL (4 tablets per day)
repaglinide oral tablet 2 mg	1	QL (8 tablets per day)
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.12 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.96 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (2.8 mL) per 28 days.)
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; SP; SMCS
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; ST; QL (20 ml per 24 days.); SP; SMCS
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
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, 60 MG/1.2ML (***somatrogon-ghla***)	3/4	PA; QL (0.172 ml per day.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (***lonapegsomatropin-tcgd***)	3/4	PA; QL (4 single-dose prefilled cartridges per month.)
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***)	3/4	PA; QL (0.143 cartridge per day.)
PROGESTINS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
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
AVERI ORAL TABLET 0.15-0.03 MG (***desogestrel-eth estrad-fe***)	3/4	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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
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***)	2	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***)	2	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (***progesterone***)	3/4	
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***)	3/4	QL (5 ml per year.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
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
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, 1-0.5 mg	1	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 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
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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)	1	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
haloette vaginal ring 0.12-0.015 mg/24hr	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	1	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	1	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	1	H
jencycla oral tablet 0.35 mg	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 est & eth est oral tablet 42-21-21-7 days	1	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg	1	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, 0.15-30 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	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
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; SM
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	SM
megestrol acetate oral suspension 40 mg/ml, 625 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
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***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	1	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, 1.5-30 mg-mcg	1	H
norethindrone oral tablet 0.35 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	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, 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
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***)	2	
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***)	2	
progesterone intramuscular oil 50 mg/ml	1	SM
progesterone oral capsule 100 mg, 200 mg	1	SM
progesterone vaginal insert 100 mg	1	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (***medroxyprogesterone acetate***)	3/4	SM
react oral tablet 1.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	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***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	1	H
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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	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	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (***levonorgestrel-eth estradiol***)	3/4	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	1	H
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	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
RAPID-ACTING INSULINS - Drugs for Diabetes		
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 &60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (***insulin regular human***)	3/4	SM
HUMALOG INJECTION SOLUTION 100 UNIT/ML (***insulin lispro***)	3/4	SM
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro***)	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	SM
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	SM
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	1	SM
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***)	2	SM
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***)	2	SM
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SM
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	SM
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SM
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	SM
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***)	2	SM
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***)	1	SM
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	SM
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***)	2	SM
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***)	1	SM
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	SM
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin regular human***)	2	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin regular human***)	2	SM
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (***bexagliflozin***)	3	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.)
SOMATOSTATIN AGONISTS - Hormones		
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 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***)	3/4	PA; QL (2 ampules per day.); SP; SMCS
SOMATOTROPIN AGONISTS - Hormones		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (***tesamorelin acetate***)	3/4	PA; QL (1 vial per day.); SP; SMCS
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (***tesamorelin acetate***)	3/4	PA; QL (4 vials per month.); SP; SMCS
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (***mecasermin***)	2	PA; QL (52 vials per month.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial per day.)
SOMATOTROPIN ANTAGONISTS - Hormones		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (***pegvisomant***)	3/4	PA; QL (1 vial per day.); SP; SMCS
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***)	3	QL (1 tablet per day)
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, 2.5 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (***glipizide***)	3/4	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	
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	QL (1 tablet per day)
THIAZOLIDINEDIONES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	QL (3 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	QL (1 tablet per day)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	QL (1 tablet per day)
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	QL (1 tablet per day)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)
THYROID AGENTS - Drugs for the Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (***thyroid***)	2	
ARMOUR THYROID TABLET 15 MG ORAL (***thyroid***)	3	
ARMOUR THYROID TABLET 15 MG ORAL (***thyroid***)	2	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
levo-t 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	
LEVOTHYROXINE SODIUM ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	3/4	
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	1	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	
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***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
THYQUIDITY ORAL SOLUTION 100 MCG/5ML (***levothyroxine sodium***)	3/4	
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG (***levothyroxine sodium***)	3/4	
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	
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	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
ANTIMETABOLITES		
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
mycophenolate mofetil oral capsule 250 mg	1	
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	
gengraf oral solution 100 mg/ml	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (5.5 mL (1 bottle) per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3	PA; QL (4 vials per day.)
COMPLEMENT INHIBITOR AGENTS (90:20)		
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; ST; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; ST; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
AURANOFIN ORAL CAPSULE 3 MG	3	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
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.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
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 (2 ml per 2 months)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2ml (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***)	3/4	PA; CM
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.); SP; SMCS
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.); SP; SMCS
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SP; SMCS
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMMUNOMODULATORY AGENTS (90:00)		
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
INTERFERONS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 syringes (1 box) per month.)
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; QL (14 vials per month.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
INTERLEUKIN INHIBITOR AGENTS, MISC		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
INTERLEUKIN-MEDIATED AGENTS, MISC		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (4 syringes (36 mL) per month)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 mL per month)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-stba***)	2	PA; QL (1 syringe every 3 months.)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab-aazg***)	3	PA
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab-aazg***)	3	PA
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-auub***)	2	PA; QL (1 single-dose vial every 3 months.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-auub***)	2	PA; QL (1 syringe per 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-kfce***)	2	PA; QL (1 single-dose vial every 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-kfce***)	2	PA; QL (1 syringe every 3 months.)
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; ST; QL (1 tablet per day.)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (***upadacitinib***)	2	PA; QL (360 mL (2 bottles) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)
XELJANZ ORAL SOLUTION 1 MG/ML (***tofacitinib citrate***)	2	PA; QL (8 mL per day.)
XELJANZ ORAL TABLET 10 MG (***tofacitinib citrate***)	2	PA; QL (2 tablets per day)
XELJANZ ORAL TABLET 5 MG (***tofacitinib citrate***)	2	PA; QL (2 tablets per day.)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (***tofacitinib citrate***)	2	PA; QL (1 tablet per day.)
MONOCARBOXYLIC ACID AMIDE AGENTS		
leflunomide oral tablet 10 mg, 20 mg	1	
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
sirolimus oral solution 1 mg/ml	1	
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***)	3/4	PA; QL (4 syringes every 50 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
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.)
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***)	3/4	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***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
tetracaine hcl ophthalmic solution 0.5 %	1	
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
dutasteride oral capsule 0.5 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	QL (1 capsule per day.)
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	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	QL (1 capsule per day.)
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	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 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	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
phytonadione oral tablet 5 mg	1	
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	
sevelamer carbonate oral tablet 800 mg	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	PA
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 mg, 200 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	1	
colchicine oral tablet 0.6 mg	1	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	1	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (***colchicine***)	3/4	
INDOCIN ORAL SUSPENSION 25 MG/5ML (***indomethacin***)	3/4	
INDOCIN RECTAL SUPPOSITORY 50 MG (***indomethacin***)	3/4	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	
indomethacin rectal suppository 50 mg	1	
MITIGARE ORAL CAPSULE 0.6 MG (***colchicine***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
probenecid oral tablet 500 mg	1	
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3/4	PA; QL (18 ml per day.); SP; SMCS
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (***eplontersen sodium***)	2	PA; QL (0.029 ml per day.)
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
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.); SM
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (***alendronate sodium***)	3/4	
calcitonin (salmon) injection solution 200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
calcitonin (salmon) nasal solution 200 unit/act	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (***estradiol valerate***)	3/4	SM
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	SM
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	SM
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	1	QL (8 patches (1 box) per 28 days.); SM
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (***estradiol***)	3	SM
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
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	1	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (50 grams (1 box) per month.); SM
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	1	QL (8 patches (1 box) per 28 days.); SM
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.); SM
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
ESTRING VAGINAL RING 7.5 MCG/24HR (***estradiol***)	2	QL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (***estradiol***)	3	QL (50 grams (1 box) per month.); SM
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	1	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***)	2	SM
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***)	3	
ibandronate sodium oral tablet 150 mg	1	
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	1	QL (8 patches (1 box) per 28 days.); SM
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***)	3	QL (4 patches (1 carton) per 28 days.); SM
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	1	H-N
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	1	
risedronate sodium oral tablet delayed release 35 mg	1	
yuvafem vaginal tablet 10 mcg	1	
BRADYKININ RECEPTOR ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.); SMCS
CARBONIC ANHYDRASE INHIBITORS (92:26)		
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.)
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
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	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	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	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
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	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
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-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COMPLEMENT INHIBITORS		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP; SMCS
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP; SMCS
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP; SMCS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; SP; SMCS
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
VOYDEYA ORAL TABLET 100 MG (***danicopan***)	2	PA; QL (6 tablets per day.)
VOYDEYA ORAL TABLET THERAPY PACK 50 & 100 MG (***danicopan***)	2	PA; QL (180 tablets per month.)
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP; SMCS
COMPLEMENT INHIBITORS (92:32)		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP; SMCS
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP; SMCS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP; SMCS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; SP; SMCS
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (4 syringes (36 mL) per month)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
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	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 mL per month)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
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***)	3	PA; ST; QL (1 tablet per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; ST; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; ST; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
penicillamine oral tablet 250 mg	1	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 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***)	3/4	PA; CM
XELJANZ ORAL SOLUTION 1 MG/ML (***tofacitinib citrate***)	2	PA; QL (8 mL per day.)
XELJANZ ORAL TABLET 10 MG (***tofacitinib citrate***)	2	PA; QL (2 tablets per day)
XELJANZ ORAL TABLET 5 MG (***tofacitinib citrate***)	2	PA; QL (2 tablets per day.)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (***tofacitinib citrate***)	2	PA; QL (1 tablet per day.)
ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)		
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; QL (4 syringes (36 mL) per month)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (***interferon gamma-1b***)	2	PA; QL (8.5 mls per month.); SP; SMCS
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 syringes (1 box) per month.)
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; QL (14 vials per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
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.); SP; SMCS
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SP; SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.)
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	3/4	PA; QL (1 capsule per day.)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	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***)	2	PA; QL (2 tablets per day.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; QL (0.02 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); SP; CM; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
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.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; ST; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
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	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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; SMCS
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; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP; SMCS
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (***pomalidomide***)	3	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***lenalidomide***)	2	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
REVLIMID ORAL CAPSULE 20 MG, 25 MG (***lenalidomide***)	2	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; SP; CM; SMCS
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (***ozanimod hcl***)	3	PA; QL (7 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZEPOSIA ORAL CAPSULE 0.92 MG (***ozanimod hcl***)	3	PA; QL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (***ozanimod hcl***)	3	PA; QL (1 starter kit (28 capsules) per year.)
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
cyclophosphamide oral capsule 25 mg, 50 mg	1	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	1	
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
leflunomide oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SP; SMCS
mercaptopurine oral suspension 2000 mg/100ml	1	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	1	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	1	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (***mycophenolate mofetil***)	1	
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	
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***)	3/4	PA; 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (***levacetylleucine***)	3/4	PA; QL (112 packets per month.)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP; SMCS
betaine oral powder	1	
CARNITOR ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CARNITOR ORAL TABLET 330 MG (***levocarnitine***)	3/4	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
CYSTADANE ORAL POWDER (***betaine***)	3/4	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (***cysteamine bitartrate***)	2	
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day)
DEMSER ORAL CAPSULE 250 MG (***metyrosine***)	3/4	PA
DIABETES MONITOR DIGIT ADD-ON KIT	3	
DIABETES MONITOR DIGIT SOLN KIT	3	
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (***givinostat hcl***)	3/4	PA; QL (420 mL per month.)
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (***prasterone (dhea)***)	3	
ELMIRON ORAL CAPSULE 100 MG (***pentosan polysulfate sodium***)	3/4	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	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; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EVRYSDI ORAL TABLET 5 MG (***risdiplam***)	2	PA; QL (30 tablets per month.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (1 tablet per day.)
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.)
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 packets per day.)
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (4 packets per day.)
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 tablets per day)
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine oral tablet 330 mg	1	
levocarnitine sf oral solution 1 gm/10ml	1	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
metyrosine oral capsule 250 mg	1	PA
miglustat oral capsule 100 mg	1	
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.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	PA; ST; SP; SMCS
PROCYSBI ORAL PACKET 300 MG, 75 MG (***cysteamine bitartrate***)	3/4	SP; SMCS
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (***belumosudil mesylate***)	3/4	PA; QL (1 tablet per day.); SP; SMCS
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (***nedosiran sodium***)	3/4	PA; QL (0.03 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day)
SKYCLARYS ORAL CAPSULE 50 MG (***omaveloxolone***)	2	PA; QL (3 capsules per day.)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (***palovarotene***)	3/4	PA; QL (1 capsule per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
tiopronin oral tablet 100 mg	1	CM
tiopronin oral tablet delayed release 100 mg, 300 mg	1	CM
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYBOST ORAL TABLET 150 MG (***cobicistat***)	2	
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***)	3/4	PA; QL (28 packets (1 carton) per month.)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (***alpelisib***)	3/4	PA; QL (28 tablets (1 blister pack) per month.)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (***alpelisib***)	3/4	PA; QL (56 tablets (2 blister packs) per month.)
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***)	3/4	PA; QL (12 capsules per 365 days.)
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (***vosoritide***)	3/4	PA; QL (1 vial per day.); SP; SMCS
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
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	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
PROTECTIVE AGENTS		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
dalfampridine er oral tablet extended release 12 hour 10 mg	1	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
mesna oral tablet 400 mg	1	CM
MESNEX ORAL TABLET 400 MG (***mesna***)	3/4	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
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***)	3/4	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
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***)	3/4	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***)	3/4	PA; QL (150 mL per month.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	SM
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
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***)	2	QL (0.87 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
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 inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
YUPELRI INHALATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
OFEV ORAL CAPSULE 100 MG, 150 MG (***nintedanib esylate***)	3/4	PA; QL (2 capsules per day.)
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	3/4	PA; QL (31 tablets per month.)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mepolizumab***)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***mepolizumab***)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***mepolizumab***)	3/4	PA; QL (0.015 ml per day.)
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
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	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
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
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	
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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.); SM
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	1	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 tablets per month.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
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.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 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.)
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.)
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.)
CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
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.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
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.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 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.)
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.)
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.)
ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SP; SMCS
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.); SP; SMCS
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (1 tablet per day.)
OPSUMIT ORAL TABLET 10 MG (***macitentan***)	2	PA; QL (1 tablet per day.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRACLEER ORAL TABLET 125 MG, 62.5 MG (***bosentan***)	2	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TRYVIO ORAL TABLET 12.5 MG (***aprocitentan***)	3/4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
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 ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
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	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP; SMCS
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (***benralizumab***)	3/4	PA; QL (1 pen every 2 months.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
ACCOLATE ORAL TABLET 10 MG, 20 MG (***zafirlukast***)	3/4	
montelukast sodium oral packet 4 mg	1	
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	1	
MAST-CELL STABILIZERS - Drugs for Inflammation		
ALOCRIL OPHTHALMIC SOLUTION 2 % (***nedocromil sodium***)	3	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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%)	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
mometasone furoate nasal suspension 50 mcg/act	1	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
NEUTROPHIL SERINE PROTEASE INHIBITORS - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	3/4	PA; QL (31 tablets per month.)
ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (***treprostinil***)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 80 MCG (***treprostinil***)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; ST; QL (20 capsules per day.); CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; ST; QL (20 capsules per day.); CM
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (***sotatercept-csrk***)	3/4	PA; QL (1 kit every 3 weeks.); SP; SMCS
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	SM
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	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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.); SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	SM
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.)
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day)
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SP; SMCS
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.); SP; SMCS
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SP; SMCS
OPSUMIT ORAL TABLET 10 MG (***macitentan***)	2	PA; QL (1 tablet per day.); SP; SMCS
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
TRACLEER ORAL TABLET 125 MG, 62.5 MG (***bosentan***)	2	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SP; SMCS
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 tablets per year.)
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.)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 %	1	
bexarotene oral capsule 75 mg	1	CM
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
imiquimod external cream 5 %	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA; SP; SMCS
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ADRENERGIC AGONISTS - Drugs for the Skin		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (***brimonidine tartrate***)	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	3/4	
brimonidine tartrate external gel 0.33 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
ALLYLAMINES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
naftifine hcl external cream 1 %, 2 %	1	
naftifine hcl external gel 2 %	1	
NAFTIN EXTERNAL GEL 2 % (***naftifine hcl***)	3/4	
ANTIBACTERIALS (84:04) - Drugs for the Skin		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	3/4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***sulfacetamide sodium-sulfur***)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
bacitracin ophthalmic ointment 500 unit/gm	1	
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	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
bp 10-1 external emulsion 10-1 %	1	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	3/4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	3/4	
CLINDACIN ETZ EXTERNAL KIT 1 % (***clindamycin phos & cleanser***)	3/4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	3/4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
doxycycline hyclate oral capsule 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
DOXYCYCLINE HYCLATE ORAL TABLET DELAYED RELEASE 80 MG	3/4	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
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***)	2	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
KLARON EXTERNAL LOTION 10 % (***sulfacetamide sodium (acne)***)	3/4	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	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 %	1	
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	1	
minocycline hcl oral capsule 100 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
mupirocin calcium external cream 2 %	1	
mupirocin external ointment 2 %	1	
neomycin sulfate oral tablet 500 mg	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	3/4	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
OVACE PLUS EXTERNAL SHAMPOO 10 % (***sulfacetamide sodium***)	3	
OVACE PLUS WASH EXTERNAL GEL 10 % (***sulfacetamide sodium***)	3	
OVACE PLUS WASH EXTERNAL LIQUID 10 % (***sulfacetamide sodium***)	3/4	
OVACE WASH EXTERNAL LIQUID 10 % (***sulfacetamide sodium***)	3/4	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
sulfacetamide sodium external liquid 10 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
sulfamez wash external emulsion 10-1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	3/4	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
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	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
doxepin hcl external cream 5 %	1	PA
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	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (1 tablet per day)
DYCLOPRO EXTERNAL SOLUTION 0.5 %	3/4	
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
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	
lidocaine external ointment 5 %	1	QL (1.19 grams per day.)
lidocaine external patch 5 %	1	PA; QL (3 patches per day)
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	
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***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
PYRIDIUM ORAL TABLET 100 MG, 200 MG (***phenazopyridine hcl***)	3	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	3/4	QL (1 tablet per day)
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
DENAVIR EXTERNAL CREAM 1 % (***penciclovir***)	3/4	
penciclovir external cream 1 %	1	
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	3/4	PA
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	3/4	
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.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	3/4	
DRYSOL EXTERNAL SOLUTION 20 % (***aluminum chloride***)	2	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	3/4	
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 %	1	
ECONAZOLE NITRATE EXTERNAL FOAM 1 %	3/4	
ECOZA EXTERNAL FOAM 1 % (***econazole nitrate***)	3/4	
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***)	3/4	QL (4 ml per month.)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	1	
LULICONAZOLE EXTERNAL CREAM 1 %	3/4	
LUZU EXTERNAL CREAM 1 % (***luliconazole***)	3/4	
miconazole 3 vaginal suppository 200 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
ORAVIG BUCCAL TABLET 50 MG (***miconazole***)	3	
oxiconazole nitrate external cream 1 %	1	
OXISTAT EXTERNAL LOTION 1 % (***oxiconazole nitrate***)	3/4	
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	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
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 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
benzoin external tincture	1	
CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin		
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	3/4	PA
clindamycin-tretinoin external gel 1.2-0.025 %	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	QL (1 capsule per day.)
finasteride oral tablet 5 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	3/4	PA
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %, 0.025 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	CM
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	3/4	
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ALA SCALP EXTERNAL LOTION 2 % (***hydrocortisone***)	3/4	
alclometasone dipropionate external cream 0.05 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
alclometasone dipropionate external ointment 0.05 %	1	
amcinonide external cream 0.1 %	1	
amcinonide external ointment 0.1 %	1	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
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***)	3/4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BRYHALI EXTERNAL LOTION 0.01 % (***halobetasol propionate***)	3/4	
budesonide rectal foam 2 mg, 2 mg/act	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
clobetasol prop emollient base external cream 0.05 %	1	
clobetasol propionate e external cream 0.05 %	1	
clobetasol propionate emulsion external foam 0.05 %	1	
CLOBETASOL PROPIONATE EXTERNAL CREAM 0.025 %	3/4	
clobetasol propionate external cream 0.05 %	1	
clobetasol propionate external foam 0.05 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external liquid 0.05 %	1	
clobetasol propionate external lotion 0.05 %	1	
clobetasol propionate external ointment 0.05 %	1	
clobetasol propionate external shampoo 0.05 %	1	
clobetasol propionate external solution 0.05 %	1	
clocortolone pivalate external cream 0.1 %	1	
clodan external shampoo 0.05 %	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
desonide external cream 0.05 %	1	
desonide external gel 0.05 %	1	
desonide external lotion 0.05 %	1	
desonide external ointment 0.05 %	1	
desoximetasone external cream 0.05 %, 0.25 %	1	
desoximetasone external gel 0.05 %	1	
desoximetasone external liquid 0.25 %	1	
desoximetasone external ointment 0.05 %, 0.25 %	1	
diflorasone diacetate external cream 0.05 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
diflorasone diacetate external ointment 0.05 %	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %, 0.1 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
flurandrenolide external lotion 0.05 %	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
halcinonide external cream 0.1 %	1	
halobetasol propionate external cream 0.05 %	1	
halobetasol propionate external ointment 0.05 %	1	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	
hydrocortisone acetate rectal suppository 25 mg, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 %, 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 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocortisone-iodoquinol external cream 1-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
IMPOYZ EXTERNAL CREAM 0.025 % (***clobetasol propionate***)	3/4	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
KOURZEQ MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
MICORT HC EXTERNAL CREAM 2.5 % (***hydrocortisone acetate***)	3/4	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	3/4	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
ORALONE MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
PRAMOSONE EXTERNAL CREAM 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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***)	3/4	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
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***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	3/4	
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	3/4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	3/4	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (***desoximetasone***)	3/4	
tovet external foam 0.05 %	1	
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide external lotion 0.025 %, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin		
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ciclodan external solution 8 %	1	
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	1	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
CICLOPIROX TREATMENT EXTERNAL KIT 8 %	3/4	
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.)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (2 mL (1 pen) per month.)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (2 mL (1 syringe) per month.)
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (***nemolizumab-ilto***)	2	PA; QL (2 pens every 4 weeks.)
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	
sirolimus oral solution 1 mg/ml	1	
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 ml per 63 days.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 ml per 63 days.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***spesolimab-sbzo***)	3/4	PA; QL (2 Prefilled syringes per month.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***spesolimab-sbzo***)	3/4	PA; QL (1 prefilled syringe per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	
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.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 auto-injector) 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (2 ml per 2 months)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2ml (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		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
SOTYKTU ORAL TABLET 6 MG (***deucravacitinib***)	2	PA; QL (1 tablet per day.)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
KERATOLYTIC AGENTS - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	3/4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
FABIOR EXTERNAL FOAM 0.1 % (***tazarotene***)	3/4	PA
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***)	2	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
isotretinoin capsule 10 mg oral	1	
isotretinoin capsule 20 mg oral	1	
isotretinoin capsule 30 mg oral	1	
isotretinoin capsule 40 mg oral	1	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RAYASAL EXTERNAL CREAM 5.9 %	3	
SALICATE EXTERNAL LIQUID 10 % (***salicylic acid***)	3	
salicylic acid external solution 26 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
sulfamez wash external emulsion 10-1 %	1	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	3/4	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tazarotene external cream 0.05 %, 0.1 %	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	3/4	PA
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	
XIRUN EXTERNAL GEL 40-10 %	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
KERATOPLASTIC AGENTS - Drugs for the Skin		
coal tar external solution 20 %	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
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***)	3/4	
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 %	1	QL (1 bottle (45 grams) per month.)
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	3/4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	3/4	
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 %	1	PA
OXABOROLES - Drugs for the Skin		
tavaborole external solution 5 %	1	QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	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	
nyamyc external powder 100000 unit/gm	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
SCABICIDES AND PEDICULICIDES - Drugs for the Skin		
CROTAN EXTERNAL LOTION 10 % (***crotamiton***)	3	
ELIMITE EXTERNAL CREAM 5 % (***permethrin***)	3/4	
malathion external lotion 0.5 %	1	
OVIDE EXTERNAL LOTION 0.5 % (***malathion***)	3/4	
permethrin external cream 5 %	1	
PRURADIK EXTERNAL LOTION 10 % (***crotamiton***)	3	
SOOLANTRA EXTERNAL CREAM 1 % (***ivermectin***)	1	
spinosad external suspension 0.9 %	1	
sulfurated lime external solution	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
B & C EXTERNAL OINTMENT	3	
balsam peru-castor oil external ointment	1	
bexarotene external gel 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
brimonidine tartrate external gel 0.33 %	1	PA
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
calcitriol external ointment 3 mcg/gm	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	QL (6 packets per day)
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	
FABIOR EXTERNAL FOAM 0.1 % (***tazarotene***)	3/4	PA
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	3/4	
FILSUVEZ EXTERNAL GEL 10 % (***birch triterpenes***)	3/4	PA; QL (14.4 grams per day.)
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	2	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (***dermatological products, misc.***)	3	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
imiquimod external cream 5 %	1	
isotretinoin capsule 10 mg oral	1	
isotretinoin capsule 20 mg oral	1	
isotretinoin capsule 30 mg oral	1	
isotretinoin capsule 40 mg oral	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
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	1	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
pimecrolimus external cream 1 %	1	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 ml per 63 days.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 ml per 63 days.)
SOTYKTU ORAL TABLET 6 MG (***deucravacitinib***)	2	PA; QL (1 tablet per day.)
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	
tazarotene external cream 0.05 %, 0.1 %	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	3/4	PA
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (2 ml per 2 months)
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA; SP; SMCS
VENELEX EXTERNAL OINTMENT (***balsam peru-castor oil***)	3	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	3/4	PA
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
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***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (1 starter pack per year.)
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	1	
flavoxate hcl oral tablet 100 mg	1	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 2.5 mg, 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	1	
tolterodine tartrate oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
trospium chloride er oral capsule extended release 24 hour 60 mg	1	
trospium chloride oral tablet 20 mg	1	
VESICARE ORAL TABLET 10 MG, 5 MG (***solifenacin succinate***)	3/4	
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
elixophyllin oral elixir 80 mg/15ml	3	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
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	
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
GEMTESA ORAL TABLET 75 MG (***vibegron***)	3/4	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (***mirabegron***)	3/4	
VITAMINS		
MULTIVITAMIN PREPARATIONS		
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
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	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	

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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
MATRONEX ORAL TABLET 27-1 MG	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	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	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	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
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 ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral 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***)	3/4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	3/4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
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-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	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	
VITAMIN B COMPLEX		
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
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	1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 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	3/4	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
MATRONEX ORAL TABLET 27-1 MG	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
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	1	
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	
prenatal plus vitamin/mineral 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	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	3/4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
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***)	3/4	
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (***peg-kcl-nacl-nasulf-na asc-c***)	2	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
DRISDOL ORAL CAPSULE 1.25 MG (50000 UT) (***ergocalciferol***)	3/4	
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	
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG (***calcitriol***)	3/4	
ROCALTROL ORAL SOLUTION 1 MCG/ML (***calcitriol***)	3/4	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	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	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (***paricalcitol***)	3/4	
VITAMIN E		
wheat germ oil oral oil	1	
VITAMIN K ACTIVITY		
phytonadione oral tablet 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 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

abacavir sulfate 34
abacavir sulfate-lamivudine ... 34
abigale 232, 245
abigale lo 232, 245
abiraterone acetate 45
abirtega 45
ABRYSVO 60
acamprosate calcium 15, 137
ACANYA 36, 307, 327
acarbose 218
ACCOLATE 299
ACCU-CHEK AVIVA 164
ACCU-CHEK FASTCLIX LANCET KIT 164
ACCU-CHEK GUIDE 165
ACCU-CHEK GUIDE CONTROL 165
ACCU-CHEK GUIDE ME 165
ACCU-CHEK GUIDE TEST 176
ACCU-CHEK SMARTVIEW CONTROL 165
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT 165
accutane 324, 329
ACD-A NOCLOT-50 76
acebutolol hcl 75, 94, 100, 102, 109
acetaminophen-codeine 119, 144, 146
acetazolamide 88, 99, 120, 178, 191
acetazolamide er 88, 99, 120, 178, 191
acetic acid 198
acetylcysteine 15, 267, 299
acitretin 324, 329
ACTEMRA 263, 275, 279
ACTEMRA ACTPEN 263, 275, 279
ACTHAR 175, 244
ACTHAR GEL 175, 243, 244
ACTHIB 60
ACTIMMUNE 279
ACTIVELLA 232, 245
ACTOPLUS MET 221, 256
ACULAR 154, 198
ACULAR LS 154, 198
ACUVAIL 154, 198
acyclovir 38, 39, 313
ADACEL 59, 60
ADALIMUMAB-ADAZ 207, 208, 265, 275, 279
adapalene-benzoyl peroxide 289, 324, 327, 329
ADBRY 322, 329
ADDYI 137
adefovir dipivoxil 39
ADEMPAS 304, 305
ADRENALIN 64, 201, 292
ADVAIR HFA 72, 192, 212, 294
ADVANTAGE SAFETY LANCETS 28G 165
ADVATE 80
ADVOCATE SAFETY LANCETS 21G 165
ADVOCATE SAFETY LANCETS 23G 165
ADVOCATE SAFETY LANCETS 28G 165
ADYNOVATE 80
ADZENYS XR-ODT 117
AEROCHAMBER HOLDING CHAMBER 165
AEROCHAMBER PLS FLOVU MTHPIECE 165
AEROCHAMBER PLUS FLO-VU INTERM 165
AEROCHAMBER PLUS FLO-VU LARGE 165
AEROCHAMBER PLUS FLO-VU MEDIUM 165
AEROCHAMBER PLUS FLO-VU SMALL 165
AEROCHAMBER2GO ANTI-STATIC 165
afirmelle 223, 232, 245
AFLURIA 60
AFLURIA PRESERVATIVE FREE 60
AFREZZA 253
AFSTYLA 80
aftera 219, 223, 245
AIMOVIG 136
AIRSUPRA 73, 192, 212, 294, 300, 303
AKEEGA 45
AKLIEF 324, 329
AKTEN 199
AKYNZEO 202, 210
ALA SCALP 192, 212, 316
albendazole 23
albuterol sulfate 73, 303
ALBUTEROL SULFATE ... 73, 303
albuterol sulfate hfa 73, 303
ALCAINE 199
alclometasone dipropionate 316, 317
ALCOHOL PREP PADS 165
ALECENSA 45
alendronate sodium 269
alfuzosin hcl er 72
aliskiren fumarate 113
allopurinol 268
ALLZITAL 119, 133, 144
almotriptan malate 157
ALOCRIL 187, 299
ALOGLIPTIN BENZOATE 230
ALOGLIPTIN-METFORMIN HCL 221, 230
ALOGLIPTIN-PIOGLITAZONE 230, 257
ALORA 232, 269
alosetron hcl 203
ALPHAGAN P 186, 306
ALPHANATE 80
ALPHANINE SD 80
alprazolam 135
alprazolam er 135
alprazolam intensol 135
alprazolam xr 135
ALPROLIX 80
ALREX 192
ALTACAINE 199, 266
altafrin 200, 201
altavera 223, 232, 245
ALTRENO 45, 316
ALTUVIIIO 80
ALUNBRIG 45
ALVAIZ 78
alvimopan 202, 208
alyacen 1/35 ..... 223, 232, 245
alyacen 7/7/7 ..... 223, 232, 245
ALYFTREK 296
alyq 112, 301, 304
amantadine hcl 21, 117
ambrisentan 114, 297, 304
amcinonide 317
AMELUZ 306, 329
amethyst 223, 232, 245
amiloride hcl 89, 113, 179
amiloride-hydrochlorothiazide 180, 182
aminocaproic acid 80
amiodarone hcl 103

AMITIZA 201, 208
amitriptyline hcl 159
AMJEVITA 208, 266, 275, 279
AMJEVITA-PED 15KG TO <30KG 208, 266, 275, 279
amlodipine besylate 105, 106, 114
amlodipine besylate-benazepril hcl 93, 105
amlodipine besylate-valsartan 91, 105
amlodipine-atorvastatin 105, 108
amlodipine-olmesartan ...91, 105
amlodipine-valsartan-hctz 91, 105, 182
amnesteem 324, 329
amoxapine 159
amoxicill-clarithro-lansopraz 22, 40, 211
amoxicillin 22, 204
amoxicillin-potassium clavulanate 23
amoxicillin-potassium clavulanate er 22
amphetamine er 117
amphetamine sulfate 118
amphetamine-dextroamphetamine 118
amphetamine-dextroamphetamine er 118
amphet-dextroamphet 3-bead er 118
ampicillin 23
AMZEEQ 24, 43, 187, 307
anagrelide hcl 87
ANALPRAM HC 192, 212, 312, 317
anastrozole 45, 219
ANCOBON 42
ANDEMBRY 88
ANGELIQ 232, 245
ANNOVERA 223, 232, 245
ANORO ELLIPTA 65, 73
ANTICOAGULANT SODIUM CITRATE 76
ANUCORT-HC 192, 212, 317
ANUSOL-HC ...192, 212, 213, 317
ANZEMET 202
apap-caff-dihydrocodeine 119, 144, 146, 151
APOKYN 143
apomorphine hcl 144
apraclonidine hcl 186, 198
aprepitant 210
apri 223, 232, 245
APRISO 204
APTENSIO XR 152
APTIOM 120, 141
APTIVUS 35
AQ INSULIN SYRINGE 165
AQINJECT PEN NEEDLE 165
AQNEURSA 286
AQUORAL 198
ARAKODA 24
aranelle 223, 232, 245
ARANESP (ALBUMIN FREE) 75, 76, 78, 79
ARBLI 91
ARCALYST 286, 299
AREXVY 60
arformoterol tartrate 73, 303
ARIKAYCE 22
aripiprazole 125, 126, 131
armodafinil 160
ARMOUR THYROID 257
ARNUITY ELLIPTA 192, 213, 294, 300
ARTISS 315, 329
ARZOL SILVER NIT APPLICATORS 189
ascomp-codeine 133, 146, 152, 155
asenapine maleate 126, 131
ashlyna 223, 232, 245
aspirin 86, 87, 128, 155
aspirin 81 ..... 86, 87, 128, 155
aspirin adult low dose 86, 87, 128, 155
aspirin adult low strength 86, 87, 128, 155
aspirin childrens 86, 87, 128, 155
aspirin ec adult low dose 86, 87, 128, 155
aspirin ec low dose 86, 87, 128, 155
aspirin ec low strength 86, 87, 128, 155
aspirin low dose 86, 87, 128, 155
aspirin regimen . 86, 87, 128, 156
aspirin-dipyridamole er 86, 112, 156, 175
ASSURE CONTROL SOLUTION 2/3 165
ASSURE ID DUO PRO PEN NEEDLES 165
ASSURE ID PRO PEN NEEDLES 166
ASTRINGYN 80
atazanavir sulfate 35
atenolol 75, 94, 100, 102, 109
atenolol-chlorthalidone 94, 100, 183
atomoxetine hcl 137, 152
ATORVALIQ 108
atorvastatin calcium 108
atovaquone 25
atovaquone-proguanil hcl 24
atropine sulfate . 15, 65, 200, 292
ATROVENT HFA 66, 292
ATTRUBY 99
aubra eq 223, 232, 245
AUGMENTIN 23
AUGTYRO 45
AUM INSULIN SAFETY PEN NEEDLE 166
AUM MINI INSULIN PEN NEEDLE 166
AUM PEN NEEDLE 166
AUM READYGARD DUO PEN NEEDLE 166
AUM SAFETY PEN NEEDLE . 166
AURANOFIN ...211, 260, 275, 279
aurovela 1.5/30 ..... 223, 232, 245
aurovela 1/20 ..... 223, 232, 245
aurovela 24 fe 223, 233, 245
aurovela fe 1.5/30 .. 223, 233, 245
aurovela fe 1/20 ..... 223, 233, 245
AUSTEDO 160
AUSTEDO XR 160
AUSTEDO XR PATIENT TITRATION 160
AUTOLET LANCING DEVICE 166
AUTOLET LITE LANCING DEVICE 166
AUVELITY 125
AUVI-Q 65, 292
avanafil 112
AVAR CLEANSER 307, 324
AVAR LS CLEANSER 307, 324
AVAR-E EMOLLIENT 307, 324
AVERI 223, 233, 245
aviane 223, 233, 245
AVIDOXY 24, 43, 307
AVIDOXY DK 43, 325, 333
AVMAPKI FAKZYNJA CO-PACK 45
AVONEX PEN 262, 279
AVONEX PREFILLED 262, 279

ayuna.....223, 233, 245
AYVAKIT.....45
AZASAN.....259, 275, 279, 284
AZASITE.....187
azathioprine...259, 275, 279, 284
azelaic acid.....307, 329
azelastine hcl.....187, 303
AZELEX..... 307, 329
azithromycin.....40
AZSTARYS.....152
AZULFIDINE
..... 42, 204, 260, 276, 280
AZULFIDINE EN-TABS
..... 42, 204, 260, 275, 280
azurette..... 223, 233, 246
B & C.....329
bac (butalbital-acetamin-caff)..... 119, 133, 144, 152
bacitracin.....28, 187, 307
bacitracin-polymyxin b
..... 28, 187, 307
bacitra-neomycin-polymyxin-hc...28, 187, 192, 307
baclofen..... 69
BACTRIM.....25, 43, 44
BACTRIM DS.....25, 43, 44
BAFIERTAM..... 261, 280
BALCOLTRA.....223, 233, 246
balsalazide disodium.....204
balsam peru-castor oil.....329
BALVERSA.....45, 46
balziva.....223, 233, 246
BANZEL.....120, 121, 141
BAQSIMI ONE PACK15, 241, 267
BAQSIMI TWO PACK
..... 15, 241, 267
BARACLUDE.....39
BAXDELA..... 42
BD AUTOSHIELD DUO PEN NEEDLES..... 166
BD BLUNT FILL NEEDLE.....166
BD ECLIPSE LUER-LOK NEEDLE.....166
BD ECLIPSE NEEDLE..... 166
BD PEN NEEDLE MICRO ULTRAFINE.....166
BD PEN NEEDLE MINI ULTRAFINE.....166
BD PEN NEEDLE NANO ULTRAFINE.....166
BD PEN NEEDLE ORIG ULTRAFINE.....166
BD PEN NEEDLE SHORT ULTRAFINE.....166
BD SAFETYGLIDE NEEDLE..166
BD SHARPS COLLECTOR.... 166
BD ULTRA-FINE INSULIN SYRINGES..... 166, 167
BD ULTRA-FINE PEN NEEDLES..... 167
BD VEO INSULIN SYR ULTRAFINE.....167
BELBUCA..... 150
belladonna alkaloids-opium
..... 66, 146
BELSOMRA.....130, 151
benazepril hcl.....92, 93
benazepril-hydrochlorothiazide.....93, 182
BENEFIX.....80
BENLYSTA..... 261, 284
benzalkonium chloride.313, 327
BENZAMYCIN..... 307, 327
BENZNIDAZOLE..... 25, 38
benzoin..... 316
benzonatate.....293
benzoyl peroxide-erythromycin..... 307, 327
benztropine mesylate..... 68, 120
bepotastine besilate..... 19, 187
BERINERT.....274
BESIFLOXACIN HCL.....187
BESIVANCE..... 187
BESREMI.....36, 46, 280
BETADINE OPHTHALMIC PREP..... 189
betaine..... 286
betamethasone dipropionate
..... 213, 317
betamethasone dipropionate aug.....213, 317
betamethasone valerate
..... 213, 317
BETAPACE AF
..... 70, 94, 100, 102, 103, 110
BETASERON.....262, 280
betaxolol hcl
..... 75, 94, 100, 102, 110, 190
bethanechol chloride.....71
BETIMOL..... 70, 94, 102, 191
BETOPTIC-S..... 75, 102, 191
BEVESPI AEROSPHERE
..... 66, 73, 313
bexarotene.....46, 306, 329
BEXSERO.....60
BEYAZ..... 224, 233, 246, 337
BEYFORTUS.....37
bicalutamide.....46
BIGFOOT UNITY PROGRAM 167
BIJUVA..... 233, 246
BIKTARVY..... 32, 33, 34
BILTRICIDE..... 23
bimatoprost..... 200
BIMZELX.....322, 330
BINOSTO.....269
bis subcit-metronid-tetracyc
..... 23, 25, 43, 202, 204
bisacodyl ec..... 205
bismuth/metronidaz/tetracyclin.....23, 25, 43, 202, 204
bisoprolol fumarate
..... 75, 94, 100, 102, 110
bisoprolol-hydrochlorothiazide94, 100, 182
blisovi 24 fe..... 224, 233, 246
blisovi fe 1.5/30..... 224, 233, 246
blisovi fe 1/20..... 224, 233, 246
BONJESTA.....203
BONSITY..... 243, 269
BOOSTRIX..... 59, 60
bosentan..... 114, 297, 304
BOSULIF.....46
bp 10-1..... 307, 325
BRAFTOVI.....46
BREATHE COMFORT CHAMBER/ADULT..... 167
BREATHE COMFORT CHAMBER/CHILD..... 167
BRENZAVVY..... 255
BREO ELLIPTA 73, 192, 213, 294
BREZTRI AEROSPHERE
..... 66, 73, 213
briellyn..... 224, 233, 246
brimonidine tartrate
..... 186, 306, 307, 330
BRINSUPRI..... 293, 300
brinzolamide.....191
BRIVIACT..... 121
bromfenac sodium.....199
bromfenac sodium (once-daily).....198
bromocriptine mesylate..... 139
BROMSITE..... 199
BRONCHITOL..... 302
BRONCHITOL TOLERANCE TEST.....302
BRUKINSA.....46
BRYHALI.....317

BRYNOVIN 230
budesonide
..... 213, 294, 295, 300, 317
bumetanide.....88, 108, 178
BUMEX..... 88, 108, 178
buprenorphine.....151
buprenorphine hcl..... 150
buprenorphine hcl-naloxone hcl.....149, 150, 151
bupropion hcl..... 125
bupropion hcl er (smoking det)..... 63, 125
bupropion hcl er (sr).....125
bupropion hcl er (xl)..... 125
BUPROPION HCL ER (XL).... 125
buspirone hcl..... 130, 143
butalbital-acetaminophen
..... 119, 133, 144
butalbital-apap-caff-cod
..... 119, 133, 144, 146, 152
butalbital-apap-caffeine
..... 119, 133, 144, 152
butalbital-asa-caff-codeine
..... 133, 146, 152, 156
butalbital-aspirin-caffeine
..... 134, 152, 156
butorphanol tartrate.....129, 151
BYLVAY..... 206, 208
BYLVAY (PELLETS).....206, 208
cabergoline.....139
CABLIVI..... 76, 87
CABOMETYX..... 46
caffeine citrate.....129, 152
CALCIFOL..... 180, 337, 340
calcipotriene.....315, 330
calcipotriene-betameth diprop.....315, 317, 330
calcitonin (salmon)221, 269, 270
CALCITRENE..... 315, 330
calcitriol..... 330, 340
calcium acetate..... 179, 180
calcium acetate (phos binder).....179, 180
CALQUENCE.....46
CAMBIA..... 129, 145
camila.....224, 246
camrese..... 224, 233, 246
camrese lo..... 224, 233, 246
CAMZYOS..... 99
candesartan cilexetil.....90, 91
candesartan cilexetil-hctz
..... 91, 182
capecitabine..... 46
CAPLYTA.....132
CAPRELSA.....46
captopril.....92, 93
captopril-hydrochlorothiazide.....93, 182
CAPVAXIVE.....60
carbamazepine..... 121, 126
carbamazepine er.....121, 126
CARBATROL..... 121, 126
carbidopa.....138
carbidopa-levodopa.....138
carbidopa-levodopa er..... 138
carbidopa-levodopa-entacapone.....137, 139
carbinoxamine maleate
..... 17, 18, 298
CARBINOXAMINE MALEATE ER.....17, 18, 298
CARBZAH.....17, 18, 298
CARDURA..... 71, 90, 94
CARDURA XL.....71, 90, 95
CAREPOINT POLY HUB NEEDLE.....167
CAREPOINT PRECISION POLY HUB.....167
CAREPOINT SAFETY 1ST NEEDLE.....167
CARESENS CONTROL SOLUTION A/B.....167
CARESENS LANCETS 30G...167
CARESENS S CONTROL SOLN A/B..... 167
CARETOUCH CONTROL SOL LEVEL 2.....167
CARETOUCH HYPODERMIC NEEDLE.....167
CARETOUCH LANCING/EJECTOR..... 167
carglumic acid.....177
carisoprodol..... 69
CARNITOR..... 286
CARNITOR SF.....286
CAROSPIR..... 89, 109, 113, 180
carteolol hcl.....191
cartia xt..... 96, 97, 98, 104, 114
carvedilol
..... 70, 72, 90, 95, 100, 102, 110
carvedilol phosphate er
..... 70, 72, 90, 95, 100, 102, 110
CAVERJECT.....106, 114
CAVERJECT IMPULSE..106, 114
CAYA..... 290
CAYSTON.....37
cefaclor..... 20
cefaclor er.....20
cefadroxil..... 20
cefdinir..... 20, 21
cefixime.....21
CEFIXIME..... 21
cefpodoxime proxetil.....21
cefprozil..... 20
cefuroxime axetil.....20
celecoxib.....138
CELONTIN.....158
cephalexin..... 20
CEQUR SIMPLICITY 2U..... 167
CERDELGA..... 185, 286
CERVIDIL..... 291
CETRAXAL..... 187
CETROTIDE..... 219
cevimeline hcl..... 71
CHANTIX..... 63, 68
CHANTIX CONTINUING MONTH PAK.....63, 68
CHANTIX STARTING MONTH PAK.....63, 68
charlotte 24 fe.....224, 233, 246
chateal eq..... 224, 233, 246
CHEMET.....15, 212, 267
CHEMSTRIP BG LOG BOOK.167
CHEMSTRIP K..... 176
CHEMSTRIP UGK..... 176
chlordiazepoxide hcl..... 135
chlordiazepoxide-amitriptyline.....135, 159
chlordiazepoxide-clidinium
..... 66, 135
chlorhexidine gluconate
..... 21, 189, 190, 313, 327
chloroquine phosphate..... 24
chlorpromazine hcl..... 151
chlorthalidone..... 89, 114, 183
chlorzoxazone..... 69
CHOLBAM..... 206, 208
cholestyramine.....96
cholestyramine light..... 96
CHORIONIC GONADOTROPIN..... 241
CHOSEN LANCETS 30G..... 167
CHOSEN LANCING DEVICE. 167
CHOSEN SAFETY LANCETS 28G..... 168
CIBINQO.....264, 276, 324, 330
ciclodan..... 322
ciclopirox..... 322
ciclopirox olamine..... 322

CICLOPIROX TREATMENT ... 322
cilostazol 86, 112
CILOXAN 187
CIMDUO 34
cimetidine 19, 210
cimetidine hcl 19, 210
CIMZIA (2 SYRINGE)
..... 208, 260, 266, 276, 280
CIMZIA-STARTER
..... 208, 260, 266, 276, 280
cinacalcet hcl 221
CIPRO 26, 42
CIPRO HC 187, 192
ciprofloxacin hcl 26, 42, 187
ciprofloxacin-dexamethasone 187, 192
ciprofloxacin-hydrocortisone
..... 187, 193
CITALOPRAM HYDROBROMIDE 157
citalopram hydrobromide 157
citroma 205
cladribine (10 tabs)
..... 46, 258, 280, 284
cladribine (4 tabs)
..... 46, 258, 280, 284
cladribine (5 tabs)
..... 47, 258, 280, 284
cladribine (6 tabs)
..... 47, 258, 280, 284
cladribine (7 tabs)
..... 47, 258, 280, 284
cladribine (8 tabs)
..... 47, 258, 280, 284
cladribine (9 tabs)
..... 47, 259, 280, 284
claravis 325, 330
CLARINEX-D 12 HOUR 20, 65
clarithromycin ... 27, 40, 204, 205
clarithromycin er 26, 40, 204
clearlax 205
clemastine fumarate . 17, 18, 298
CLEMSZA 17, 18, 298
CLENPIQ 205
CLEOCIN 36, 307, 308
CLEOCIN-T 36, 308
CLEVER CHOICE COMFORT EZ 168
CLIMARA PRO 233, 246
clindacin 36, 308
clindacin etz 36, 308
CLINDACIN ETZ 308
clindacin-p 36, 308
CLINDAGEL 36, 308
clindamycin hcl 36, 308
clindamycin palmitate hcl
..... 37, 308
clindamycin phos (once-daily) 37, 308
clindamycin phos (twice-daily) 37, 308
clindamycin phos-benzoyl perox 37, 308, 327
clindamycin phosphate .. 37, 308
clindamycin-tretinoin
..... 37, 308, 316, 330
CLINDESSE 37, 308
CLINPRO 5000 ..... 162, 271
clobazam 134, 135
clobetasol prop emollient base 317
CLOBETASOL PROPIONATE
..... 193, 317
clobetasol propionate ... 317, 318
clobetasol propionate e 317
clobetasol propionate emulsion 317
clocortolone pivalate 318
clodan 318
clomid 232
clomiphene citrate 232
clomipramine hcl 159
clonazepam 134, 135
clonidine 65, 100, 107
clonidine hcl 65, 100, 107
clonidine hcl er 65, 107
clopidogrel bisulfate 86
clorazepate dipotassium
..... 134, 135
clotrimazole 314
clotrimazole-betamethasone
..... 314, 318
clozapine 132
CLOZARIL 132
COAGADEX 80
coal tar 327
COARTEM 24
COBENFY 130, 333
COBENFY STARTER PACK
..... 130, 333
codeine sulfate 146, 293
colchicine 268
colchicine-probenecid .. 184, 268
colesevelam hcl 96, 219
COLESTID 96
colestipol hcl 96
colistimethate sodium (cba) .. 41
COLY-MYCIN M 41
COMBIGAN 186, 191, 307
COMBIPATCH 233, 246
COMBIVENT RESPIMAT
..... 66, 73, 292
COMETRIQ 47
COMFORT EZ PRO PEN NEEDLES 168
COMFORT TOUCH TWIST LANCET 30G 168
COMIRNATY 60
COMIRNATY 5-11 YEARS 60
COMPLERA 33, 34, 39
CONDOMS 290
CONDYLOX 325, 330
constulose 177
CONTOUR CONTROL 168
CONTOUR NEXT CONTROL . 168
CONTOUR NEXT EZ 168
CONTOUR NEXT GEN MONITOR 168
CONTOUR NEXT MONITOR . 168
CONTOUR NEXT ONE 168
CONTOUR NEXT TEST 176
CONTOUR PLUS BLUE 168
CONTOUR PLUS CONTROL SOLUTION 168
CONTOUR PLUS TEST 176
CONZIP 146
COPIKTRA 47
CORDRAN 318
CORIFACT 81
CORLANOR 99, 114, 115
CORPHENA 18, 19
CORTANE-B
..... 193, 214, 312, 318, 327
CORTEF 193, 214, 318
CORTENEMA 193, 214, 318
CORTIFOAM 193, 214, 318
CORTISONE ACETATE 214
CORTISPORIN-TC 188, 193
CORTROPHIN 175, 244
CORTROPHIN GEL 175, 244
CORTROSYN 175
COSENTYX (300 MG DOSE)
..... 263, 276, 330
COSENTYX 150 MG/ML
..... 263, 276, 330
COSENTYX SENSOREADY (300 MG) 263, 276, 330
COSENTYX SENSOREADY PEN 263, 276, 330

COSENTYX UNOREADY 263, 276, 330
COSOPT 191
cosyntropin 175
COTELLIC 47
COTEMPLA XR-ODT 152
COVARYX 218, 233
COVARYX HS 218, 233
CRENESSITY 81, 244
CREON 185, 207
CRESEMBA 28
CREXONT 139
CRINONE 246
cromolyn sodium .. 187, 198, 299
CROTAN 329
cryselle 224, 233, 246
CTEXLI 206
CUVPOSA 66, 313
cyanocobalamin 86, 337
CYANOCOBALAMIN 86, 337
cyclobenzaprine hcl 69
CYCLOGYL 200
CYCLOMYDRIL 200, 201
cyclopentolate hcl 200
cyclophosphamide . 47, 262, 284
CYCLOPHOSPHAMIDE 47, 262, 284
cycloserine 27
CYCLOSET 219
cyclosporine 190, 259, 276, 280, 284
cyclosporine modified 190, 259, 276, 280, 284
cyproheptadine hcl ... 17, 18, 298
cyred eq 224, 233, 246
CYSTADANE 286
CYSTADROPS 198, 199
CYSTAGON 286
CYSTARAN 198, 199
CYTOTEC 210
cytra k crystals 177
dabigatran etexilate mesylate 78
dalfampridine er 286, 289
danazol 218
DANTRIUM 69
dantrolene sodium 69
dapsone 24, 25, 308, 330
DAPTACEL 59, 60
DARAPRIM 24
darifenacin hydrobromide er 333
darunavir 35
dasatinib 47
dasetta 1/35 (28) 224, 234, 246
dasetta 7/7/7 ..... 224, 234, 246
DAURISMO 47
DAVIMET-FLUORIDE 161, 162, 271, 334
DAYBUE 137
daysee 224, 234, 246
DEBACTEROL 198, 327
deblitane 224, 246
deferasirox 212
deferasirox granules 212
deferiprone 212
DELESTROGEN 234, 270
DELSTRIGO 33, 34
delyla 224, 234, 246
demeclocycline hcl 43
DEMSER 176, 286
DENAVIR 313
DENGVAXIA 60
DENTA 5000 PLUS 161, 162, 271
DENTA 5000 PLUS SENSITIVE 162, 271
DENTAGEL 161, 162, 271
DEPAKOTE 121, 126, 129, 140
DEPAKOTE ER 121, 126, 129, 139
DEPAKOTE SPRINKLES 121, 126, 129
DEPEN TITRATABS . 15, 212, 276
DEPO-ESTRADIOL 234, 270
DEPO-PROVERA ... 224, 246, 247
DEPO-SUBQ PROVERA 104 ..... 224, 247
DEPO-TESTOSTERONE 218, 219, 220
DERMACINRX UREA 88, 178, 200, 325
DERMACURE ... 88, 178, 200, 325
DERMA-SMOOTHE/FS BODY 193, 318
DERMA-SMOOTHE/FS SCALP 193, 318
DERMOTIC 193, 318
DESCOVY 34, 39
desipramine hcl 159
desloratadine 20, 303
desmopressin ace spray refrig 81, 244
desmopressin acetate 81, 244
DESMOPRESSIN ACETATE 81, 244
desmopressin acetate pf 81, 244
desmopressin acetate spray 81, 244
desogestrel-ethinyl estradiol 224, 234, 247
desonide 318
desoximetasone 318
DESVENLAFAXINE ER 156
desvenlafaxine succinate er 156
dexamethasone 193, 214
dexamethasone intensol 193, 214
dexamethasone sodium phosphate 193
DEXCOM G6 RECEIVER 168
DEXCOM G6 SENSOR 168
DEXCOM G6 TRANSMITTER 168
DEXCOM G7 15 DAY SENSOR 168
DEXCOM G7 RECEIVER 168
DEXCOM G7 SENSOR 169
dexmethylphenidate hcl 152
dexmethylphenidate hcl er ... 152
dextroamphetamine sulfate . 118
dextroamphetamine sulfate er 118
DIABECIN HR 312, 327
DIABETES MONITOR DIGIT ADD-ON 169, 286
DIABETES MONITOR DIGIT SOLN 169, 286
DIACOMIT 121, 140
DIASTIX REAGENT 176
diazepam 134, 135
diazepam intensol 134, 135
diazoxide 221
dichlorphenamide 88, 271
diclofenac potassium 145
diclofenac potassium(migraine) 129, 145
diclofenac sodium 145, 154, 160, 199, 328
diclofenac sodium er 145
diclofenac-misoprostol 145, 210
dicloxacillin sodium 41
dicyclomine hcl 66
DIFICID 40
diflorasone diacetate 318, 319
diflunisal 145, 154
difluprednate 193
digoxin 94, 99
dihydroergotamine mesylate 71, 129
DILANTIN 101, 141

DILANTIN INFATABS..... 101, 141
DILANTIN-125..... 102, 141
diltiazem hcl..... 97, 98, 104, 115
diltiazem hcl er.. 97, 98, 104, 115
diltiazem hcl er beads
..... 97, 98, 104, 115
diltiazem hcl er coated beads.....97, 98, 104, 115
dilt-xr..... 97, 98, 104, 115
dimethyl fumarate..... 261, 280
dimethyl fumarate starter pack.....261, 281
DIPENTUM..... 204
diphenhydramine hcl
..... 17, 18, 68, 120, 131, 293, 298
diphenoxylate-atropine.. 66, 202
DIPROLENE..... 214, 319
dipyridamole....86, 112, 115, 175
disopyramide phosphate..... 101
disulfiram.....15, 267
DIURIL..... 89, 114, 182
divalproex sodium
..... 121, 126, 129, 140
divalproex sodium er
..... 121, 126, 129, 140
DIVIGEL.....234, 270
dofetilide..... 104
DOJOLVI.....177
dolishale..... 224, 234, 247
donepezil hcl..... 71
DOPTELET..... 79
DOPTELET SPRINKLE..... 79
DORZOLAMIDE HCL..... 191
dorzolamide hcl.....191
dorzolamide hcl-timolol mal 191
dorzolamide hcl-timolol mal pf.....191
dotti..... 234, 270
DOVATO.....32, 34
doxazosin mesylate.... 71, 90, 95
doxepin hcl..... 159, 312
doxercalciferol..... 340
doxycycline hyclate
..... 24, 43, 308, 309
DOXYCYCLINE HYCLATE
..... 24, 43, 309
doxycycline monohydrate
..... 24, 43, 309
doxylamine-pyridoxine.....203
DRISDOL..... 340
DRIZALMA SPRINKLE..... 156
dronabinol..... 203, 208
DROPLET MICRON..... 169
DROPSAFE ACTI-LANCE 23G..... 169
DROPSAFE AUTOPROTECT DUO..... 169
DROPSAFE MEDLANCE LANCET 30G..... 169
DROPSAFE SAFETY SYRINGE/NEEDLE..... 169
DROPSAFE SICURA.....169
drospiren-eth estrad-levomefol..... 224, 234, 247, 337
drospirenone-ethinyl estradiol.....224, 234, 247
DROXIA..... 47
droxidopa.....65
DRYSOL..... 313
DUAVEE..... 232, 234
DUETACT.....256, 257
DULERA..... 73, 214
duloxetine hcl.....139, 156
DUOPA..... 139
DUPIXENT
..... 299, 322, 323, 330, 331
DUREX EXTRA SENSITIVE THIN.....290
DUREX TROPICAL..... 290
dutasteride.....267
dutasteride-tamsulosin hcl
..... 72, 267
DUVYZAT..... 286
DYANAVEL XR.....118
DYCLOPRO.....312
E.E.S. GRANULES..... 29
EASIVENT..... 169
EASY COMFORT SHARPS CONTAINER.....169
EASY TOUCH HEALTHPRO HIGH/LOW.....169
EASYGEL..... 161, 162, 271
EASYMAX 15 LEVEL 2-3 CONTROL..... 169
EASYMAX CONTROL..... 169
EASYMAX CONTROL NORMAL/HIGH.....169
EBGLYSS..... 323
econazole nitrate.....314
ECONAZOLE NITRATE..... 314
econtra one-step... 220, 224, 247
ECOZA.....314
EC-RX DHEA.....286
EDARBI.....91
EDARBYCLOR..... 91, 182
EDEX (2 CARTRIDGE)...107, 115
EDEX (6 CARTRIDGE)...107, 115
EDLUAR..... 131, 143
EDURANT.....33
EDURANT PED..... 33
EEMT..... 218, 234
EEMT HS..... 218, 234
efavirenz..... 33
efavirenz-emtricitab-tenofo df.....33, 34
efavirenz-lamivudine-tenofovir.....33, 34
EFFER-K.....180
effer-k..... 180
EGATEN..... 23
EGRIFTA SV.....255
EGRIFTA WR..... 255
ELESTRIN..... 234, 270
eletriptan hydrobromide.....157
ELIMITE..... 329
elinest.....225, 234, 247
ELIQUIS.....77
ELIQUIS (1.5 MG PACK).....77
ELIQUIS (2 MG PACK).....77
ELIQUIS DVT/PE STARTER PACK..... 77
ELITE-OB.....84, 334, 337
elixophyllin
..... 107, 152, 178, 306, 334
ELLA..... 225, 247
ELMIRON.....286
ELOCTATE..... 81
eltrombopag olamine.....79
eluryng..... 225, 234, 247
EMBECTA AUTOSHIELD DUO.....169
EMBECTA INS SYR U/F 1/2 UNIT.....169
EMBECTA INSULIN SYR ULTRAFINE..... 169
EMBECTA INSULIN SYRINGE
..... 169
EMBECTA INSULIN SYRINGE U-100..... 170
EMBECTA INSULIN SYRINGE U-500..... 170
EMBECTA PEN NEEDLE NANO.....170
EMBECTA PEN NEEDLE NANO 2 GEN.....170
EMBECTA PEN NEEDLE ULTRAFINE..... 170
EMBRACE PEN NEEDLES.... 170
EMEND..... 210

EMGALITY 136
EMPAVELI 274
EMSAM 142
emtricitabine 34
emtricitabine-tenofovir df . 34, 39
emtricitab-rilpivir-tenofov df 33, 34, 39
EMTRIVA 34
EMVERM 23
emzahh 225, 247
enalapril maleate 92, 93
enalapril-hydrochlorothiazide 93, 183
ENBRACE HR .. 84, 286, 334, 337
ENBREL 266, 276, 281
ENBREL MINI 266, 276, 281
ENBREL SURECLICK 266, 276, 281
ENCARE 290
ENDARI 286, 331
endocet 119, 144, 147
ENDOMETRIN 247
ENFLONSIA 37
ENGERIX-B 60, 61
enilloring 225, 234, 247
ENLITE GLUCOSE SENSOR . 170
enoxaparin sodium 83
ENSACOVE 47
enskyce 225, 234, 247
ENSPRYNG 264, 281
ENSTILAR 316, 319, 331
entacapone 137
ENTADFI 112, 267, 316
entecavir 39
ENTRESTO 90, 91, 113
ENTYVIO PEN 201, 208, 260
enulose 177
EPANED 92, 93
EPCLUSA 30, 31
EPIDIOLEX 121
EPIFOAM 312, 319
epinastine hcl 20, 187
epinephrine 65, 292
EPINEPHRINE 65, 292
EPIVIR 34
eplerenone 89, 109, 113, 180
EQUETRO 121, 126
ergocalciferol 340
ERGOMAR 71, 129
ergotamine-caffeine 71, 129, 152
ERIVEDGE 47
ERLEADA 47, 48
erlotinib hcl 48
errin 225, 247
ERY 29, 188, 309
ERYPED 400 29
erythromycin 29, 188, 309
erythromycin base 29
erythromycin ethylsuccinate . 29
escitalopram oxalate 158
eslicarbazepine acetate 121, 141
esomeprazole magnesium ... 211
est estrogens-methyltest 219, 234
est estrogens-methyltest ds 218, 234
est estrogens-methyltest hs 218, 234
estarylla 225, 235, 247
estazolam 135
estradiol 235, 270
estradiol valerate 235, 270
estradiol-norethindrone acet 235, 247
ESTRATEST H.S. 219, 235
ESTRING 235, 270
ESTROGEL 235, 270
estrogens conjugated ... 235, 270
eszopiclone 131, 143
ethacrynic acid 88, 108, 178
ethambutol hcl 27
ethosuximide 158, 159
ethynodiol diac-eth estradiol 225, 235, 247
etodolac 145, 154
etodolac er 145, 154
etonogestrel-ethinyl estradiol 225, 235, 247
etoposide 48
etravirine 33
EUCRISA 311, 328
EVAMIST 235, 270
EVEKEO 118
everolimus 48, 262, 284
EVEXITHROID 257
EVOTAZ 35, 286
EVRYSDI 286, 287
EXELDERM 314
exemestane 48, 219
EXENATIDE 242
EXODERM 17, 311, 325
EYSUVIS 193
EZALLOR SPRINKLE 108
ezetimibe 101
ezetimibe-simvastatin ... 101, 108
FABHALTA 259, 274
FABIOR 325, 331
falmina 225, 235, 247
famciclovir 39
famotidine 19, 210
FANAPT 132
FANAPT TITRATION PACK A 132
FANAPT TITRATION PACK B 132
FANAPT TITRATION PACK C 132
FASENRA PEN 299
FC2 FEMALE CONDOM 290
febuxostat 268
FEIBA 81
feirza 1.5/30 ..... 225, 235, 247
feirza 1/20 ..... 225, 235, 247
felbamate 121
FELBATOL 121
felodipine er 105, 106
FEM PH 327, 331
FEMCAP 290
FEMLYV 225, 235, 247
FEMRING 235, 270
fenofibrate 107
fenofibrate micronized 107
fenofibric acid 107
fentanyl 147
FERRIPROX 212
FERRIPROX TWICE-A-DAY .. 212
FETZIMA 156
FETZIMA TITRATION 156
fidaxomicin 40
FILSPARI 113, 278, 287, 297
FILSUVEZ 331
FINACEA 309, 331
finasteride 267, 316
fingolimod hcl 265, 281
FINTEPLA 122
finzala 225, 236, 247
FIORICET 119, 134, 144, 152
FIRDAPSE 71, 287
FIRMAGON 48, 220
FIRMAGON (240 MG DOSE) 48, 220
FIRST-LANSOPRAZOLE 211
FIRVANQ 29
FLAREX 193
flavoxate hcl 333
flecainide acetate 102
FLEQSUVY 69
FLEXICHAMBER 170
FLEXICHAMBER ADULT MASK/SMALL 170
FLEXICHAMBER CHILD MASK/LARGE 170

FLEXICHAMBER CHILD MASK/SMALL 170
FLOLIPID 108
FLORIVA 161, 162, 271, 340
FLORIVA PLUS 161, 162, 271, 334
FLOTREX 161, 162, 163, 272, 335
FLUAD 61
FLUARIX 61
FLUCELVAX 61
fluconazole 28
flucytosine 42
fludrocortisone acetate 214
FLULAVAL 61
FLUMIST 61
flunisolide 193, 214, 295, 300
fluocinolone acetonide 193, 194, 319
fluocinolone acetonide body 193, 319
fluocinolone acetonide scalp 194, 319
fluocinonide 319
fluocinonide emulsified base 319
FLUORIDEX 163, 272
FLUORIDEX DAILY RENEWAL 161, 163, 272
FLUORIDEX ENHANCED WHITENING 163, 272
FLUORIMAX 5000 ..... 163, 272
FLUORIMAX 5000 SENSITIVE 163, 272
fluorometholone 194
fluorouracil 48, 306, 331
fluoxetine hcl 158
fluoxetine hcl (pmdd) 158
fluphenazine hcl 151
flurandrenolide 319
flurazepam hcl 135
flurbiprofen 145, 154, 199
flurbiprofen sodium 154, 199
FLUTICASONE FUROATE-VILANTEROL 73, 74, 194, 214, 295
fluticasone propionate 194, 214, 215, 295, 300, 319
FLUTICASONE PROPIONATE HFA 194, 214, 295, 300
FLUTICASONE-SALMETEROL .. 74, 194, 215, 295
fluticasone-salmeterol 74, 194, 215, 295
fluvastatin sodium 108
fluvastatin sodium er 108
fluvoxamine maleate 158
fluvoxamine maleate er 158
FLUZONE 61
FLUZONE HIGH-DOSE 61
FML FORTE 194
FML LIQUIFILM 194
FOCALIN 152
folic acid 337
FOLLISTIM AQ 241
fondaparinux sodium 76, 84
FONDCIRCLE CONTROL SOLUTION 170
FONDCIRCLE LANCING DEVICE 170
FONDCIRCLE SINGLE USE LANCETS 170
FORA TEST N' GO ADVANCE 170
FORA TEST N'GO ADV-VOICE-6 CON 176
FORANE 141
formaldehyde 176
formoterol fumarate 74, 303
FOSAMAX 270
FOSAMAX PLUS D 271, 340
fosamprenavir calcium 35
fosfomycin tromethamine 44
fosinopril sodium 92, 93
fosinopril sodium-hctz ... 93, 183
FOSRENOL 179, 267
FOTIVDA 48
FRAGMIN 83
FREESTYLE LIBRE 14 DAY READER 170
FREESTYLE LIBRE 14 DAY SENSOR 170
FREESTYLE LIBRE 2 PLUS SENSOR 170
FREESTYLE LIBRE 2 READER 170
FREESTYLE LIBRE 2 SENSOR 170
FREESTYLE LIBRE 3 PLUS SENSOR 171
FREESTYLE LIBRE 3 READER 171
FREESTYLE LIBRE 3 SENSOR 171
FREESTYLE LIBRE READER 171
frovatriptan succinate 157
FRUZAQLA 48
ft aspirin 86, 87, 129, 156
ft aspirin low dose 86, 87, 129, 156
ft clearlax 205
ft folic acid 337
ft laxative 205
ft magnesium citrate 205
ft naloxone hcl 15, 150
ft nicotine 63, 64, 68
ft nicotine mini 63, 68
FUROSCIX 88, 109, 178
furosemide 88, 109, 178
fyavolv 236, 247
FYCOMPA 122
FYREMADEL 220
gabapentin 119, 122, 140
GALAFOLD 184, 287
galantamine hydrobromide 71
galantamine hydrobromide er 71
galbriela 225, 236, 248
gallifrey 248
GALZIN 180
ganirelix acetate 220
GARDASIL 9 61
gatifloxacin 188
GATTEX 207, 208
gavilax 205
gavilyte-c 205
gavilyte-g 205
gavilyte-n with flavor pack ... 205
GAVRETO 48
gefitinib 48
GELFILM 81
gemfibrozil 107
gemmily 225, 236, 248
GEMTESA 334
generlac 177
gengraf ... 190, 259, 276, 281, 284
gentamicin sulfate .. 22, 188, 309
gentle laxative 205
GENVOYA 32, 34
GILENYA 265, 281
GILOTRIF 48
glatiramer acetate 258, 281
glatopa 258, 281
GLEOSTINE 48
glimepiride 256
glipizide 256
glipizide er 256
glipizide-metformin hcl . 221, 256

GLOPERBA 268
glucagon emergency kit 15, 241, 267
GLUCAGON EMERGENCY KIT 15, 241, 267
GLUCOTROL XL 256
glutaraldehyde 176
glyburide 256
glyburide micronized 256
glyburide-metformin 221, 256
glycerol phenylbutyrate 177
glycolax 205
glycopyrrolate 66, 313
glydo 312
GLYXAMBI 231, 255
GOLYTELY 205
GOMEKLI 49
GONAL-F 241
GONAL-F RFF REDIJECT 241
goodsense aspirin low dose 86, 87, 129, 156
goodsense nicotine 64, 68
goodsense nicotine policrilex 64, 68
GORDOFILM 315, 325
granisetron hcl 202
GRASTEK 58
griseofulvin microsize 23
griseofulvin ultramicrosize 23
guaifenesin-codeine 293, 298
guanfacine hcl 100, 107, 137
guanfacine hcl er 137
GUARDIAN 4 GLUCOSE SENSOR 171
GUARDIAN 4 TRANSMITTER 171
GUARDIAN LINK 3 TRANSMITTER 171
GUARDIAN REAL-TIME CHARGER 171
GUARDIAN REAL-TIME TEST PLUG 171
GUARDIAN SENSOR 3 171
GVOKE HYPOPEN 1-PACK 15, 241, 267
GVOKE HYPOPEN 2-PACK 15, 241, 267
GVOKE KIT 15, 241, 267
GVOKE PFS 15, 241, 267
GYNAZOLE-1 314
habitrol 64, 68
HAEGARDA 274
hailey 1.5/30 ..... 225, 236, 248
hailey 24 fe 225, 236, 248
hailey fe 1.5/30 ..... 225, 236, 248
hailey fe 1/20 ..... 225, 236, 248
halcinonide 319
HALCION 135
halobetasol propionate 319
haloette 225, 236, 248
haloperidol 136
haloperidol lactate 136
HALUCORT 331
HAN-EASE 171
HARVONI 30, 31
HAVRIX 61
heather 225, 248
HEMANGEOL 70, 95, 100, 102, 110, 129
HEMATINIC/FOLIC ACID . 84, 337
HEMLIBRA 81
HEMMOREX-HC 194, 215, 319
HEMOFIL M 81
heparin na (pork) lock flsh pf . 83
heparin sod (pork) lock flush . 83
heparin sodium (porcine) 84
heparin sodium (porcine) +rfid 84
heparin sodium (porcine) pf .. 84
HEPLISAV-B 61
HEPZATO W/50MM CATHETER 49
HEPZATO W/62MM CATHETER 49
her style 220, 225, 248
HERNEXEOS 49
HETLIOZ 131, 142
HETLIOZ LQ 131, 142
HIBERIX 61
HIPREX 44
HUMALOG 253, 254
HUMALOG KWIKPEN 253
HUMALOG MIX 50/50 KWIKPEN 254
HUMALOG MIX 75/25 KWIKPEN 254
HUMALOG MIX 75/25 VIAL 254
HUMALOG U-100 JUNIOR KWIKPEN 254
HUMATE-P 81
HUMATIN 21, 22
HUMULIN 70/30 KWIKPEN 242, 254
HUMULIN 70/30 VIAL 242, 254
HUMULIN N KWIKPEN 242
HUMULIN N VIAL 242
HUMULIN R U-500 KWIKPEN 254
HUMULIN R VIAL 254
HYCAMTIN 49
hydralazine hcl 107
HYDRO 40 ..... 89, 178, 200, 325
hydrochlorothiazide 89, 114, 183
hydrocod poli-chlorphe poli er 18, 19, 294
hydrocodone bitartrate er 147
hydrocodone bit-homatrop mbr 66, 294
hydrocodone-acetaminophen 119, 144, 147
hydrocodone-ibuprofen 145, 147, 154
hydrocortisone 195, 215, 320
hydrocortisone (perianal) 194, 215, 319
hydrocortisone ace-pramoxine 194, 215, 312, 319
HYDROCORTISONE ACETATE 194, 215, 319
hydrocortisone acetate 194, 215, 319
hydrocortisone butyrate 194, 195, 215, 320
hydrocortisone valerate 195, 215, 320
hydrocortisone-acetic acid 195, 198, 215, 320
hydrocortisone-iodoquinol 21, 314, 320, 327
hydrocort-pramoxine (perianal) 195, 215, 312, 320
hydromet 66, 294
hydromorphone hcl 147
hydromorphone hcl er 147
hydroxychloroquine sulfate 24, 260, 276, 281
hydroxyurea 49
hydroxyzine hcl 18, 19, 131
hydroxyzine pamoate 18, 19, 131
HYFTOR 264, 284, 323, 331
HYMPAVZI 81
hyoscyamine sulfate 15, 16, 66, 292
hyoscyamine sulfate er 15, 66, 292
hyoscyamine sulfate sl 16, 66, 292
hyosyne 16, 66, 292
HYPERSAL 299
ibandronate sodium 271
IBRANCE 49

IBTROZI 49
ibuprofen 129, 145, 154
icatibant acetate 88, 271, 274
iclevia 225, 236, 248
ICLUSIG 49
IDELVION 81
IDHIFA 49
IHEALTH CONTROL SOLUTION 171
IHEALTH LANCING DEVICE . 171
ILEVRO 199
imatinib mesylate 49
IMBRUVICA 49
imipramine hcl 159
imipramine pamoate 159
imiquimod 306, 331
IMKELDI 50
IMPAVIDO 25, 38
IMPOYZ 320
IMVEXXY MAINTENANCE PACK 236
IMVEXXY STARTER PACK ... 236
INBRIJA 139
incassia 225, 248
INCRELEX 255
indapamide 89, 114, 183
INDOCIN 145, 154, 268
indomethacin . 145, 154, 155, 268
indomethacin er 145, 154, 268
INFANRIX 59, 61
INGREZZA 160
INLYTA 50
INPEN 100-BLUE-LILLY-HUMALOG 171
INPEN 100-BLUE-NOVOLOG-FIASP 171
INPEN 100-GREY-LILLY-HUMALOG 171
INPEN 100-GREY-NOVOLOG-FIASP 171
INPEN 100-PINK-LILLY-HUMALOG 171
INPEN 100-PINK-NOVOLOG-FIASP 171
INQOVI 50
INSPIREASE RESERVOIR BAGS 172
INSULIN LISPRO 254
INSULIN LISPRO (1 UNIT DIAL) 254
INSULIN LISPRO JUNIOR KWIKPEN 254
INSULIN LISPRO PROT & LISPRO 254
INSULIN PEN NEEDLES 172
INSULIN SYRINGES 172
INSUL-TOTE ULTIMATE 172
INSUPEN32G EXTR3ME 172
INTELENCE 33
INTRAROSA 215
introvale 225, 236, 248
INVELTYS 195
INZIRQO 89, 183
iodine strong 16, 23, 221, 298, 314
iodine tincture 314, 327
IOPIDINE 186, 198
IPOL 61
ipratropium bromide 66, 292
ipratropium-albuterol 67, 74, 292
IQIRVO 206, 208
irbesartan 91
irbesartan-hydrochlorothiazide 91, 183
IRESSA 50
ISENTRESS 32
ISENTRESS HD 32
isibloom 225, 236, 248
isoflurane 141
isoniazid 27
isosorb dinitrate-hydralazine 107, 110, 111
isosorbide dinitrate 110, 111
isosorbide mononitrate 110, 111
isosorbide mononitrate er 110, 111
isotretinoin 325, 331
isradipine 105, 106
ISTALOL 70, 95, 102, 191
ISTURISA 215, 287
ITOVEBI 50
itraconazole 28
ivabradine hcl 99, 115
ivermectin 23
IWILFIN 50
IYUZEH 200
jaimiess 225, 236, 248
JAKAFI 50, 324
jantoven 77
JARDIANCE 255
jasmiel 225, 236, 248
JAVYGTOR 184, 287
JAYPIRCA 50
jencycla 226, 248
JENTADUETO 222, 231
JENTADUETO XR 222, 231
jinteli 236, 248
JIVI 81
JOENJA 281
jolessa 226, 236, 248
JORNAY PM 153
JOURNAVX 119
joyeaux 226, 236, 248
JUBLIA 314
juleber 226, 236, 248
JULUCA 32, 33
junel 1.5/30 ..... 226, 236, 248
junel 1/20 ..... 226, 236, 248
junel fe 1.5/30 ..... 226, 236, 248
junel fe 1/20 ..... 226, 236, 248
junel fe 24 ..... 226, 236, 248
JUST RIGHT 5000 ..... 163, 272
JUXTAPID 94, 109
JYLAMVO . 50, 260, 276, 281, 284
kaitlib fe 226, 236, 248
KALETRA 35
kalliga 226, 236, 248
KALYDECO 297
KAPSPARGO SPRINKLE 75, 95, 100, 102, 110
KARBINAL ER 17, 18, 298
kariva 226, 236, 248
KATERZIA 105, 106, 115
kelnor 1/35 ..... 226, 236, 248
KEPPRA 122
KEPPRA XR 122
KERENDIA 109
KESIMPTA 281
ketoconazole 28, 314
ketodan 28, 314
KETO-DIASTIX 176
KETONE CARE 176
ketorolac tromethamine 146, 155, 199
KETOSTIX 176
KEVZARA 263, 277
KHINDIVI 195, 215, 320
KINERET 263, 277, 281
KISQALI (200 MG DOSE) 50
KISQALI (400 MG DOSE) 50
KISQALI (600 MG DOSE) 50
KLARON 309
klayesta 41, 328
KLISYRI (250 MG) 306, 331
KLISYRI (350 MG) 306, 331
klor-con 180
klor-con 10 180
klor-con m10 180

klor-con m15 180
klor-con m20 180
KLOXXADO 16, 150
KOATE 82
KOATE-DVI 82
KOSELUGO 50, 51
KOURZEQ 320
KOVALTRY 82
K-PHOS 180
K-PHOS NO 2 177
K-PHOS-NEUTRAL 180
KRAZATI 51
KRINTAFEL 24
KRISTALOSE 177
KT TAPE CGM PATCH 172
kurvelo 226, 236, 248
KYZATREX 219, 220
labetalol hcl
..... 70, 72, 90, 95, 100, 103, 110
lacosamide 122, 141
lactulose 177
lactulose encephalopathy 177
LAGEVRIO 39
LAMICTAL 122, 126
LAMICTAL ODT 122, 126
LAMICTAL STARTER 122, 127
LAMICTAL XR 122, 127
lamivudine 34
lamivudine-zidovudine 35
lamotrigine 122, 123, 127
lamotrigine er 122, 127
lamotrigine starter kit-blue
..... 123, 127
lamotrigine starter kit-green
..... 123, 127
lamotrigine starter kit-orange 123, 127
LAMPIT 26
LANCETS 172
LANCETS 28G THIN 172
LANCETS SUPER THIN 172
LANOXIN 94, 100
lansoprazole 211
lanthanum carbonate 179, 268
LANTUS SOLOSTAR 243
LANTUS U-100 VIAL 243
lapatinib ditosylate 51
larin 1.5/30 ..... 226, 236, 248
larin 1/20 ..... 226, 237, 249
larin 24 fe 226, 237, 249
larin fe 1.5/30 ..... 226, 237, 249
larin fe 1/20 ..... 226, 237, 249
LASIX 88, 109, 178
latanoprost 200
LAZCLUZE 51
LEDIPASVIR-SOFOSBUVIR
..... 30, 31
leflunomide 264, 277, 281, 284
lenalidomide 51, 281
LENVIMA 51
lessina 226, 237, 249
letrozole 51, 219
leucovorin calcium . 17, 268, 337
LEUKERAN 51
LEUKINE 79
leuprolide acetate 51, 241
levalbuterol hcl 74, 303
LEVALBUTEROL HFA 74, 303
LEVBID 16, 67, 292
levetiracetam 123
LEVETIRACETAM 123
levetiracetam er 123
levobunolol hcl 191
levocarnitine 287
levocarnitine sf 287
levocetirizine dihydrochloride 20
levofloxacin 27, 42, 188, 309
levonest 226, 237, 249
levonorgest-eth est & eth est
..... 226, 237, 249
levonorgest-eth estrad 91-day 226, 237, 249
levonorgest-eth estradiol-iron 226, 237, 249
levonorgestrel 220, 226, 249
levonorgestrel-ethinyl estrad
..... 226, 237, 249
levonorg-eth estrad triphasic
..... 226, 237, 249
levorphanol tartrate 147
levo-t 257
LEVOTHYROXINE SODIUM .. 257
levothyroxine sodium 257
levoxyl 257
LEVSIN 16, 67, 292
LEVSIN/SL 16, 67, 293
LEVULAN KERASTICK .. 306, 331
l-glutamine 287, 331
lidocaine 312
lidocaine hcl 199, 312
lidocaine hcl urethral/mucosal 312
lidocaine viscous hcl 199
lidocaine-prilocaine 312
LIKMEZ 21, 26, 38, 205, 309
linezolid 41
LINZESS 201, 208
liomny 257
liothyronine sodium 257
LIPOFEN 107
liraglutide 120, 242
lisdexamfetamine dimesylate
..... 118
lisinopril 92, 93
lisinopril-hydrochlorothiazide 93, 183
LITFULO 324, 331
lithium 127
lithium carbonate 127
lithium carbonate er 127
LITHOBID 127
LITHOSTAT 177
LIVALO 108
LIVDELZI 206
LIVMARLI 206, 207, 209
LIVTENCITY 27
LO LOESTRIN FE ... 226, 237, 249
LODOCO 77, 287
lofexidine hcl 65
lojaimiess 226, 237, 249
LOKELMA 179
LOMOTIL 67, 202
lomustine 51
LONSURF 51
LOPID 108
lopinavir-ritonavir 35
LOPRESSOR
..... 75, 95, 100, 103, 110
lorazepam 134, 136
lorazepam intensol 134, 136
LORBRENA 51
LOREEV XR 134, 136
loryna 227, 237, 249
losartan potassium 91
losartan potassium-hctz . 91, 183
LOTEMAX 195
LOTEMAX SM 195
LOTENSIN 92, 93
LOTENSIN HCT 93, 183
loteprednol etabonate 195
loteprednol-tobramycin 188, 195
lovastatin 108
low-ogestrel 227, 237, 249
loxapine succinate 130, 138
lo-zumandimine 227, 237, 249
lubiprostone 201, 209
LUCEMYRA 65

LUGOLS STRONG IODINE 314, 327
luizza 1.5/30 ..... 227, 237, 249
luizza 1/20 ..... 227, 237, 249
LULICONAZOLE 314
LUMAKRAS 51, 52
LUMIGAN 200
LUMRYZ 137, 160, 269
LUMRYZ STARTER PACK 160, 269
LUPKYNIS 265, 285
lurasidone hcl 132
LURBIRO 146, 155, 199
lutera 227, 237, 249
LUZU 314
lyleq 227, 249
lyllana 237, 271
LYNPARZA 52
LYRICA 123, 139, 140
LYSODREN 52
LYTGOBI (12 MG DAILY DOSE) 52
LYTGOBI (16 MG DAILY DOSE) 52
LYTGOBI (20 MG DAILY DOSE) 52
LYUMJEV KWIKPEN 254
LYUMJEV VIAL 254
lyza 227, 249
MACROBID 44
MACRODANTIN 44
magnesium citrate 205
MALARONE 24
malathion 329
maraviroc 32
marlissa 227, 237, 249
MARPLAN 142
MATRONEX 84, 335, 337
MATULANE 52
matzim la 97, 98, 104, 115
MAVENCLAD 52, 259, 282, 285
MAVYRET 30, 31
MAXIDEX 195
MAXITROL 188, 195
maxi-tuss ac 294, 298
MAYZENT 265, 282
MAYZENT STARTER PACK 265, 282
me/naphos/mb/hyo1 . 44, 67, 287
meclofenamate sodium 146, 155
MEDROL 216
medroxyprogesterone acetate 227, 249
mefenamic acid 146, 155
mefloquine hcl 24
megestrol acetate ... 52, 249, 250
MEKINIST 52
MEKTOVI 52
meleya 227, 250
MELOXICAM 146, 155
meloxicam 146, 155
memantine hcl 137
memantine hcl er 137
memantine hcl-donepezil hcl er 72, 137
MENOPUR 241
MENOSTAR 237, 271
MENQUADFI 61
MENVEO 61, 62
meperidine hcl 147
meprobamate 131, 143
mercaptopurine 52, 262, 285
mesalamine 204
mesalamine-cleanser 204
mesna 290
MESNEX 290
MESTINON 72
metaxalone 69
metformin hcl 222
metformin hcl er 222
methadone hcl 148
methadone hcl intensol 147
METHADOSE 148
methadose 148
METHADOSE SUGAR-FREE . 148
methamphetamine hcl 118
methazolamide 88, 99, 192
methenamine hippurate 44
methenamine mandelate 44
METHERGINE 291
methimazole 221
METHITEST 219
methocarbamol 33, 69
methotrexate sodium 52, 260, 277, 282, 285
methotrexate sodium (pf) 52, 260, 277, 282, 285
methoxsalen rapid 328
methscopolamine bromide 67
methsuximide 159
methyl salicylate 315
methyldopa 65, 100, 107
methylergonovine maleate ... 291
METHYLIN 153
methylphenidate 153
methylphenidate hcl 153
methylphenidate hcl er 153
methylphenidate hcl er (cd) . 153
methylphenidate hcl er (la) .. 153
methylphenidate hcl er (osm) 153
methylphenidate hcl er (xr) .. 153
methylprednisolone 216
methyltestosterone 219
metoclopramide hcl 210
metolazone 89, 114, 184
METOPIRONE 176
metoprolol succinate er 75, 95, 100, 103, 110
metoprolol tartrate 75, 95, 100, 103, 110
metoprolol-hydrochlorothiazide 95, 100, 183
METROCREAM 21, 38, 309
metronidazole 21, 26, 38, 205, 309
metyrosine 176, 287
mexiletine hcl 102
MIACALCIN 221, 271
mibelas 24 fe 227, 237, 250
miconazole 3 314
MICONAZOLE-ZINC OXIDE-PETROLAT 313, 315, 322
MICORT HC 195, 216, 320
microgestin 1.5/30 . 227, 237, 250
microgestin 1/20 .... 227, 237, 250
microgestin fe 1.5/30 ..... 227, 237, 250
microgestin fe 1/20 227, 237, 250
MICROLET NEXT LANCING DEVICE 172
midazolam hcl 136
midodrine hcl 65
MIEBO 190, 198
MIFEPREX 291
mifepristone 219, 291
MIGERGOT 71, 129, 153
miglitol 218
miglustat 185, 287
mili 227, 237, 250
milophene 232
mimvey 238, 250
mineral oil heavy 205
minocycline hcl 25, 44, 188, 309, 310
minocycline hcl er 25, 44, 188, 309, 331
minoxidil 107, 316
minzoya 227, 238, 250

MIPLYFFA 184
mirabegron er 334
mirtazapine 125, 158
MIRVASO 186, 307, 331
misoprostol 211
MITIGARE 268
MITOSOL 188
mm aspirin 86, 87, 129, 156
mm clearlax 205
M-M-R II 62
M-NATAL PLUS 84, 335, 337
MNEXSPIKE 62
MOBILE LANCETS 30G 172
modafinil 160
MODEYSO 52
moexipril hcl 92, 93
molindone hcl 130, 138
mometasone furoate 195, 216, 295, 300, 320
mono-linyah 227, 238, 250
MONSELS FERRIC SUBSULFATE 82
montelukast sodium 299
morphine sulfate 148
morphine sulfate (concentrate) 148
morphine sulfate er 148
morphine sulfate er beads ... 148
MOTOFEN 67, 202
MOTPOLY XR 123, 141
MOUNJARO 242
MOVIPREP 205, 339
moxifloxacin hcl 27, 42, 188, 310
moxifloxacin hcl (2x day) 42, 188
MOZOBIL 79
MUCOSITISRX 198
MULPLETA 79
MULTAQ 104
multivitamin w/fluoride 161, 163, 272, 335
multivitamin/fluoride 161, 163, 272, 335, 337
multi-vitamin/fluoride 161, 163, 272, 335
multi-vitamin/fluoride/iron 84, 272, 335
MULTI-VIT-FLOR 161, 163, 272, 335
mupirocin 310
mupirocin calcium 310
my choice 220, 227, 250
my way 220, 227, 250
MYALEPT 243
mycophenolate mofetil . 259, 285
mycophenolate sodium 285
mycophenolic acid 285
MYDAYIS 118
MYFEMBREE 220, 238, 250
MYHIBBIN 285
MYLERAN 52
MYRBETRIQ 334
MYSOLINE 133
MYTESI 203
MYXREDLIN 180, 254
na sulfate-k sulfate-mg sulf . 205
nabumetone 146, 155
nadolol 70, 75, 90, 95, 101, 103, 110
naftifine hcl 307
NAFTIN 307
naloxone hcl 16, 150, 268
naltrexone hcl 15, 16, 64, 150, 267, 268
NAMZARIC 72, 137
naproxen 129, 146, 155, 269
naproxen dr ... 129, 146, 155, 269
naproxen sodium 130, 146, 155, 269
naproxen sodium er 130, 146, 155, 269
naratriptan hcl 157
NARCAN 16, 150
NARDIL 143
NASCOBAL 86, 338
NATACYN 189
NATAL PNV 84, 335, 338
NATAZIA 227, 238, 250
nateglinide 243
NAYZILAM 134, 136
nebivolol hcl 70, 95, 101, 103
NEBUPENT 26
NEBUSAL 299
necon 0.5/35 (28) ... 227, 238, 250
nefazodone hcl 158
NEFFY 65
NEMLUVIO 323
neomycin sulfate 22, 188, 310
neomycin-bacitracin zn-polymyx 188
neomycin-polymyxin-dexameth 188, 196
neomycin-polymyxin-gramicidin 188
neomycin-polymyxin-hc 188, 189, 196
NEONATAL COMPLETE 84, 335, 338
NEONATAL PLUS 84, 335, 338
NEO-SYNALAR 310, 320
NEOTUSS PLUS .. 18, 19, 65, 294
NERLYNX 53
NESTABS 84, 335, 338
NESTABS ONE 84, 287, 335, 338
neuac 37, 310, 327
NEULASTA 79
NEUPRO 144
NEURONTIN ... 119, 120, 123, 140
NEVANAC 199
nevirapine 33
nevirapine er 33
new day 220, 227, 250
NEXIUM 211
NEXLETOL 89, 94
NEXLIZET 89, 94, 101
NEXTSTELLIS 227, 238, 250
NGENLA 244
niacin er (antihyperlipidemic) 94, 338
nicardipine hcl 105, 106, 115
NICORETTE 64, 68
NICORETTE MINI 64, 68
nicotine 64, 69
nicotine mini 64, 68
nicotine polacrilex 64, 68, 69
nicotine polacrilex mini 64, 68
nicotine step 1 ..... 64, 69
nicotine step 2 ..... 64, 69
nicotine step 3 ..... 64, 69
NICOTROL NS 64, 69
nifedipine 105, 106, 115
nifedipine er 105, 106, 115
nifedipine er osmotic release 105, 106, 115
nikki 227, 238, 250
nilotinib hcl 53
nimodipine 105, 106, 115
NIMODIPINE 105, 106, 115
NINLARO 53
nisoldipine er 105, 106
nitazoxanide 25, 26
NITRO-BID 110, 111
NITRO-DUR 110, 111
nitrofurantoin 44
nitrofurantoin macrocrystal ... 44
nitrofurantoin monohydrate macrocrystals 44
nitroglycerin .. 110, 111, 316, 331
NITROSTAT 111

NITRO-TIME 111
NIVA THYROID 257
NIVESTYM 79
nizatidine 19, 210
nora-be 227, 250
NORDIPEN 5 INJECTION DEVICE 172
NORDITROPIN FLEXPRO 244, 256
norelgestromin-eth estradiol 228, 238, 250
norethin ace-eth estrad-fe 228, 238, 250
norethindrone 228, 250
norethindrone acetate 250
norethindrone acet-ethinyl est 228, 238, 250
norethindrone-eth estradiol 238, 251
norethin-eth estradiol-fe 228, 238, 251
norgestimate-eth estradiol 228, 238, 251
norgestimate-ethinyl estradiol triphasic . 228, 238, 251
NORLIQVA 105, 106, 115
norlyroc 228, 251
NORPACE 101
NORPACE CR 101
NORPRAMIN 159
nortrel 0.5/35 (28) .. 228, 238, 251
nortrel 1/35 (21) 228, 238, 251
nortrel 1/35 (28) 228, 238, 251
nortrel 7/7/7 ..... 228, 238, 251
nortriptyline hcl 159
NORVIR 36
NOURIANZ 117, 137
NOVAREL 241
NOVOEIGHT 82
NOVOFINE PEN NEEDLE 172
NOVOFINE PLUS PEN NEEDLE 172
NOVOLIN R FLEXPEN 254
NOVOLIN R FLEXPEN RELION 255
NOVOPEN ECHO 172
NOVOSEVEN RT 82
NOXAFIL 28
np thyroid 257
NUBEQA 53
NUCALA 293
NUCORT 196, 216, 320
NUCYNTA 149
NUCYNTA ER 148
NUEDEXTA 138
NULEV 16, 67, 293
NUPLAZID 132
NURTEC 136
NUVESSA 21, 38, 310
NUWIQ 82
NUZYRA 22
nyamyc 41, 328
nylia 1/35 ..... 228, 238, 251
nylia 7/7/7 ..... 228, 238, 251
NYMALIZE 105, 106, 115
nystatin 41, 328, 329
nystatin-triamcinolone 41, 320, 329
nystop 41, 329
OBIZUR 82
OCALIVA 207, 209
octreotide acetate 209, 255
OCUFLOX 42, 189
ODACTRA 58
ODEFSEY 33, 35, 39
ODOMZO 53
OFEV 293
ofloxacin 42, 189
OGSIVEO 53
OHTUVAYRE 291
OJEMDA 53
OJJAARA 53
olanzapine 127, 132, 203
olanzapine-fluoxetine hcl 127, 132, 158, 203
olmesartan medoxomil 91, 92
olmesartan medoxomil-hctz 92, 183
olmesartan-amlodipine-hctz 92, 105, 183
olopatadine hcl 19, 187
OLUMIANT 264, 277
omega-3-acid ethyl esters 94, 112
omeprazole 211
OMNARIS 196, 216, 295
OMNIFLEX DIAPHRAGM 290
OMNIPOD 5 DEXG7G6 INTRO GEN 5 172
OMNIPOD 5 DEXG7G6 PODS GEN 5 173
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 173
OMNIPOD 5 LIBRE2 PLUS G6 PODS 173
OMNITROPE 244, 256
OMVOH 201, 202, 209
OMVOH (300 MG DOSE) 201
ondansetron hcl 202
ondansetron odt 202
ONE VITE WOMENS PLUS 84, 335, 338
ONENATAL RX . 84, 180, 335, 338
ONETOUCH DELICA PLUS LANCING 173
ONETOUCH DELICA SAFETY LANCING 173
ONETOUCH ULTRA 173
ONETOUCH VERIO 173
ONEXTON 37, 310, 327
ONFI 134, 136
ONGENTYS 137
ONUREG 53
ONYDA XR 65
ONZETRA XSAIL 157
opcicon one-step .. 220, 228, 251
OPFOLDA 185, 287
OPILL 228, 251
opium 149, 203
OPSUMIT 116, 297, 304
option 2 ..... 220, 228, 251
OPTIONS GYNOL II CONTRACEPTIVE 290
OPVEE 150
OPZELURA 53, 324, 332
ORACIT 177
ORAL CITRATE 177
ORALAIR 58
ORALAIR ADULT STARTER PACK 58
ORALAIR CHILDRENS STARTER PACK 58
ORALONE 320
ORAPRED ODT 196, 216
ORAVIG 315
ORENCIA 260, 277, 282
ORENCIA CLICKJECT 260, 277, 282
ORENITRAM 116, 301, 304
ORENITRAM MONTH 1 ..... 116, 301, 304
ORENITRAM MONTH 2 ..... 116, 301, 304
ORENITRAM MONTH 3 ..... 116, 301, 304
ORFADIN 185, 287
ORGOVYX 53, 220
ORIAHNN 220, 238, 251
ORILISSA 220

ORKAMBI 296, 297
ORLYNVAH 44, 184, 269
orphenadrine citrate er 70, 75, 120
orquidea 228, 251
ORSERDU 53
OSCIMIN 16, 67, 293
oseltamivir phosphate 38
OSPHENA 232
OTEZLA 265, 277, 282, 332
OTEZLA XR 265
OVACE PLUS 310
OVACE PLUS WASH 310
OVACE WASH 310
OVIDE 329
OVIDREL 241
oxaprozin 146, 155
oxazepam 136
oxcarbazepine 123, 141
OXERVATE 190, 198
oxiconazole nitrate 315
OXISTAT 315
oxybutynin chloride 333
oxybutynin chloride er 333
oxycodone hcl 149
oxycodone-acetaminophen 120, 145, 149
oxymorphone hcl 149
oxymorphone hcl er 149
OZEMPIC 242
OZOBAX DS 69
PACERONE 104
PALFORZIA 58, 59
PALFORZIA (1 MG DAILY DOSE) 58
PALFORZIA INITIAL DOSE 1-3YRS 58
PALFORZIA INITIAL DOSE 4-17YRS 58
paliperidone er 132
PALYNZIQ 185
PANCREAZE 185, 207
PANRETIN 306, 332
pantoprazole sodium 211
PARI VORTEX ADULT MASK 173
PARI VORTEX PEDIATRIC MASK 173
paricalcitol 340
PARNATE 143
paroxetine hcl 158
paroxetine hcl er 158
paroxetine mesylate 158
PAXLOVID (150/100) 27, 28
PAXLOVID (300/100 & 150/100) 27, 29
PAXLOVID (300/100) 27, 29
pazopanib hcl 53
PEDIARIX 59, 62
PEDVAX HIB 62
peg 3350 205
peg 3350-kcl-na bicarb-nacl . 205
peg-3350/electrolytes 205
peg-3350/electrolytes/ascorbat 206, 339
PEGASYS 36, 53, 262, 282
peg-kcl-nacl-nasulf-na asc-c 206, 339
PEG-PREP 206
PEMAZYRE 54
PEN NEEDLE/5-BEVEL TIP ... 173
PENBRAYA 62
penciclovir 313
penicillamine 16, 212, 277
penicillin v potassium 37
PENMENVY 62
PENTACEL 59, 62
pentamidine isethionate 26
pentazocine-naloxone hcl 150, 151
pentoxifylline er 80
perampanel 123
PERFECT POINT SAFETY LANCETS 173
PERFECT POINT SAFETY NEEDLE 173
PERFOROMIST 74, 303
PERIDEX 21, 190, 314, 327
perindopril erbumine 92, 93
periogard 21, 190, 314, 328
permethrin 329
perphenazine 151
perphenazine-amitriptyline 151, 159
PERTZYE 185, 207
phenazopyridine hcl 312
phenelzine sulfate 143
phenobarbital 133, 134
phenoxybenzamine hcl .. 71, 114
phenylephrine hcl 200, 201
phenytek 102, 141
phenytoin 102, 141
phenytoin infatabs 102, 141
phenytoin sodium extended 102, 141
PHEXX 290
philith 228, 238, 251
PHOSPHA 250 NEUTRAL 181
PHOSPHOLINE IODIDE 199
phosphorous 181
phospho-trin 250 neutral 181
PHOXILLUM B22K4/0 181
PHOXILLUM BK4/2.5 181
phytonadione 16, 268, 340
PIFELTRO 33
pilocarpine hcl 72, 199
pimecrolimus 285, 323, 332
pimozide 130, 138
pimtrea 228, 239, 251
pindolol 70, 95, 101, 103, 111
pioglitazone hcl 257
pioglitazone hcl-glimepiride 256, 257
pioglitazone hcl-metformin hcl 222, 257
PIP GLUCOSE CONTROL SOLUTION 173
PIQRAY 54
pirfenidone 293, 302
piroxicam 146, 155
pitavastatin calcium 108
PLAN B ONE-STEP 220, 228, 251
PLEGRIDY 282, 283
PLEGRIDY STARTER PACK . 283
PLENVU 206, 339
plerixafor 79
PLEXION 310, 325
PLEXION CLEANSER 310, 325
PLEXION CLEANSING CLOTH 310, 325
PNEUMOVAX 23 62
pnv 27-ca/fe/fa 84, 335, 338
PODOCON-25 ..... 325, 332
podofilox 325, 332
POKONZA 181
polyethylene glycol 3350 206
polymyxin b-trimethoprim 42, 189, 310
POLY-VI-FLOR 161, 163, 272, 335
POLY-VI-FLOR/IRON 84, 85, 272, 335
POMALYST 54, 283
portia-28 ..... 228, 239, 251
posaconazole 28
potassium chloride 181
potassium chloride crys er .. 181
potassium chloride er 181
potassium citrate er 177

potassium citrate-citric acid 177
potassium iodide (expectorant) 298
PRADAXA 78
pramipexole dihydrochloride 144
PRAMOSONE 312, 320, 321
PRAMOTIC 190, 199
prasugrel hcl 86
pravastatin sodium 108
praziquantel 23
prazosin hcl 71, 90, 95
PRED MILD 196, 216
prednisolone 196, 216
prednisolone acetate 196, 216
prednisolone sodium phosphate 196, 216
prednisone 216
prednisone intensol 216
pregabalin 123, 139, 140
pregabalin er 120, 139, 140
PREGNYL 242
PREMARIN 239, 271
PREMESISRX 181, 287, 336, 338
PREMPHASE 239, 251
PREMPRO 239, 251
prenatal 85, 336, 338
prenatal plus vitamin/mineral 85, 336, 338
PRENATE 181, 336, 338
PRENATE DHA 85, 181, 287, 336, 338
PRENATE ELITE 85, 336, 338
PRENATE ENHANCE 85, 181, 288, 336, 338
PRENATE ESSENTIAL 85, 181, 288, 336, 338
PRENATE MINI 85, 181, 288, 336, 338
PRENATE PIXIE 85, 181, 288, 336, 338
PRENATE RESTORE 85, 181, 288, 336, 338
PREPIDIL 291
PRETOMANID 27
prevalite 96
PREVIDENT ... 161, 162, 164, 273
PREVIDENT 5000 BOOSTER PLUS 163, 272
PREVIDENT 5000 DRY MOUTH 161, 163, 272
PREVIDENT 5000 ENAMEL PROTECT 163, 272
PREVIDENT 5000 KIDS . 163, 273
PREVIDENT 5000 ORTHO DEFENSE 163, 273
PREVIDENT 5000 PLUS 161, 163, 273
PREVIDENT 5000 SENSITIVE 164, 273
PREVNAR 20 62
PREVYMIS 27
PREZCOBIX 36, 288
PREZISTA 36
PRIFTIN 27, 42
PRILOSEC 211
primaquine phosphate 25
primidone 133
PRIORIX 62
PRISMASOL B22GK 4/0 181
PRISMASOL BGK 0/2.5 182
PRISMASOL BGK 2/0 182
PRISMASOL BGK 2/3.5 182
PRISMASOL BGK 4/0/1.2 182
PRISMASOL BGK 4/2.5 182
PRISMASOL BK 0/0/1.2 182
probenecid 184, 269
PROCENTRA 119
prochlorperazine 151, 203
prochlorperazine maleate 151, 203
PROCORT 196, 216, 313, 321
PROCTOCORT 196, 216, 321
PROCTOFOAM HC 196, 217, 313, 321
procto-med hc 196, 217, 321
PROCTOSOL HC ... 196, 217, 321
PROCTOZONE-HC 196, 217, 321
PROCYSBI 288
PROFILNINE 82
progesterone 251
PROGLYCEM 221
PROGRAF 259, 285, 323
PROLENSA 199
PROMACTA 79
promethazine hcl 17, 18, 19, 131, 203, 207, 298
promethazine-codeine 18, 19, 294
promethazine-dm 18, 19, 294
promethazine-phenylephrine 18, 19, 65
PROMETHEGAN 18, 19, 131, 203, 207, 298
PRONAL 315, 325
propafenone hcl 102
propafenone hcl er 102
proparacaine hcl 199
propranolol hcl 70, 95, 101, 103, 111, 130
propranolol hcl er 70, 95, 101, 103, 111, 130
propylthiouracil 221
PROQUAD 62
PROTONIX 211
protriptyline hcl 159
PROVERA 251
prucalopride succinate 209
PRURADIK 329
pseudoephedrine-bromphen-dm 18, 19, 65, 294
PULMOSAL 299
PULMOZYME 186, 299
PURE COMFORT SAFETY PEN NEEDLE 173
PURIXAN 54, 262, 285
PYLERA 24, 26, 44, 203, 204
pyrazinamide 27
PYRIDIUM 313
pyridostigmine bromide 72
pyridostigmine bromide er 72
PYRIDOSTIGMINE BROMIDE ER 72
pyrimethamine 25
PYROGALLIC ACID 291, 325, 332
PYRUKYND 77
PYRUKYND TAPER PACK 77
QBRELIS 93
QFITLIA 82
QINLOCK 54
QNASL 196, 217, 295, 300
QNASL CHILDRENS 196, 217, 295, 300
QUADRACEL 59, 62
QUESTRAN 96
QUESTRAN LIGHT 96
quetiapine fumarate 128, 132
quetiapine fumarate er . 127, 132
QUICK TOUCH INSULIN PEN NEEDLE 173
QUILLICHEW ER 153
QUILLIVANT XR 154
quinapril hcl 92, 93
quinapril-hydrochlorothiazide 93, 183
quinidine gluconate er 25, 101
quinidine sulfate 25, 101
quinine sulfate 25
QULIPTA 136

QVAR REDIHALER 217, 295, 301
RABEPRAZOLE SODIUM..... 211
rabeprazole sodium..... 211
RADICAVA ORS.....117, 138
RADICAVA ORS STARTER KIT..... 117, 138
RADIOGARDASE..... 16, 179, 268
RAGWITEK.....59
RALDESY..... 158
raloxifene hcl.....232, 271
ramelteon.....131, 142
ramipril.....92, 93
ranolazine er.....99
rasagiline mesylate.....142, 143
RASUVO.....260, 261, 277, 278
RAYA SURE PEN NEEDLE... 173
RAYASAL..... 325
react..... 220, 228, 251
reclipsen..... 228, 239, 252
RECOMBINATE.....82
RECOMBIVAX HB..... 62
RECOTHROM..... 82
RECOTHROM SPRAY KIT.....82
RECTIV.....111, 316, 332
REGLAN..... 210
RELENZA DISKHALER..... 38
RELISTOR..... 150, 202, 209
RELNATE DHA.85, 288, 336, 339
RENTHYROID..... 257
repaglinide.....243
REPATHA.....112
REPATHA SURECLICK..... 112
RESTASIS..... 190, 197, 259
RESTASIS MULTIDOSE 190, 197, 259
RESTORIL.....136
RETACRIT.....76, 79
RETEVMO..... 54
RETIN-A MICRO PUMP... 54, 316
RETROVIR..... 35
REVLIMID.....54, 283
REVUFORJ.....54
REXTOVY.....16, 150
REXULTI.....133
REYATAZ..... 36
REZDIFFRA.....257
REZLIDHIA..... 54
REZUROCK.....288
RHOFADE..... 201, 307, 332
RHOPRESSA..... 201
ribavirin.....39
RIDAURA.....212, 261, 278, 283
rifabutin.....27, 42
rifampin.....27, 42
riluzole..... 117, 138
rimantadine hcl..... 21
RINVOQ.....264, 278
RINVOQ LQ.....264
risedronate sodium.....271
risperidone..... 128, 133
ritonavir.....36
rivaroxaban.....77
rivastigmine.....72
rivastigmine tartrate..... 72
rivelsa.....228, 239, 252
RIVFLOZA..... 288
RIVIVE..... 16, 150
RIXUBIS.....82
rizatriptan benzoate..... 157
ROCALTROL.....340
ROCKLATAN.....200, 201
roflumilast.....301, 324, 328
ROMVIMZA.....54
ropinirole hcl..... 144
ropinirole hcl er.....144
rosuvastatin calcium..... 108
rosyrah.....228, 239, 252
ROTARIX..... 62
ROTATEQ.....62
ROWASA..... 204
roweepra.....123
ROZLYTREK..... 54
RUBRACA..... 55
RUCONEST.....274, 275
rufinamide.....123, 141
RUKOBIA.....32
RYALTRIS 19, 187, 197, 217, 295, 300
RYBELSUS.....242
RYCLORA.....18, 19
RYDAPT..... 55
sacubitril-valsartan... 90, 92, 113
SAFETY PEN NEEDLES.....173
SAFYRAL.....229, 239, 252, 339
SALAGEN.....72, 200
SALICATE.....325
salicylic acid.....325
salsalate.....156
SALVAX DUO PLUS.....315, 326
SAMSCA.....184
SANTYL.....186, 316, 332
sapropterin dihydrochloride..... 184, 288
SAVAYSA..... 77
SAVELLA.....139, 156
SAVELLA TITRATION PACK 139, 156
saxagliptin hcl.....231
saxagliptin-metformin er..... 222, 231
SCALACORT DK.....321, 326
SCEMBLIX.....55
scopolamine.....67, 203, 210
SDAMLO.....106, 116
SELECT-OB.....85, 336, 339
selegiline hcl..... 142, 143
selenium sulfide.....314, 328
SELZENTRY.....32
SENSILANCE SAFETY LANCETS 21G.....173
SENSILANCE SAFETY LANCETS 26G.....173
SENSILANCE SAFETY LANCETS 28G.....173
SEPHIENCE..... 185
SEREVENT DISKUS..... 74, 304
SERNIVO.....217, 321
SEROSTIM..... 244, 256
sertraline hcl.....158
setlakin.....229, 239, 252
sevelamer carbonate..... 17, 179, 268
SEVENFACT..... 83
sevoflurane.....141
sf.....162, 164, 273
sf 5000 plus..... 162, 164, 273
SFROWASA..... 204
sharobel.....229, 252
SHARPS COLLECTOR..... 173
SHARPS CONTAINER.....173
shewise.....220, 229, 252
SHINGRIX.....62
SIGNIFOR.....255
sildenafil citrate..... 112, 113, 301, 304, 334
SILENOR..... 159, 313
silodosin..... 72
SILVADENE.....314, 328
silver nitrate.....190
silver sulfadiazine.....314, 328
SIMBRINZA..... 186, 192
simliya.....229, 239, 252
simpesse.....229, 239, 252
SIMPONI.....209, 266, 278, 283
simvastatin..... 108
SINEMET..... 139
SINGULAIR.....299
sirolimus.....264, 285, 323

SIRTURO 27
SITAGLIPT BASE-METFORM HCL ER 222, 231
SITAGLIPTIN 231
SITAGLIPTIN BASE-METFORMIN HCL 222, 231
SIVEXTRO 41
SKYCLARYS 288
SKYRIZI 209, 323, 332
SKYRIZI PEN 323, 332
SKYTROFA 245
SLYND 220, 229, 252
smooth lax 206
SOAANZ 88, 109, 178
sod citrate-citric acid 177
sod fluoride-potassium nitrate 164, 273
sodium chloride 300
sodium fluoride 162, 164, 273
sodium fluoride 5000 enamel 164, 273
sodium fluoride 5000 plus 162, 164, 273
sodium fluoride 5000 ppm 162, 164, 273
sodium fluoride 5000 sensitive 164, 273
SODIUM OXYBATE 138, 160, 269
sodium phenylbutyrate 177
sodium polystyrene sulfonate 17, 179, 268
sodium sulfacetamide 310
sodium sulfacetamide wash 310
SOFOSBUVIR-VELPATASVIR 30, 31
SOHONOS 288
solifenacin succinate 333
SOLIQUA 242, 243
SOLOSEC 26
SOMAVERT 256
SOOLANTRA 329
sorafenib tosylate 55
sotalol hcl 70, 95, 101, 103, 104, 111
sotalol hcl (af) 70, 95, 101, 103, 104, 111
SOTYKTU 324, 332
SOTYLIZE 70, 95, 101, 103, 104, 111
SOVALDI 30
SPEVIGO 323
SPIKEVAX 63
SPIKEVAX 6M-11Y 63
spinosad 329
SPIRIVA HANDIHALER 67, 293
SPIRIVA RESPIMAT 67, 293
spironolactone 89, 109, 113, 114, 180
spironolactone-hctz 89, 109, 114, 180, 183
SPORANOX 28
SPRAVATO (56 MG DOSE) 125, 143
SPRAVATO (84 MG DOSE) 125, 143
sprintec 28 ..... 229, 239, 252
SPRITAM 123
SPRIX 146, 155, 199
SPS (SODIUM POLYSTYRENE SULF) 17, 179, 268
sronyx 229, 239, 252
ssd 314, 328
SSKI 298
sss 10-5 ..... 310, 326
ST JOSEPH LOW DOSE 86, 87, 130, 156
STENDRA 112, 113
STEQEYMA 263
STIOLTO RESPIMAT 67, 74
STIVARGA 55
STRENSIQ 186
STRIBILD 32, 35, 288
STRIVERDI RESPIMAT ... 74, 304
STROMECTOL 23
SUBOXONE 150, 151
subvenite 124, 128
subvenite starter kit-blue 124, 128
subvenite starter kit-green 124, 128
subvenite starter kit-orange 124, 128
SUCRAID 186
sucralfate 211
SUFLAVE 206
SULAR 106
SULCONAZOLE NITRATE 315
sulfacetamide sodium .. 189, 311
sulfacetamide sodium (acne) 310
sulfacetamide sodium (cleans) 310
sulfacetamide sodium-sulfur 311, 326
sulfacetamide sod-sulfur wash 311, 326
sulfacetamide-prednisolone 189, 197
sulfacetamide-sulfur in urea 311, 326
SULFACLEANSE 8/4 ..... 311, 326
sulfadiazine 43
sulfamethoxazole-trimethoprim 26, 43, 44
sulfamez wash 311, 326
SULFAMYLON 311, 328
sulfasalazine 43, 204, 261, 278, 283
sulfatrim pediatric 26, 43, 44
sulfurated lime 329
sulindac 146, 155
sumatriptan 157
sumatriptan succinate 157
SUMAXIN 311, 326
SUMAXIN CP 311, 326
sunitinib malate 55
SUNLENCA 26, 32
SUNOSI 160
SUPREP BOWEL PREP KIT .. 206
SUTAB 206
syeda 229, 239, 252
SYMBICORT 74, 217
SYMDEKO 296, 297
SYMFI 33, 35
SYMPAZAN 134, 136
SYMPROIC 202, 209
SYNALAR 197, 321
SYNAREL 242
SYNDROS 203, 209
SYNJARDY 222, 255
SYNJARDY XR 222, 255
TABLOID 55
TABRECTA 55
TACLONEX 316, 321, 332
tacrolimus 259, 285, 323, 332
tadalafil 112, 113, 301
tadalafil (pah) . 112, 113, 301, 305
TADLIQ 112, 113, 301, 305
TAFINLAR 55
tafluprost (pf) 200
TAGRISSO 55
take action 220, 229, 252
TAKHZYRO 88, 275, 286
TALZENNA 55
tamoxifen citrate 55, 232
tamsulosin hcl 72
TANLOR 69

TAPERDEX 12-DAY 197, 217
TAPERDEX 6-DAY 197, 217
TAPERDEX 7-DAY 197, 217
tarina 24 fe 229, 239, 252
tarina fe 1/20 eq 229, 239, 252
TARPEYO 217
tasimelteon 131, 142
tavaborole 328
TAVALISSE 77
TAVNEOS 259, 274, 275
taysofy 229, 239, 252
TAYTULLA 229, 239, 252
tazarotene 326, 332
TAZAROTENE 326, 332
TAZORAC 326, 332
TAZVERIK 55
TECHLITE LANCETS 26G 174
TECHLITE PLUS PEN NEEDLES 174
TEGLUTIK 117, 138
TEGRETOL 124, 128
TEGRETOL-XR 124, 128
TEKTURNA 113
telmisartan 91, 92
telmisartan-amlodipine ... 92, 106
telmisartan-hctz 92, 183
temazepam 136
TEMBEXA 39
temozolomide 55
TENCON 120, 134, 145
TENIVAC 59
tenofovir disoproxil fumarate 35
TEPMETKO 55
terazosin hcl 71, 90, 96
terbinafine hcl 21
terbutaline sulfate 74, 304
terconazole 315
teriflunomide 259, 283
TERIPARATIDE 243, 269
terrell 141
TESTIM 219, 221
testosterone 219, 221
testosterone cypionate . 219, 221
testosterone enanthate 219, 221
tetrabenazine 160
tetracaine hcl 199, 266
tetracycline hcl .. 25, 44, 205, 311
TEXACORT 197, 217, 321
TEZRULY 71, 90
TEZSPIRE 299, 302
THALITONE 89, 114, 184
THALOMID 55, 283
THEO-24 . 107, 154, 178, 306, 334
theophylline 107, 154, 178, 306, 334
theophylline er 107, 154, 178, 306, 334
thioridazine hcl 151
thiothixene 159
THROMBIN-JMI 83
THROMBIN-JMI EPISTAXIS 83
THROMBOGEN 83
THYQUIDITY 258
thyroid 258
tiadylt er 97, 98, 99, 104, 116
tiagabine hcl 124, 140
TIAZAC 97, 98, 99, 104, 116
TIBSOVO 55
ticagrelor 87
TIGLUTIK 117, 138
TIKOSYN 104
tilia fe 229, 239, 252
timolol hemihydrate 70, 96, 103, 191
timolol maleate 70, 96, 101, 103, 111, 130, 191
timolol maleate (once-daily) 70, 96, 103, 191
timolol maleate ocudose 70, 96, 103, 191
timolol maleate pf 71, 96, 103, 191
TIMOPTIC OCUDOSE 71, 96, 103, 191
tinidazole 26
tiopronin 288
TIROSINT 258
TIROSINT-SOL 258
TISSEEL 316, 332
TIVICAY 32
TIVICAY PD 32
tizanidine hcl 69
TOBI NEBULIZER 22, 189
TOBI PODHALER 22, 189
TOBRADEX 22, 189, 197
TOBRADEX ST 22, 189, 197
tobramycin 22, 189
tobramycin-dexamethasone 22, 189, 197
TOBREX 22, 189
TODAY SPONGE 290
TOLAK 56, 306, 333
tolcapone 137
tolterodine tartrate 333
tolterodine tartrate er 333
tolvaptan 184
TOPAMAX 124, 130
TOPAMAX SPRINKLE 124, 130
TOPICORT 321
topiramate 124, 130
toremifene citrate 56, 232
torpenz 56, 262
torsemide 88, 109, 178
TOSYMRA 157
TOUJEO MAX SOLOSTAR 243
TOUJEO SOLOSTAR 243
tovet 321
TPOXX 27
TRACLEER 116, 298, 305
TRADJENTA 231
tramadol hcl 149
TRAMADOL HCL (ER BIPHASIC) 149
tramadol hcl (er biphasic) 149
tramadol hcl er 149
tramadol-acetaminophen 120, 145, 149
trandolapril 92, 93
trandolapril-verapamil hcl er 93, 99
tranexamic acid 83
tranylcypromine sulfate 143
travoprost (bak free) 200
trazodone hcl 158
TRELEGY ELLIPTA 67, 74, 197, 217, 218, 296
TREMFYA 261, 324, 333
TREMFYA ONE-PRESS 261, 323, 333
TREMFYA PEN 261, 323
TREMFYA-CD/UC INDUCTION 261, 324
tretinoin 56, 316
tretinoin microsphere 56, 316
tretinoin microsphere pump 56, 316
TRETTEN 83
TREXALL .. 56, 261, 278, 283, 285
TREZIX 120, 145, 149, 154
triamcinolone acetonide 218, 321, 322
triamterene 89, 113, 180
triamterene-hctz 180, 183
triazolam 136
TRICITRASOL 76
tricitrates 177
triderm 218, 322
trientine hcl 212
tri-estarylla 229, 239, 252

trifluoperazine hcl 151
trifluridine 190
trihexyphenidyl hcl 68, 120
TRIJARDY XR 222, 231, 255
TRIKAFTA 296, 297
tri-legest fe 229, 239, 252
TRILEPTAL 124, 142
tri-linyah 229, 239, 252
tri-lo-estarylla 229, 239, 252
tri-lo-marzia 229, 239, 252
tri-lo-mili 229, 239, 252
tri-lo-sprintec 229, 239, 252
trimethobenzamide hcl 203
trimethoprim 44
tri-mili 229, 240, 252
trimipramine maleate 159
TRINATE 85, 336, 339
TRINTELLIX 158
tri-sprintec 229, 240, 252
TRISTART DHA
..... 85, 182, 288, 336, 339
TRIUMEQ 33, 35
TRIUMEQ PD 33, 35
TRI-VI-FLOR
162, 164, 273, 336, 337, 339, 340
TRI-VI-FLORO
162, 164, 273, 336, 337, 339, 340
TRI-VITAMIN WITH
FLUORIDE 162, 164, 273, 336
tri-vite/fluoride
162, 164, 273, 336, 337, 339, 340
tri-vylibra 229, 240, 252
tri-vylibra lo 229, 240, 252
trospium chloride 334
trospium chloride er 334
TRUE COMFORT SAFETY
PEN NEEDLE 174
TRUE COVER 290
TRUE FOLIC ACID 339
TRUE METRIX LEVEL 1 174
TRUE METRIX LEVEL 2 174
TRUE METRIX LEVEL 3 174
TRULANCE 201, 209
TRULICITY 242
TRUMENBA 63
TRUQAP 56
TRUVADA 35, 39
TRYNGOLZA 94, 218, 269
TRYPTYR 198
TRYVIO 298
TUKYSA 56
TURALIO 56
turpentine 315
turqoz 229, 240, 252
TUXARIN ER 19, 20, 294
TWIIST REFILL KIT 174
TWIIST REFILL
KIT/INFUSION SET 174
TWIIST STARTER KIT 174
TWINRIX 63
TWIRLA 229, 240, 253
TWYNEO 316, 328
TYBLUME 230, 240, 253
TYBOST 289
tydemy 230, 240, 253, 339
TYENNE 263
TYMLOS 243, 269
TYRVAYA 64, 198
TYVASO 117, 302, 305
TYVASO DPI INSTITUTIONAL
KIT 116, 302, 305
TYVASO DPI MAINTENANCE
KIT 116, 302, 305
TYVASO DPI TITRATION KIT
..... 116, 302, 305
TYVASO REFILL KIT
..... 117, 302, 305
TYVASO STARTER KIT
..... 117, 302, 305
UBRELVY 136
UCERIS 218
UDENYCA 79
ULTANE 141
UNIFINE OTC PEN NEEDLES
..... 174
UNIFINE PROTECT PEN
NEEDLE 174
UNISTRIP CONTROL 174
unithroid 258
UPNEEQ 201
UPTRAVI 305
UPTRAVI TITRATION 305
URAMAXIN 89, 178, 200, 326
urea 89, 178, 200, 326
URELLE 45, 67, 120, 289
UREMEZ-40 ..... 89, 178, 200, 326
uretron d/s 45, 67, 120, 289
UROCIT-K 10 177
UROCIT-K 15 177
UROGESIC-BLUE 45, 67, 289
ursodiol 207
VAFSEO 79
valacyclovir hcl 39
VALCHLOR 306, 333
valganciclovir hcl 39
valproic acid .. 124, 128, 130, 140
valsartan 91, 92
valsartan-
hydrochlorothiazide 92, 183
VALTOCO 10 MG DOSE 134
VALTOCO 15 MG DOSE 135
VALTOCO 20 MG DOSE 135
VALTOCO 5 MG DOSE 135
valtya 1/35 ..... 230, 240, 253
valtya 1/50 ..... 230, 240, 253
VANCOCIN 29
vancomycin hcl 29
VANDAZOLE 21, 38, 311
VANFLYTA 56
VANRAFIA 279, 298
VAQTA 63
vardenafil hcl 112, 113
varenicline tartrate 64, 69
varenicline tartrate (starter)
..... 64, 69
varenicline tartrate(continue)
..... 64, 69
VARIVAX 63
VAXELIS 59, 60, 63
VAXNEUVANCE 63
VCF VAGINAL
CONTRACEPTIVE 290
VECAMYL 114
velivet 230, 240, 253
VELPHORO 179
VELTASSA 179
VENCLEXTA 56
VENCLEXTA STARTING
PACK 56
VENELEX 333
VENLAFAXINE BESYLATE
ER 157
venlafaxine hcl 157
venlafaxine hcl er 157
VEOZAH 138
verapamil hcl
..... 97, 98, 99, 105, 117
verapamil hcl er
..... 97, 98, 99, 104, 117
VEREGEN 326, 333
VERIFINE INSULIN PEN
NEEDLE 174
VERIFINE INSULIN SYRINGE
..... 174
VERIFINE PLUS PEN
NEEDLE 174
VERIFINE SAFE LANCET
MINI 21G 174

VERIFINE SAFE LANCET MINI 23G 174
VERIFINE SAFE LANCET MINI 28G 174
VERIFINE SAFE LANCET MINI 30G 174
VERIFINE SHARPS CONTAINER 174
VERISAFE SAFETY STERILE NEEDLE 175
VERKAZIA 190, 198, 259
VERQUVO 101, 117
VERSACLOZ 133
VERSAPENN (AG) ANHYDROUS 291
VERSAPENN (AL) ANHYD LIPID 291
VERZENIO 57
VESICARE 334
vestura 230, 240, 253
VFEND 28
VIBERZI 203, 209
vienva 230, 240, 253
vigabatrin 124, 140
VIGADRONE 124, 140
VIGAFYDE 140
VIJOICE 289
vilazodone hcl 158
VILEVEV MB 45, 68, 120, 289
VIMPAT 124, 142
VIOKACE 186, 207
viorele 230, 240, 253
VIRACEPT 36
VIREAD 35
VISTOGARD 17, 268
VITAFOL FE+ 85, 182, 289, 336, 339
VITAFOL-OB+DHA 85, 182, 289, 336, 339
VITAMIN C BRIGHTENING SERUM 315
vitamin d (ergocalciferol) 340
VITATHELY WITH GINGER 85, 337, 339
VITRAKVI 57
VIVAGUARD INO CONTROL SOLUTION 175
VIVAGUARD LANCETS 30G . 175
VIVAGUARD LANCING DEVICE 175
VIVAGUARD SAFETY LANCETS 28G 175
VIVJOA 28
VIZIMPRO 57
VOCABRIA 33
volnea 230, 240, 253
VONVENDI 83
VOQUEZNA 210, 211
VOQUEZNA DUAL PAK ... 23, 210
VOQUEZNA TRIPLE PAK 23, 40, 41, 210
VORANIGO 57
voriconazole 28
VORTEX VALVE CHAMBER-PEDI MASK 175
VORTEX VALVED HOLDING CHAMBER 175
VOSEVI 30, 31
VOWST 209, 289
VOXZOGO 289
VOYDEYA 274
VRAYLAR 133
VTAMA 311, 316, 333
VUSION 313, 315, 322
vyfemla 230, 240, 253
VYLEESI 138, 212
vylibra 230, 240, 253
VYNDAMAX 99, 138, 289
VYVGART HYTRULO 264
VYZULTA 200
WAINUA 269
WAKIX 161
warfarin sodium 77
WELIREG 57
wera 230, 240, 253
WESCAP-PN DHA 85, 182, 289, 337, 339
WESNATAL DHA COMPLETE 85, 182, 289, 337, 339
WESNATE DHA 85, 289, 337, 339
WESTGEL DHA 85, 182, 289, 337, 339
WEZLANA 263, 264
wheat germ oil 340
WIDE-SEAL DIAPHRAGM 60 290
WIDE-SEAL DIAPHRAGM 65 290
WIDE-SEAL DIAPHRAGM 70 291
WIDE-SEAL DIAPHRAGM 75 291
WIDE-SEAL DIAPHRAGM 80 291
WIDE-SEAL DIAPHRAGM 85 291
WIDE-SEAL DIAPHRAGM 90 291
WIDE-SEAL DIAPHRAGM 95 291
WILATE 83
WINREVAIR 302
wixela inhub 74, 197, 218, 296
wymzya fe 230, 240, 253
XACIATO 37, 311
xarah fe 230, 240, 253
XARELTO 77, 78
XARELTO STARTER PACK 78
XATMEP ... 57, 261, 278, 283, 285
XCOPRI 125, 142
XDEMVY 190
XELJANZ 264, 278
XELJANZ XR 264, 278
XELPROS 200
xelria fe 230, 240, 253
XELSTRYM 119
XERMELO 203
XIFAXAN 42
XIIDRA 190, 198
XIRUN 315, 326
XOFLUZA (40 MG DOSE) .. 27, 29
XOFLUZA (80 MG DOSE) .. 27, 29
XOLAIR 262, 263, 302, 303
XOLREMDI 80
XOPENEX HFA 75, 304
XOSPATA 57
XPHOZAH 179, 210
XPOVIO (100 MG ONCE WEEKLY) 57
XPOVIO (40 MG ONCE WEEKLY) 57
XPOVIO (40 MG TWICE WEEKLY) 57
XPOVIO (60 MG ONCE WEEKLY) 57
XPOVIO (60 MG TWICE WEEKLY) 57
XPOVIO (80 MG ONCE WEEKLY) 57
XPOVIO (80 MG TWICE WEEKLY) 57
XROMI 57
XTAMPZA ER 149
XTANDI 58
xulane 230, 240, 253
XYNTHA 83
XYNTHA SOLOFUSE 83
XYWAV 138
YASMIN 28 ..... 230, 240, 253
YAZ 230, 240, 253
YESINTEK 264
YEZTUGO 32
YORVIPATH 243
YUPELRI 68, 293
yuvafem 240, 271
ZACARE 315, 328
ZACLIR CLEANSING 328

zafemy 230, 240, 253
zafirlukast 299
zaleplon 131, 143
ZANAFLEX 69
ZARONTIN 159
ZARXIO 80
ZAVZPRET 137
ZELAPAR 142, 143
ZELBORAF 58
ZELSUVMI 313, 333
zelvysia 185, 289
ZEMBRACE SYMTOUCH 157
ZEMPLAR 340
zenatane 327, 333
ZENPEP 186, 207
ZEPATIER 31
ZEPOSIA 284
ZEPOSIA 7-DAY STARTER PACK 283
ZEPOSIA STARTER KIT 284
ZESTRIL 92, 94
ZIAGEN 35
zidovudine 35
ZILBRYSQ 259, 260, 274
zileuton er 299
ZILXI 25, 44, 189, 311
ZIOPTAN 200
ziprasidone hcl 128, 133
ZIPSOR 146
ZIRGAN 39, 190
ZITHROMAX 40, 41
ZITHROMAX TRI-PAK 40, 41
ZITHROMAX Z-PAK 40, 41
ZITUVIMET 223, 231
ZITUVIMET XR 223, 231
ZITUVIO 231
ZOKINVY 185, 289
ZOLINZA 58
zolmitriptan 157
ZOLPIDEM TARTRATE .. 131, 143
zolpidem tartrate 131, 143
zolpidem tartrate er 131, 143
ZOMIG 157
ZONEGRAN 125, 142
ZONISADE 125, 142
zonisamide 125, 142
ZONTIVITY 87
ZORYVE 301, 324, 328, 333
zovia 1/35 (28) 230, 240, 253
ZOVIRAX 39, 313
ZTALMY 125, 141
ZTLIDO 266, 313
ZUBSOLV 150, 151
zumandimine 230, 240, 253
ZURNAI 150
ZURZUVAE 125
ZYDELIG 58
ZYLET 189, 197
ZYPITAMAG 108
ZYVOX 41