



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

Please note: This Prescription Drug List (PDL) is accurate as of Sept. 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 All previous versions of this PDL are no longer in effect.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.pdf](#).

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

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

- Heritage Plus
- Heritage Select

Updated 5/1/2026

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 this PDL 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.

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

Prior authorization 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 both available and 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 <i>(irbesartan)</i>	3/4	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	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	SP	Specialty Medication
Drug Tier 2	Your mid-range cost medications	CM	Orally administered anti-cancer medication
Drug Tier 3	Your mid-range to high-cost medications	SMCS	Specialty medication cost share may apply
Drug Tier 3/4	Your highest cost medications	E	Excluded from coverage unless covered as part of health care reform preventive
PA	Prior authorization required	SM	Cost-share cap by state mandate applies when condition appropriate
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		

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.

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. For information related to specialty medication cost share, please refer to the Specialty Medication Cost Share (SMCS) section below.

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 provider 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

These medications are 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.

Specialty Medication Cost Share (SMCS) – Specialty medication cost share may apply. Please refer to the Pharmacy Schedule of Benefits for specific cost share.

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](https://www.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 provider 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.

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

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे क्लर्क बॅ 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ヤ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: ຖ້າຫາກທ່ານເວົ້າພາສາລາວ (Lao), ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ໂທຫາເບີໂທຟຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

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

بوجه: لکریه بدان **فارسی (Persian-Farsi)** صحبت می‌کنید، خدمات پلکان کمک بدلی و لطایط اب
پلکان در والابه ای بکتر، ملید حاب برر ک، در سیرس سما هیدد. دلس ماره پلکان مدرح روی کار
س پللی عصفو سار سما س بکود.

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

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

ਦਿਆਨ ਦਿਓ ਿ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ
ਛੋਟੇ ਮੈਟ੍ਰਿਕ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫਤ 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.

مہرحمدی: اگر اب اردو (Urdu) ردا ے لہےصحبو ردا ے کی معاو ے خدمات اوربذکر وایمبسے
مواطن اب، حسے درفرب، اب کلے معب سہابسمے ممدس بلحی کارب ریدے کفول وری
سمبر کال کیں۔

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	44
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	89
CARDIOVASCULAR DRUGS - Drugs for the Heart	90
CENTRAL NERVOUS SYSTEM AGENTS	116
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System	117
DENTAL AGENTS	159
DENTAL AGENTS - Oral Care	160
DEVICES - Medical Supplies and Durable Medical Equipment	162
DIAGNOSTIC AGENTS	173
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants	175
ELECTROLYTIC, CALORIC, AND WATER BALANCE	175
ENZYMES	182
EYE, EAR, NOSE AND THROAT (EENT) PREPS.	184
GASTROINTESTINAL DRUGS	198
GASTROINTESTINAL DRUGS - Drugs for the Stomach	198
GOLD COMPOUNDS	208
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron	208
HORMONES AND SYNTHETIC SUBSTITUTES	208
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones	209
IMMUNOMODULATORY AGENTS (90:00)	252
LOCAL ANESTHETICS - Drugs for Numbing	261
MISCELLANEOUS THERAPEUTIC AGENTS	261
NONHORMONAL CONTRACEPTIVES - Drugs for Women	284
OXYTOCICS - Drugs for Women	285
PHARMACEUTICAL AIDS	285
RESPIRATORY TRACT AGENTS	286
RESPIRATORY TRACT AGENTS - Drugs for the Lungs	286
SKIN AND MUCOUS MEMBRANE AGENTS	300
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin	300
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles	325
VITAMINS	326

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN ORAL TABLET 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
<i>penicillamine oral tablet 250 mg</i>	1	
<i>phytonadione oral tablet 5 mg</i>	1	QL (5 tablets per prescription.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	SM
REZENOPY NASAL LIQUID 10 MG/0.11ML (<i>naloxone hcl</i>)	3/4	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
ANTIDOTES (91:04)		
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	
RADIOGARDASE ORAL CAPSULE 0.5 GM (<i>prussian blue insoluble</i>)	3	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	1	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	1	
<i>sodium polystyrene sulfonate oral powder</i>	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (<i>sodium polystyrene sulfonate</i>)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (<i>sodium polystyrene sulfonate</i>)	3	
CHEMOTHERAPY ANTIDOTES/PROTECTANTS		
<i>lederle leucovorin oral tablet 5 mg</i>	1	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
CYANIDE ANTIDOTES		
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	3	
FLUOROPYRIMIDINE ANTIDOTE		
VISTOGARD ORAL PACKET 10 GM (<i>uridine triacetate</i>)	2	QL (20 packets per prescription.)
ANTI-HISTAMINE DRUGS - Drugs for Allergy		
ANTI-HISTAMINE DRUGS - Drugs for Allergy		
<i>promethazine hcl oral tablet 25 mg</i>	1	
ETHANOLAMINE DERIVATIVES - Drugs for Allergy		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (<i>phenylephrine-chlorphen-dm</i>)	3	
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ANTIHISTAMINES - Drugs for Allergy		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>olopatadine hcl nasal solution 0.6 %</i>	1	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	1	PA; QL (360 ml per month.)
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (<i>phenylephrine-chlorphen-dm</i>)	3	
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
<i>epinastine hcl ophthalmic solution 0.05 %</i>	1	QL (5 ml per prescription)
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	1	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTI-INFECTIVE AGENTS - Drugs for Infections		
1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
<i>cefadroxil oral capsule 500 mg</i>	1	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	1	
<i>cefadroxil oral tablet 1 gm</i>	1	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	1	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	1	
2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	1	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	1	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	1	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	1	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	1	
3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
<i>cefdinir oral capsule 300 mg</i>	1	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cefixime oral capsule 400 mg</i>	1	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
CEFIXIME ORAL TABLET 400 MG	3/4	
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	1	
ADAMANTANE ANTIVIRALS - Drugs for Viral Infections		
<i>amantadine hcl oral capsule 100 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>amantadine hcl oral solution 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
<i>rimantadine hcl oral tablet 100 mg</i>	1	
ALLYLAMINE ANTIFUNGALS - Drugs for Fungus		
<i>terbinafine hcl oral tablet 250 mg</i>	1	
AMEBICIDES - Drugs for the Mouth and Throat		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
HUMATIN ORAL CAPSULE 250 MG (<i>paromomycin sulfate</i>)	2	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	3/4	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	3/4	
<i>periogard mouth/throat solution 0.12 %</i>	1	
VANDAZOLE VAGINAL GEL 0.75 % (<i>metronidazole</i>)	3/4	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (<i>amikacin sulfate liposome</i>)	3/4	PA; QL (8.4 ml per day.)
<i>gentamicin sulfate external cream 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate external ointment 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	QL (15 ml per prescription.)
HUMATIN ORAL CAPSULE 250 MG (<i>paromomycin sulfate</i>)	2	
<i>neomycin sulfate oral tablet 500 mg</i>	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (<i>tobramycin</i>)	3/4	PA; QL (280 ml (1 carton) per 56 days.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TOBI PODHALER INHALATION CAPSULE 28 MG (<i>tobramycin</i>)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	3	
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	1	PA; QL (224 ml per 56 days.)
<i>tobramycin ophthalmic solution 0.3 %</i>	1	QL (5 ml per prescription.)
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (<i>tobramycin</i>)	3	QL (3.5 grams per prescription.)
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (<i>omadacycline tosylate</i>)	3/4	QL (30 tablets per prescription.)
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	
<i>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</i>	1	
<i>amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	1	
<i>ampicillin oral capsule 500 mg</i>	1	
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicillin-clarithro-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
<i>albendazole oral tablet 200 mg</i>	1	QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (<i>praziquantel</i>)	3/4	
EGATEN ORAL TABLET 250 MG (<i>triclabendazole</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EMVERM ORAL TABLET CHEWABLE 100 MG (<i>mebendazole</i>)	3/4	QL (6 tablets per 3 days.)
<i>ivermectin oral tablet 3 mg</i>	1	PA; QL (20 tablets per 3 months.)
<i>ivermectin oral tablet 6 mg</i>	1	PA
<i>praziquantel oral tablet 600 mg</i>	1	
STROMECTOL ORAL TABLET 3 MG (<i>ivermectin</i>)	3/4	PA; QL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	1	
<i>griseofulvin microsize oral tablet 500 mg</i>	1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	1	
ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3/4	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
<i>dapsone external gel 5 %, 7.5 %</i>	1	QL (60 grams per prescription.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3/4	QL (30 grams per prescription.)
ARAKODA ORAL TABLET 100 MG (<i>tafenoquine succinate</i>)	3/4	QL (16 tablets per month.)
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	1	
AVIDOXY ORAL TABLET 100 MG	3/4	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	1	
COARTEM ORAL TABLET 20-120 MG (<i>artemether-lumefantrine</i>)	2	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DARAPRIM ORAL TABLET 25 MG (<i>pyrimethamine</i>)	3/4	PA
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
KRINTAFEL ORAL TABLET 150 MG (<i>tafenoquine succinate</i>)	1	QL (2 tablets per prescription.)
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (<i>atovaquone-proguanil hcl</i>)	3/4	
<i>mefloquine hcl oral tablet 250 mg</i>	1	
<i>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</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	1	
<i>pyrimethamine oral tablet 25 mg</i>	1	PA
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
<i>quinine sulfate oral capsule 324 mg</i>	1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
ZILXI EXTERNAL FOAM 1.5 % (<i>minocycline hcl micronized</i>)	3/4	PA; QL (30 grams per prescription.)
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
<i>nitazoxanide oral tablet 500 mg</i>	1	QL (6 tablets per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
<i>atovaquone oral suspension 750 mg/5ml</i>	1	
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>dapsone external gel 5 %, 7.5 %</i>	1	QL (60 grams per prescription.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
IMPAVIDO ORAL CAPSULE 50 MG (<i>miltefosine</i>)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (<i>nifurtimox</i>)	3/4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (<i>nifurtimox</i>)	3/4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	3/4	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (<i>pentamidine isethionate</i>)	3/4	
<i>nitazoxanide oral tablet 500 mg</i>	1	QL (6 tablets per prescription.)
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	1	
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3/4	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (<i>secnidazole</i>)	3/4	QL (1 packet per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>pyrazinamide oral tablet 500 mg</i>	1	
<i>rifabutin oral capsule 150 mg</i>	1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	1	
SIRTURO ORAL TABLET 100 MG, 20 MG (<i>bedaquiline fumarate</i>)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (<i>maribavir</i>)	3/4	PA; QL (4 tablets per day.)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	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 (<i>nirmatrelvir-ritonavir</i>)	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 (<i>nirmatrelvir-ritonavir</i>)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
PREVYMIS ORAL PACKET 120 MG, 20 MG (<i>letermovir</i>)	2	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG (<i>letermovir</i>)	2	PA
TPOXX ORAL CAPSULE 200 MG (<i>tecovirimat</i>)	3/4	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
AZOLE ANTIFUNGALS - Drugs for Fungus		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (<i>isavuconazonium sulfate</i>)	3	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	
<i>itraconazole oral capsule 100 mg</i>	1	QL (180 capsules per 365 days)
<i>itraconazole oral solution 10 mg/ml</i>	1	QL (1800 ml per 365 days)
<i>ketoconazole external cream 2 %</i>	1	QL (30 grams per prescription.)
<i>ketoconazole external foam 2 %</i>	1	
<i>ketoconazole external shampoo 2 %</i>	1	
<i>ketoconazole oral tablet 200 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>ketodan external foam 2 %</i>	1	
NOXAFIL ORAL PACKET 300 MG (<i>posaconazole</i>)	2	
<i>posaconazole oral suspension 40 mg/ml</i>	1	
<i>posaconazole oral tablet delayed release 100 mg</i>	1	
SPORANOX ORAL CAPSULE 100 MG (<i>itraconazole</i>)	3/4	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>voriconazole</i>)	3/4	QL (300 mL per prescription.)
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (<i>oteseconazole</i>)	3	PA; QL (18 capsules per 84 days.)
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	1	QL (300 mL per prescription.)
<i>voriconazole oral tablet 200 mg</i>	1	QL (62 tablets per prescription.)
<i>voriconazole oral tablet 50 mg</i>	1	QL (124 tablets per prescription)
BACITRACIN ANTIBIOTICS - Antibiotics		
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	
CORONAVIRUS (COVID-19) - Drugs for Viral Infections		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	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 (<i>nirmatrelvir-ritonavir</i>)	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 (<i>nirmatrelvir-ritonavir</i>)	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 (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
ERYTHROMYCIN ANTIBIOTICS - Antibiotics		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>erythromycin ethylsuccinate</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ERY EXTERNAL PAD 2 %	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (<i>erythromycin ethylsuccinate</i>)	3/4	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	1	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	1	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	1	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (<i>vancomycin hcl</i>)	3/4	
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (<i>vancomycin hcl</i>)	3/4	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	1	
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	1	
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (2 packets per day and 84 packets per 720 days.)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 packet per day and 84 packets per 720 days.)
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (84 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; QL (1 pellet packet per day and 28 pellet packets per month.)
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	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 (<i>sofosbuvir</i>)	3/4	PA; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.)
SOVALDI ORAL TABLET 200 MG, 400 MG (<i>sofosbuvir</i>)	3/4	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	2	PA; QL (84 tablets per 720 days.)
HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (168 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	2	PA; QL (84 tablets per 720 days.)
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	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 (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (2 packets per day and 84 packets per 720 days.)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 packet per day and 84 packets per 720 days.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (84 tablets per 720 days.)
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; QL (1 pellet packet per day and 28 pellet packets per month.)
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	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 (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	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 (<i>sofosbuvir-velpatasvir-voxilaprevir</i>)	2	PA; QL (84 tablets per 720 days.)
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	2	PA; QL (84 tablets per 720 days (12 weeks).)
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	3/4	PA; QL (24 tablets per year.)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (<i>lenacapavir sodium</i>)	3/4	PA; QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	3/4	PA; QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	3/4	QL (4 tablets per year.); SM
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
<i>maraviroc oral tablet 150 mg, 300 mg</i>	1	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	2	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (<i>maraviroc</i>)	3/4	PA
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofof</i>)	3/4	QL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	2	QL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	3/4	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	2	SM
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	2	QL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	3/4	QL (1 tablet per day.); SM
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	3	SM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	3	SM
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivud</i>)	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 (<i>cabotegravir sodium</i>)	3/4	SM
HIV NONNUCLEOSIDE REV.TRANScrip. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofof</i>)	3/4	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofof df</i>)	2	QL (1 tablet per day.)
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	2	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (<i>rilpivirine hcl</i>)	2	SM
<i>efavirenz oral tablet 600 mg</i>	1	
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	1	QL (1 tablet per day.)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	1	QL (1 tablet per day.)
<i>emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg</i>	1	QL (1 tablet per day.); SM
<i>etravirine oral tablet 100 mg, 200 mg</i>	1	SM
INTELENCE ORAL TABLET 100 MG, 200 MG (<i>etravirine</i>)	3/4	SM
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	2	SM
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	2	QL (1 tablet per day.)
<i>methocarbamol oral tablet 500 mg</i>	1	
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	1	
<i>nevirapine oral suspension 50 mg/5ml</i>	1	
<i>nevirapine oral tablet 200 mg</i>	1	
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofov af</i>)	3/4	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (<i>doravirine</i>)	3	
<i>rilpivirine hcl oral tablet 25 mg</i>	1	SM
SYMFI ORAL TABLET 600-300-300 MG (<i>efavirenz-lamivudine-tenofovir</i>)	2	QL (1 tablet per day.)
HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections		
<i>abacavir sulfate oral solution 20 mg/ml</i>	1	
<i>abacavir sulfate oral tablet 300 mg</i>	1	
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofov</i>)	3/4	QL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (<i>lamivudine-tenofovir</i>)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofov df</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	3/4	QL (1 tablet per day.); H; SM
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	2	QL (1 tablet per day.)
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	1	QL (1 tablet per day.)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	1	QL (1 tablet per day.)
<i>emtricitabine oral capsule 200 mg</i>	1	SM
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1	QL (1 tablet per day.); SM
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	QL (1 tablet per day.); H; SM
<i>emtricitab-rilpivir-tenofovir df oral tablet 200-25-300 mg</i>	1	QL (1 tablet per day.); SM
EMTRIVA ORAL CAPSULE 200 MG (<i>emtricitabine</i>)	3/4	SM
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	2	SM
EPIVIR ORAL SOLUTION 10 MG/ML (<i>lamivudine</i>)	3/4	SM
EPIVIR ORAL TABLET 150 MG, 300 MG (<i>lamivudine</i>)	3/4	SM
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	3/4	QL (1 tablet per day.)
<i>lamivudine oral solution 10 mg/ml</i>	1	SM
<i>lamivudine oral tablet 100 mg</i>	1	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	1	SM
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	1	SM
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofovir af</i>)	3/4	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (<i>zidovudine</i>)	3/4	SM
RETROVIR ORAL SYRUP 50 MG/5ML (<i>zidovudine</i>)	3	SM
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	3/4	QL (1 tablet per day.); SM
SYMFI ORAL TABLET 600-300-300 MG (<i>efavirenz-lamivudine-tenofovir</i>)	2	QL (1 tablet per day.)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	1	H-N

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>abacavir-dolutegravir-lamivudine</i>)	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 (<i>emtricitabine-tenofovir df</i>)	3/4	QL (1 tablet per day.); SM
VIREAD ORAL POWDER 40 MG/GM (<i>tenofovir disoproxil fumarate</i>)	3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	2	
ZIAGEN ORAL SOLUTION 20 MG/ML (<i>abacavir sulfate</i>)	3/4	
<i>zidovudine oral capsule 100 mg</i>	1	SM
<i>zidovudine oral syrup 50 mg/5ml</i>	1	SM
<i>zidovudine oral tablet 300 mg</i>	1	SM
HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
APTIVUS ORAL CAPSULE 250 MG (<i>tipranavir</i>)	2	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	1	SM
<i>darunavir oral tablet 600 mg, 800 mg</i>	1	SM
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	2	
<i>fosamprenavir calcium oral tablet 700 mg</i>	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML (<i>lopinavir-ritonavir</i>)	3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (<i>lopinavir-ritonavir</i>)	3/4	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	1	
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	2	SM
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	2	SM
PREZISTA ORAL TABLET 150 MG, 75 MG (<i>darunavir</i>)	2	SM
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	2	SM
<i>ritonavir oral tablet 100 mg</i>	1	SM
VIRACEPT ORAL TABLET 250 MG, 625 MG (<i>nelfinavir mesylate</i>)	2	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	
LINCOMYCIN ANTIBIOTICS - Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (<i>clindamycin hcl</i>)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (<i>clindamycin hcl</i>)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (<i>clindamycin palmitate hcl</i>)	3/4	
CLEOCIN VAGINAL CREAM 2 % (<i>clindamycin phosphate</i>)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (<i>clindamycin phosphate</i>)	3/4	
<i>clindacin etz external swab 1 %</i>	1	
<i>clindacin external foam 1 %</i>	1	
<i>clindacin-p external swab 1 %</i>	1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	1	
<i>clindamycin phos (twice-daily) external gel 1 %</i>	1	QL (75 grams per prescription.)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
<i>clindamycin phosphate external foam 1 %</i>	1	
<i>clindamycin phosphate external lotion 1 %</i>	1	
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>clindamycin phosphate vaginal cream 2 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CLINDESSE VAGINAL CREAM 2 % (<i>clindamycin phosphate</i> (1 dose))	2	
<i>neuac external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
XACIATO VAGINAL GEL 2 % (<i>clindamycin phosphate</i>)	2	QL (1 gel tube (8 grams) per prescription.)
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (<i>aztreonam lysine</i>)	3/4	PA; 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 (<i>nirsevimab-alip</i>)	3	H
ENFLONIA INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 105 MG/0.7ML (<i>clesrovimab-cfor</i>)	3	H
NATURAL PENICILLIN ANTIBIOTICS - Antibiotics		
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	1	
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	1	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>zanamivir</i>)	3	
NITROIMIDAZOLE DERIVATIVE, ANTI-LEISHMAL - Drugs for the Mouth and Throat		
IMPAVIDO ORAL CAPSULE 50 MG (<i>miltefosine</i>)	2	QL (84 capsules per course of therapy.)
NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL - Drugs for the Mouth and Throat		
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (240 tablets per 720 days.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 (<i>metronidazole</i>)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	3/4	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	
VANDAZOLE VAGINAL GEL 0.75 % (<i>metronidazole</i>)	3/4	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
<i>acyclovir external ointment 5 %</i>	1	
<i>acyclovir oral capsule 200 mg</i>	1	
<i>acyclovir oral suspension 200 mg/5ml</i>	1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	
<i>adefovir dipivoxil oral tablet 10 mg</i>	1	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (<i>entecavir</i>)	2	
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitabine-rilpivir-tenofovir</i>)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	3/4	QL (1 tablet per day.); H; SM
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1	QL (1 tablet per day.); SM
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	QL (1 tablet per day.); H; SM
<i>emtricitabine-rilpivir-tenofovir df oral tablet 200-25-300 mg</i>	1	QL (1 tablet per day.); SM
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	1	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LAGEVRIO ORAL CAPSULE 200 MG (<i>molnupiravir</i>)	2	QL (80 capsules per 365 days. 40 capsules per prescription.)
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofovir af</i>)	3/4	QL (1 tablet per day.)
<i>ribavirin inhalation solution reconstituted 6 gm</i>	1	
<i>ribavirin oral capsule 200 mg</i>	1	
<i>ribavirin oral tablet 200 mg</i>	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (<i>brincidofovir</i>)	3/4	
TEMBEXA ORAL TABLET 100 MG (<i>brincidofovir</i>)	3/4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (<i>emtricitabine-tenofovir df</i>)	3/4	QL (1 tablet per day.); SM
<i>valacyclovir hcl oral tablet 1 gm</i>	1	QL (31 tablets per prescription)
<i>valacyclovir hcl oral tablet 500 mg</i>	1	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	1	
<i>valganciclovir hcl oral tablet 450 mg</i>	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (<i>ganciclovir</i>)	3	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fidaxomicin</i>)	3	QL (136 mL per 10 days.)
<i>fidaxomicin oral tablet 200 mg</i>	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicillin-clarithromycin-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>azithromycin</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	3/4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fidaxomicin</i>)	3	QL (136 mL per 10 days.)
<i>fidaxomicin oral tablet 200 mg</i>	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>azithromycin</i>)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	3/4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	1	
<i>linezolid oral tablet 600 mg</i>	1	
SIVEXTRO ORAL TABLET 200 MG (<i>tedizolid phosphate</i>)	3	QL (6 tablets per prescription.)
ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (<i>linezolid</i>)	3/4	
PENICILLINASE-RESISTANT PENICILLINS - Antibiotics		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	1	
POLYENE ANTIFUNGALS - Drugs for Fungus		
<i>klayesta external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>nystatin external cream 100000 unit/gm</i>	1	QL (90 grams per prescription.)
<i>nystatin external ointment 100000 unit/gm</i>	1	QL (90 grams per prescription.)
<i>nystatin external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	1	
<i>nystatin oral tablet 500000 unit</i>	1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	1	
<i>nystop external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
POLYMYXIN ANTIBIOTICS - Antibiotics		
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	1	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (<i>colistimethate sodium</i>)	3/4	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (<i>flucytosine</i>)	3/4	
ANCOBON ORAL CAPSULE 500 MG (<i>flucytosine</i>)	3	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	1	
QUINOLONE ANTIBIOTICS - Antibiotics		
BAXDELA ORAL TABLET 450 MG (<i>delafloxacin meglumine</i>)	3	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (<i>ciprofloxacin</i>)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (<i>ciprofloxacin hcl</i>)	3/4	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>levofloxacin ophthalmic solution 0.5 %, 1.5 %</i>	1	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (<i>ofloxacin</i>)	3/4	
<i>ofloxacin ophthalmic solution 0.3 %</i>	1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	
<i>ofloxacin otic solution 0.3 %</i>	1	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	2	
<i>rifabutin oral capsule 150 mg</i>	1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	1	
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	3	PA; QL (9 tablets per prescription)
XIFAXAN ORAL TABLET 550 MG (<i>rifaximin</i>)	3	PA; QL (62 tablets per month.)
SULFONAMIDES - Antibiotics		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3/4	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3/4	
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	
<i>sulfadiazine oral tablet 500 mg</i>	1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<i>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3/4	QL (30 grams per prescription.)
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-suncreen-sal acid</i>)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>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</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3/4	QL (120 capsules per 180 days.)
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
ZILXI EXTERNAL FOAM 1.5 % (<i>minocycline hcl micronized</i>)	3/4	PA; QL (30 grams per prescription.)
TRIAZAACENAPHTHYLENES - Antibiotics		
BLUJEPA ORAL TABLET 750 MG (<i>gepotidacin mesylate</i>)	3/4	QL (20 tablets per course of therapy.)
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>fosfomycin tromethamine oral packet 3 gm</i>	1	
HIPREX ORAL TABLET 1 GM (<i>methenamine hippurate</i>)	3/4	
MACROBID ORAL CAPSULE 100 MG (<i>nitrofurantoin monohyd macro</i>)	3/4	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>nitrofurantoin macrocrystal</i>)	3/4	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>methenamine hippurate oral tablet 1 gm</i>	1	
<i>methenamine mandelate oral tablet 0.5 gm, 1 gm</i>	1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystals oral capsule 100 mg</i>	1	
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	1	
ORLYNVAH ORAL TABLET 500-500 MG (<i>sulopenem etzadrox-probenecid</i>)	3/4	QL (10 tablets per course of therapy.)
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	
<i>trimethoprim oral tablet 100 mg</i>	1	
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (<i>methen-hyosc-meth blue-na phos</i>)	2	
VILEVEV MB ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
<i>abiraterone acetate oral tablet 250 mg</i>	1	QL (4 tablets per day.); CM
<i>abirtega oral tablet 250 mg</i>	1	QL (4 tablets per day.); CM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (<i>niraparib-abiraterone acetate</i>)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
ALECENSA ORAL CAPSULE 150 MG (<i>alectinib hcl</i>)	2	PA; QL (8 capsules per day.); CM
ALUNBRIG ORAL TABLET 180 MG, 90 MG (<i>brigatinib</i>)	2	PA; QL (1 tablet per day.); CM
ALUNBRIG ORAL TABLET 30 MG (<i>brigatinib</i>)	2	PA; QL (4 tablets per day.); CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (<i>brigatinib</i>)	2	PA; QL (30 packs per year.); CM
<i>anastrozole oral tablet 1 mg</i>	1	H-N
AUGTYRO ORAL CAPSULE 160 MG (<i>repotrectinib</i>)	2	PA; QL (60 capsules per month.); CM
AUGTYRO ORAL CAPSULE 40 MG (<i>repotrectinib</i>)	2	PA; QL (8 capsules per day.); CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (<i>avutometinib-defactinib</i>)	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 (<i>avapritinib</i>)	3/4	PA; QL (1 tablet per day.); CM
BALVERSA ORAL TABLET 3 MG (<i>erdafitinib</i>)	3/4	PA; QL (3 tablets per day.); SP; CM; SMCS
BALVERSA ORAL TABLET 4 MG (<i>erdafitinib</i>)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
BALVERSA ORAL TABLET 5 MG (<i>erdafitinib</i>)	3/4	PA; QL (1 tablet per day.); SP; CM; SMCS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
<i>bexarotene external gel 1 %</i>	1	QL (60 grams per prescription.)
<i>bexarotene oral capsule 75 mg</i>	1	CM
<i>bicalutamide oral tablet 50 mg</i>	1	CM
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	2	PA; QL (3 Capsules per day.); SP; CM; SMCS
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	2	PA; QL (1 Capsule 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BOSULIF ORAL TABLET 100 MG (<i>bosutinib</i>)	2	PA; QL (4 tablets per day.); SP; CM; SMCS
BOSULIF ORAL TABLET 400 MG, 500 MG (<i>bosutinib</i>)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
BRAFTOVI ORAL CAPSULE 75 MG (<i>encorafenib</i>)	3/4	PA; QL (6 capsules per day.); SP; CM; SMCS
BRUKINSA ORAL CAPSULE 80 MG (<i>zanubrutinib</i>)	3	PA; CM
BRUKINSA ORAL TABLET 160 MG (<i>zanubrutinib</i>)	3	PA; QL (60 capsules per month.); CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
CALQUENCE ORAL TABLET 100 MG (<i>acalabrutinib maleate</i>)	2	PA; QL (2 tablets per day.); CM
<i>capecitabine oral tablet 150 mg, 500 mg</i>	1	CM
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	2	PA; QL (2 tablets per day.); SP; CM; SMCS
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	2	PA; QL (1 tablet per day.); SP; CM; SMCS
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
COMETRIQ ORAL KIT 20 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (93 capsules per month.); SP; CM; SMCS
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (124 capsules per month.); SP; CM; SMCS

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COMETRIQ ORAL KIT 80 & 20 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (62 capsules per month.); SP; CM; SMCS
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (<i>duvelisib</i>)	3/4	PA; QL (2 capsules per day.); SP; CM; SMCS
COTELLIC ORAL TABLET 20 MG (<i>cobimetinib fumarate</i>)	2	PA; QL (63 tablets per 21 days); SP; CM; SMCS
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg</i>	1	PA; QL (1 tablet per day.); CM
<i>dasatinib oral tablet 20 mg</i>	1	PA; QL (90 tablets per month.); CM
DAURISMO ORAL TABLET 100 MG, 25 MG (<i>glasdegib maleate</i>)	2	PA; QL (2 tablets per day.); SP; CM; SMCS
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	1	CM
ENSACOVE ORAL CAPSULE 100 MG, 25 MG (<i>ensartinib hcl</i>)	2	PA; QL (60 capsules per month.); CM
ERIVEDGE ORAL CAPSULE 150 MG (<i>vismodegib</i>)	2	PA; QL (1 capsule per day.); SP; CM; SMCS
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	2	PA; QL (1 tablet per day.)
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	2	PA; QL (4 tablets per day.); CM
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	1	PA; QL (1 tablet per day.); SP; CM; SMCS
<i>erlotinib hcl oral tablet 25 mg</i>	1	PA; QL (2 tablets per day.); SP; CM; SMCS
<i>etoposide oral capsule 50 mg</i>	1	CM
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	1	
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.); CM
<i>everolimus oral tablet 2.5 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); CM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	1	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>exemestane oral tablet 25 mg</i>	1	H-N
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (<i>degarelix acetate</i>)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	3	
<i>fluorouracil external cream 5 %</i>	1	
<i>fluorouracil external solution 2 %, 5 %</i>	1	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (<i>tivozanib hcl</i>)	3/4	PA; QL (0.75 capsules per day.); SP; CM; SMCS
FRUZAQLA ORAL CAPSULE 1 MG (<i>fruquintinib</i>)	3/4	PA; QL (84 capsules per 21 days.); CM
FRUZAQLA ORAL CAPSULE 5 MG (<i>fruquintinib</i>)	3/4	PA; QL (21 capsules per 21 days.); CM
GAVRETO ORAL CAPSULE 100 MG (<i>pralsetinib</i>)	3/4	PA; QL (4 capsules per day.); CM
<i>gefitinib oral tablet 250 mg</i>	1	PA; QL (2 tablets per day.); CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (<i>afatinib dimaleate</i>)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (<i>lomustine</i>)	2	CM
GOMEKLI ORAL CAPSULE 1 MG (<i>mirdametinib</i>)	3/4	PA; QL (42 capsules per 4 weeks.); SP; SMCS
GOMEKLI ORAL CAPSULE 2 MG (<i>mirdametinib</i>)	3/4	PA; QL (84 capsules per 4 weeks.); SP; SMCS
GOMEKLI ORAL TABLET SOLUBLE 1 MG (<i>mirdametinib</i>)	3/4	PA; QL (168 tablets per 4 weeks.); SP; SMCS
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (<i>melphalan hcl</i>)	3	
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (<i>melphalan hcl</i>)	3	
HERNEXEOS ORAL TABLET 60 MG (<i>zongertinib</i>)	3/4	PA; QL (90 tablets per month.); SP; CM; SMCS
HYCANTIN ORAL CAPSULE 0.25 MG (<i>topotecan hcl</i>)	2	PA; QL (20 capsules per three weeks.); CM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HYCANTIN ORAL CAPSULE 1 MG (<i>topotecan hcl</i>)	2	PA; QL (30 capsules per 3 weeks.); CM
<i>hydroxyurea oral capsule 500 mg</i>	1	CM
HYRNUO ORAL TABLET 10 MG (<i>sevabertinib</i>)	2	PA; QL (120 tablets per month.); CM
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	3/4	PA; QL (21 capsules per month.); CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	3/4	PA; QL (0.75 tablets per day.); CM
IBTROZI ORAL CAPSULE 200 MG (<i>taletrectinib adipate</i>)	3/4	PA; QL (90 capsules per month.); SP; CM; SMCS
ICLUSIG ORAL TABLET 15 MG, 45 MG (<i>ponatinib hcl</i>)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
IDHIFA ORAL TABLET 100 MG, 50 MG (<i>enasidenib mesylate</i>)	2	PA; QL (1 tablet per day.); CM
<i>imatinib mesylate oral tablet 100 mg</i>	1	QL (6 tablets per day.); CM
<i>imatinib mesylate oral tablet 400 mg</i>	1	QL (1 tablet per day.); CM
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	2	PA; QL (4 capsules per day.); CM
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	2	PA; QL (1 capsule per day.); CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (<i>ibrutinib</i>)	2	PA; QL (7.2 ml per day.); CM
IMBRUVICA ORAL TABLET 420 MG (<i>ibrutinib</i>)	2	PA; QL (1 tablet per day.); CM
IMKELDI ORAL SOLUTION 80 MG/ML	3/4	PA; QL (280 ml (2 bottles) per month.); CM
INLURIYO ORAL TABLET 200 MG (<i>imlunestrant tosylate</i>)	2	PA; QL (56 tablets per month.); CM
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	3	PA; QL (6 tablets per day.); SP; CM; SMCS
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	3	PA; QL (124 tablets per 30 days.); SP; CM; SMCS
INQOVI ORAL TABLET 35-100 MG (<i>decitabine-cedazuridine</i>)	3/4	PA; QL (5 tablets per month.); SP; CM; SMCS

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IRESSA ORAL TABLET 250 MG (<i>gefitinib</i>)	3/4	PA; QL (2 tablets per day.); CM
ITOVEBI ORAL TABLET 3 MG (<i>inavolisib</i>)	2	PA; QL (56 tablets per month.); CM
ITOVEBI ORAL TABLET 9 MG (<i>inavolisib</i>)	2	PA; QL (28 tablets per month.); CM
IWILFIN ORAL TABLET 192 MG (<i>eflornithine hcl</i>)	2	PA; QL (8 tablets per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	2	PA; QL (2 tablets per day.); CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (<i>ruxolitinib phosphate</i>)	2	PA; CM
JAYPIRCA ORAL TABLET 100 MG (<i>pirtobrutinib</i>)	3/4	PA; QL (3 tablets per day.); CM
JAYPIRCA ORAL TABLET 50 MG (<i>pirtobrutinib</i>)	3/4	PA; QL (1 tablet per day.); CM
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (21 tablets per month.); CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (42 tablets per 21 days.); CM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (63 tablets per 21 days.); CM
KOMZIFTI ORAL CAPSULE 200 MG (<i>ziftomenib</i>)	3/4	PA; QL (90 capsules per month.); CM
KOSELUGO ORAL CAPSULE 10 MG (<i>selumetinib sulfate</i>)	3	PA; QL (8 capsules per day.); CM
KOSELUGO ORAL CAPSULE 25 MG (<i>selumetinib sulfate</i>)	3	PA; QL (4 capsules per day.); CM
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (<i>selumetinib sulfate</i>)	3	PA
KRAZATI ORAL TABLET 200 MG (<i>adagrasib</i>)	3/4	PA; QL (6 tablets per day.); CM
<i>lapatinib ditosylate oral tablet 250 mg</i>	1	PA; QL (186 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LAZCLUZE ORAL TABLET 240 MG (<i>lazertinib mesylate</i>)	3	PA; QL (30 tablets per month.); CM
LAZCLUZE ORAL TABLET 80 MG (<i>lazertinib mesylate</i>)	3	PA; QL (60 tablets per month.); CM
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg</i>	1	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
<i>lenalidomide oral capsule 20 mg, 25 mg</i>	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 (<i>lenvatinib mesylate</i>)	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 (<i>lenvatinib mesylate</i>)	2	PA; QL (3 capsules per day.); SP; CM; SMCS
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (<i>lenvatinib mesylate</i>)	2	PA; QL (1 capsule per day.); SP; CM; SMCS
<i>letrozole oral tablet 2.5 mg</i>	1	H-N
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	2	CM
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SM
LIFYORLI (125 MG DOSE) ORAL CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG (<i>relacorilant</i>)	3/4	PA; CM
LIFYORLI (150 MG DOSE) ORAL CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG (<i>relacorilant</i>)	3/4	PA; CM
<i>lomustine oral capsule 10 mg, 100 mg, 40 mg</i>	1	CM
LONSURF ORAL TABLET 15-6.14 MG (<i>trifluridine-tipiracil</i>)	3/4	PA; QL (100 tablets per month.); SP; CM; SMCS
LONSURF ORAL TABLET 20-8.19 MG (<i>trifluridine-tipiracil</i>)	3/4	PA; QL (80 tablets per 21 days.); SP; CM; SMCS
LORBRENA ORAL TABLET 100 MG (<i>lorlatinib</i>)	3	PA; QL (30 tablets per month.); CM
LORBRENA ORAL TABLET 25 MG (<i>lorlatinib</i>)	3	PA; QL (90 tablets per month.); CM
LUMAKRAS ORAL TABLET 120 MG (<i>sotorasib</i>)	3/4	PA; QL (240 tablets per month.); CM
LUMAKRAS ORAL TABLET 240 MG (<i>sotorasib</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>sotorasib</i>)	3/4	PA; QL (3 tablets per day.); CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (<i>olaparib</i>)	2	PA; QL (4 tablets per day.); SP; CM; SMCS
LYSODREN ORAL TABLET 500 MG (<i>mitotane</i>)	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	3/4	PA; QL (84 tablets per month.); CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	3/4	PA; QL (112 tablets per month.); CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	3/4	PA; QL (140 tablets per month.); CM
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	2	SP; CM; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml</i>	1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (<i>trametinib dimethyl sulfoxide</i>)	3/4	QL (17.4 ml per day.); CM
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	3/4	PA; QL (2 tablets per day.); CM
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	3/4	PA; QL (1 tablet per day.); CM
MEKTOVI ORAL TABLET 15 MG (<i>binimetinib</i>)	3/4	PA; QL (6 tablets per day.); SP; CM; SMCS
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	1	CM
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
MODEYSO ORAL CAPSULE 125 MG (<i>dordaviprone hcl</i>)	3/4	PA; QL (20 capsules per month.); SP; CM; SMCS
MYLERAN ORAL TABLET 2 MG (<i>busulfan</i>)	2	CM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>neratinib maleate</i>)	2	PA; QL (6 tablets per day.); CM
<i>nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg</i>	1	PA; QL (4 capsules per day.); SP; CM; SMCS
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (<i>ixazomib citrate</i>)	2	PA; QL (3 capsules per prescription.); SP; CM; SMCS
NUBEQA ORAL TABLET 300 MG (<i>darolutamide</i>)	2	PA; QL (4 tablets per day.); CM
ODOMZO ORAL CAPSULE 200 MG (<i>sonidegib phosphate</i>)	2	PA; QL (1 capsule per day.); CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (<i>nirogacestat hydrobromide</i>)	2	PA; QL (56 tablets per month.); CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (<i>tovorafenib</i>)	3/4	PA; QL (96 ml per month.); CM
OJEMDA ORAL TABLET 100 MG (<i>tovorafenib</i>)	3/4	PA; QL (24 tablets per month.); CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (<i>momelotinib dihydrochloride</i>)	3/4	PA; QL (1 tablet per day.); CM
ONUREG ORAL TABLET 200 MG, 300 MG (<i>azacitidine</i>)	2	PA; QL (14 tablets per 24 days.); CM
OPZELURA EXTERNAL CREAM 1.5 % (<i>ruxolitinib phosphate</i>)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
ORGOVYX ORAL TABLET 120 MG (<i>relugolix</i>)	3	PA; QL (1 tablet per day); CM
ORSERDU ORAL TABLET 86 MG (<i>elacestrant hydrochloride</i>)	2	PA; QL (3 tablets per day.); CM
<i>pazopanib hcl oral tablet 200 mg</i>	1	PA; QL (4 tablets per day.); SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (<i>pemigatinib</i>)	3/4	PA; QL (31 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (<i>alpelisib</i>)	2	PA; QL (2 tablets per day.); CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (<i>alpelisib</i>)	2	PA; QL (1 tablet per day.); CM
<i>pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg</i>	1	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	3	CM
QINLOCK ORAL TABLET 50 MG (<i>ripretinib</i>)	3/4	PA; QL (3 tablets per day.); SP; CM; SMCS
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (<i>selpercatinib</i>)	3/4	PA; QL (60 tablets per month.); CM
RETEVMO ORAL TABLET 40 MG (<i>selpercatinib</i>)	3/4	PA; QL (90 tablets per month.); CM
REVUFORJ ORAL TABLET 110 MG (<i>revumenib citrate</i>)	3/4	PA; QL (120 tablets per month.); SP; CM; SMCS
REVUFORJ ORAL TABLET 160 MG (<i>revumenib citrate</i>)	3/4	PA; QL (60 tablets per month.); SP; CM; SMCS
REVUFORJ ORAL TABLET 25 MG (<i>revumenib citrate</i>)	3/4	PA; QL (240 tablets per month.); SP; CM; SMCS
REZLIDHIA ORAL CAPSULE 150 MG (<i>olutasidenib</i>)	2	PA; QL (2 capsules per day.); CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (<i>vimseltinib</i>)	2	PA; QL (8 capsules per 4 weeks.); SP; CM; SMCS
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (<i>entrectinib</i>)	2	PA; QL (3 capsules per day.); CM
ROZLYTREK ORAL PACKET 50 MG (<i>entrectinib</i>)	2	PA; QL (84 packets (2 boxes) per month.); CM
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (<i>rucaparib camsylate</i>)	3	PA; QL (4 tablets per day.); SP; CM; SMCS
RYDAPT ORAL CAPSULE 25 MG (<i>midostaurin</i>)	2	PA; QL (8 capsules per day.); CM
SCEMBLIX ORAL TABLET 100 MG (<i>asciminib hcl</i>)	3/4	PA; QL (120 tablets per month.); SP; CM; SMCS
SCEMBLIX ORAL TABLET 20 MG, 40 MG (<i>asciminib hcl</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>sorafenib tosylate oral tablet 200 mg</i>	1	PA; QL (4 tablets per day.); SP; CM; SMCS
STIVARGA ORAL TABLET 40 MG (<i>regorafenib</i>)	2	PA; QL (84 tablets per 21 days.); SP; CM; SMCS
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	1	PA; QL (1 capsule per day.); SP; CM; SMCS
TABLOID ORAL TABLET 40 MG (<i>thioguanine</i>)	2	CM
TABRECTA ORAL TABLET 150 MG, 200 MG (<i>capmatinib hcl</i>)	3/4	PA; QL (4 tablets per day.); CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (<i>dabrafenib mesylate</i>)	3/4	PA; QL (4 capsules per day.); CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (<i>dabrafenib mesylate</i>)	3/4	QL (420 tablets per month.); CM
TAGRISSE ORAL TABLET 40 MG, 80 MG (<i>osimertinib mesylate</i>)	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 (<i>talazoparib tosylate</i>)	3/4	PA; QL (1 capsule per day.); SP; CM; SMCS
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H-N
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	1	CM
TEPMETKO ORAL TABLET 225 MG (<i>tepotinib hcl</i>)	3/4	PA; QL (2 tablets per day.); SP; CM; SMCS
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	2	PA; QL (28 capsules per prescription.); SP; CM; SMCS
TIBSOVO ORAL TABLET 250 MG (<i>ivosidenib</i>)	2	PA; QL (2 tablets per day.); SP; CM; SMCS
<i>toremifene citrate oral tablet 60 mg</i>	1	CM
<i>torpenz oral tablet 10 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.); CM
<i>torpenz oral tablet 2.5 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); CM
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	1	QL (20 grams per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
tretinoin oral capsule 10 mg	1	QL (279 capsules per prescription.); 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
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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VORANIGO ORAL TABLET 40 MG (<i>vorasidenib</i>)	2	PA; QL (31 tablets per month.); SP; CM; SMCS
WELIREG ORAL TABLET 40 MG (<i>belzutifan</i>)	3/4	PA; QL (3 tablets day.); SP; CM; SMCS
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
XOSPATA ORAL TABLET 40 MG (<i>gilteritinib fumarate</i>)	3	PA; QL (3 tablets per day.); CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (<i>selinexor</i>)	3/4	PA; QL (0.26 tablet per day.); CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (<i>selinexor</i>)	3/4	PA; QL (16 tablets per month.); CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (<i>selinexor</i>)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (<i>selinexor</i>)	3/4	PA; QL (1 therapy pack per month.); CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (<i>selinexor</i>)	3/4	PA; QL (0.86 tablets per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (<i>selinexor</i>)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (<i>selinexor</i>)	3/4	PA; QL (4 tablets per month.); CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (<i>selinexor</i>)	3/4	PA; QL (1.15 tablets per day.); CM
XROMI ORAL SOLUTION 100 MG/ML (<i>hydroxyurea</i>)	3/4	PA
XTANDI ORAL CAPSULE 40 MG (<i>enzalutamide</i>)	2	PA; QL (4 capsules per day.); SP; CM; SMCS
<i>yulithira oral tablet 10 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.); CM
<i>yulithira oral tablet 2.5 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); CM
ZELBORAF ORAL TABLET 240 MG (<i>vemurafenib</i>)	2	PA; QL (8 tablets per day.); SP; CM; SMCS
ZOLINZA ORAL CAPSULE 100 MG (<i>vorinostat</i>)	2	PA; QL (4 capsules per day.); CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (<i>idelalisib</i>)	3/4	PA; QL (60 tablets per month.); SP; CM; SMCS

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASSTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (<i>timothy grass pollen allergen</i>)	3/4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (<i>dust mite mixed allergen ext</i>)	3/4	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	3/4	PA; QL (3 tablets per year.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (<i>grass mix pollens allergen ext</i>)	3/4	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	3/4	PA; QL (1 tablet per day.)
PALFORZIA (1 MG DAILY DOSE) ORAL 1 X 1 MG (<i>peanut powder-dnfp</i>)	3	PA
PALFORZIA INITIAL DOSE 1-3YRS ORAL 0.5 & 1 & 1.5 & 3 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (7 capsules (1 pack) per 365 days.)
PALFORZIA INITIAL DOSE 4-17YRS ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (13 capsules per year.)
PALFORZIA ORAL 2 X 1 MG & 10 MG, 3 X 1 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (45 capsules per 13 days.)
PALFORZIA ORAL 2 X 100 MG, 2 X 20 MG, 20 MG & 100 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (30 capsules per 13 days.)
PALFORZIA ORAL 2 X 20 MG & 2 X 100 MG, 4 X 20 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (60 capsules per 13 days.)
PALFORZIA ORAL 20 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (15 capsules per 13 days.)
PALFORZIA ORAL 3 X 20 MG & 100 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (60 capsule per 13 days.)
PALFORZIA ORAL 6 X 1 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (90 capsules per 13 days.)
PALFORZIA ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (1 capsule per day.)
PALFORZIA ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	3	PA; QL (15 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (<i>short ragweed pollen ext</i>)	3/4	PA; QL (1 tablet per day.)
TOXOIDS - Vaccines		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	3	H
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	2	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	3	H
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	3	H
VACCINES - Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (<i>rsv pre-fusion f a&b vac rcmb</i>)	3	H
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	2	H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	3	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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
ENGRIX-B INJECTION SUSPENSION 20 MCG/ML (hepatitis b vac recombinant)	2	H
ENGRIX-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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	3	H
FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	3	H
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac split high-dose</i>)	3	H
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (<i>hepatitis a vaccine</i>)	3	H
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (<i>hepatitis b vac recomb adj</i>)	3	H
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (<i>haemophilus b polysac conj vac</i>)	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	3	H
IPOLE INJECTION SUSPENSION (<i>poliovirus vaccine inactivated</i>)	2	H
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (<i>mening acy&w-135 tetanus conj</i>)	3	H
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	3	H
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	3	H
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2	H
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (<i>covid-19 mrna virus vaccine</i>)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (<i>haemophilus b polysac conj vac</i>)	2	H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	3	H
PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	3	H
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>pneumococcal vac polyvalent</i>)	2	H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 20-val conj vacc</i>)	3	H
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	3	H
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	3	H
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	2	H
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	2	H
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	3	H
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	3	H
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</i>)	3	H
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	3	H
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b vac (recomb)</i>)	3	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (<i>hepatitis a-hep b recomb vac</i>)	3	H
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	2	H
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	2	H
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (<i>varicella virus vaccine live</i>)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	3	H
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 15-val conj vacc</i>)	3	H
AUTONOMIC DRUGS		
SMOKING CESSATION AGENTS		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	1	H
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (<i>varenicline tartrate</i>)	1	H
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	1	H
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	1	H
<i>goodsense nicotine polacrilex mouth/throat gum 4 mg</i>	1	H
<i>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	1	H
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	1	H
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	1	H
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	1	H
<i>nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr</i>	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	1	H
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	3/4	PA; QL (0.28 ml per day.)
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	1	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	1	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	1	H
AUTONOMIC DRUGS - Drugs for the Nervous System		
ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (<i>epinephrine</i>)	2	QL (2 pens per prescription.); SM
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	2	QL (2 injections per prescription.); SM
<i>droxidopa oral capsule 100 mg</i>	1	PA; QL (90 tablets per month.)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	1	PA; QL (180 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml</i>	1	QL (2 injections per prescription.); SM
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.); SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (<i>epinephrine</i>)	3/4	QL (2 nasal sprays (1 box) per copay.)
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs		
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	1	
JAVADIN ORAL SOLUTION 0.02 MG/ML (<i>clonidine hcl</i>)	3/4	PA
<i>lofexidine hcl oral tablet 0.18 mg</i>	1	
LUCEMYRA ORAL TABLET 0.18 MG (<i>lofexidine hcl</i>)	1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	1	PA
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (<i>phenylephrine-chlorphen-dm</i>)	3	
ONYDA XR ORAL SUSPENSION EXTENDED RELEASE 0.1 MG/ML (<i>clonidine hcl</i>)	3	QL (120 mL per month.)
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	1	
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	3	SM
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	3/4	QL (0.87 grams per day.); SM
<i>belladonna alkaloids-opium rectal suppository 16.2-60 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	2	QL (0.36 grams per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	3	QL (0.36 grams per day.); SM
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	3	QL (0.28 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (<i>glycopyrrolate</i>)	3/4	
<i>dicyclomine hcl oral capsule 10 mg</i>	1	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	1	
<i>dicyclomine hcl oral tablet 20 mg</i>	1	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	1	PA; QL (120 mL per prescription and 360 ml per month.)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	1	PA
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
<i>ipratropium bromide hfa inhalation aerosol solution 17 mcg/act</i>	1	QL (0.87 grams per day.); SM
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN ORAL TABLET 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
LOMOTIL ORAL TABLET 2.5-0.025 MG (<i>diphenoxylate-atropine</i>)	3/4	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>methscopolamine bromide oral tablet 2.5 mg, 5 mg</i>	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (<i>tiotropium bromide</i>)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (<i>tiotropium bromide</i>)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>tiotropium bromide</i>)	2	SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	2	SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (<i>methen-hyosc-meth blue-na phos</i>)	2	
VILEVEV MB ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (<i>revefenacin</i>)	3/4	PA; QL (3 ml per day.); SM
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	
AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System		
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (<i>varenicline tartrate</i>)	1	H
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	1	H
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	1	H
<i>goodsense nicotine polacrilex mouth/throat gum 4 mg</i>	1	H
<i>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	1	H
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	1	H
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	1	H
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	1	H
<i>nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr</i>	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	1	H
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	1	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	1	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	1	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
<i>carisoprodol oral tablet 350 mg</i>	1	
<i>chlorzoxazone oral tablet 500 mg</i>	1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	1	
<i>metaxalone oral tablet 400 mg, 800 mg</i>	1	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	1	
TANLOR ORAL TABLET 1000 MG (<i>methocarbamol</i>)	3	
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	1	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (<i>cyclobenzaprine hcl (fibromy)</i>)	3/4	PA; QL (60 sublingual tablets per month.)
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (<i>tizanidine hcl</i>)	3/4	
ZANAFLEX ORAL TABLET 4 MG (<i>tizanidine hcl</i>)	3/4	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (<i>dantrolene sodium</i>)	3/4	
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	1	
GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
<i>baclofen oral solution 10 mg/5ml</i>	1	PA
<i>baclofen oral solution 5 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>baclofen oral suspension 25 mg/5ml</i>	1	PA
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	1	
OZOBAX DS ORAL SOLUTION 10 MG/5ML (<i>baclofen</i>)	3/4	PA
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	
NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3/4	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3/4	QL (5 ml per prescription.)
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	3/4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	3/4	PA
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	1	QL (5 ml per prescription.)
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ocudose ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3/4	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3/4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
TEZRULY ORAL SOLUTION 1 MG/ML (<i>terazosin hcl</i>)	3/4	PA
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
CAFERGOT ORAL TABLET 1-100 MG (<i>ergotamine-caffeine</i>)	3/4	
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	1	QL (8 mL per prescription.)
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (<i>ergotamine tartrate</i>)	3/4	QL (5 tablets per prescription.)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	3	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	1	
PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS) - Drugs for Bladder Incontinence		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
<i>cevimeline hcl oral capsule 30 mg</i>	1	
<i>donepezil hcl oral tablet 10 mg, 23 mg, 5 mg</i>	1	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	1	
FIRDAPSE ORAL TABLET 10 MG (<i>amifampridine phosphate</i>)	2	PA; QL (300 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	1	
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	1	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	1	
MESTINON ORAL SOLUTION 60 MG/5ML (<i>pyridostigmine bromide</i>)	3/4	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	1	
PYRIDOSTIGMINE BROMIDE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG	3	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (<i>pilocarpine hcl</i>)	3/4	
SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	1	
<i>tamsulosin hcl oral capsule 0.4 mg</i>	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 (<i>fluticasone-salmeterol</i>)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (1 inhaler per copay.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (1 inhaler per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (18 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (6.7 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (8.5 grams per prescription.); 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	PA
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, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.); 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)	3	QL (0.28 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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	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/3ml	1	QL (90 ml per prescription.); SM
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	1	QL (30 vials per prescription); SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.); 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, 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
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (levalbuterol tartrate)	3	QL (15 grams per prescription.); 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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	3	
<i>bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3/4	
LOPRESSOR ORAL SOLUTION 10 MG/ML (<i>metoprolol tartrate</i>)	3/4	PA
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood		
ANTIANEMIA DRUGS - Vitamins and Minerals		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	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 (<i>darbepoetin alfa</i>)	2	QL (4 vials per month)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	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 (<i>anticoagulant cit dext soln a</i>)	3	
ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML	3	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml</i>	1	QL (24 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	1	QL (15 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	1	QL (12 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	1	QL (18 ml (30 syringes) per prescription)
TRICITRASOL IN VITRO CONCENTRATE 46.7 % (<i>anticoagulant sodium citrate</i>)	3	
ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (<i>caplacizumab-yhdp</i>)	2	PA; QL (1 vial per day and 58 vials per 120 days.); SP; SMCS
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (<i>mitapivat sulfate</i>)	3	PA; QL (56 tablets per 28 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (<i>mitapivat sulfate</i>)	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 (<i>mitapivat sulfate</i>)	3	PA; QL (14 tablets per 365 days.); CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (<i>fostamatinib disodium</i>)	3/4	PA; QL (2 tablets per day.); SP; SMCS
WAYRILZ ORAL TABLET 400 MG (<i>rilzabrutinib</i>)	3/4	PA; QL (60 tablets per month.)
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (<i>apixaban</i>)	2	QL (152 tablets per month.)
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (<i>apixaban</i>)	2	QL (152 tablets per month.)
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (<i>apixaban</i>)	2	QL (76 sprinkle capsules per month.)
ELIQUIS ORAL TABLET 2.5 MG (<i>apixaban</i>)	2	QL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG (<i>apixaban</i>)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (<i>apixaban</i>)	2	QL (152 tablets per month.)
<i>rivaroxaban oral suspension reconstituted 1 mg/ml</i>	1	QL (20 ml per day.)
<i>rivaroxaban oral tablet 2.5 mg</i>	1	QL (2 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (<i>edoxaban tosylate</i>)	3/4	QL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>rivaroxaban</i>)	2	QL (1 tablet per day.)
XARELTO ORAL TABLET 15 MG (<i>rivaroxaban</i>)	2	QL (52 tablets per month initial 1 tablet per day for maintenance.)
XARELTO ORAL TABLET 2.5 MG (<i>rivaroxaban</i>)	2	QL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG (<i>rivaroxaban</i>)	2	QL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	2	QL (51 tablets per year.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
<i>dabigatran etexilate mesylate oral capsule 110 mg</i>	1	QL (2 tablets per day.)
<i>dabigatran etexilate mesylate oral capsule 150 mg, 75 mg</i>	1	QL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (<i>dabigatran etexilate mesylate</i>)	3/4	PA; QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (<i>dabigatran etexilate mesylate</i>)	3/4	PA; QL (2 packets per day.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (<i>eltrombopag choline</i>)	3/4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	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 (<i>darbepoetin alfa</i>)	2	QL (4 vials per month)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month)
DOPTELET ORAL TABLET 20 MG (<i>avatrombopag maleate</i>)	3/4	PA; QL (60 tablets per month.)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (<i>avatrombopag maleate</i>)	3/4	PA; QL (60 capsules per month.)
<i>eltrombopag olamine oral packet 12.5 mg, 25 mg</i>	1	PA; QL (6 packets per day.)
<i>eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg</i>	1	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (<i>sargramostim</i>)	2	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (<i>plerixafor</i>)	3/4	
MULPLETA ORAL TABLET 3 MG (<i>lusutrombopag</i>)	3/4	PA; QL (7 tablets per prescription.)
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim</i>)	2	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	2	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	2	
<i>plerixafor subcutaneous solution 24 mg/1.2ml</i>	1	
PROMACTA ORAL PACKET 12.5 MG, 25 MG (<i>eltrombopag olamine</i>)	3/4	PA; QL (6 packets per day.)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (4 ml per 21 days.)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	2	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	2	
VAFSEO ORAL TABLET 150 MG, 300 MG (<i>vadadustat</i>)	3/4	PA; QL (31 tablets per month.)
XOLREMDI ORAL CAPSULE 100 MG (<i>mavorixafor</i>)	2	PA; QL (120 capsules per month.); SP; SMCS
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	2	
HEMORRHEOLOGIC AGENTS - Drugs for Blood Flow		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	1	
HEMOSTATICS - Drugs to Prevent Bleeding		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	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 (<i>antihemophil fact single chain</i>)	3/4	
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor-vwf</i>)	2	
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>coagulation factor ix</i>)	2	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>coagulation factor ix (rfixfc)</i>)	3	
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact fc-vwf-xten-eh1</i>)	3/4	
<i>aminocaproic acid oral solution 0.25 gm/ml</i>	1	
<i>aminocaproic acid oral tablet 1000 mg, 500 mg</i>	1	
ASTRINGYN EXTERNAL SOLUTION 259 MG/GM (<i>ferric subsulfate</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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-rfviiiic))	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.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (coagulation factor ix (rix-fp))	3	
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (ahf (bdd-rfviii peg-aucl))	3/4	
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; QL (0.2 mL (1 vial) per month.)
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (fitusiran sodium)	3/4	PA; QL (0.5 mL (1 pen) per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml</i>	1	QL (24 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	1	QL (15 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	1	QL (12 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	1	QL (18 ml (30 syringes) per prescription)
IRON PREPARATIONS - Vitamins and Minerals		
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	3/4	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	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 (<i>prenatal vit-fe fumarate-fa</i>)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
NESTABS ORAL TABLET 32-1 MG (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (<i>prenatal multivit-min-fe-fa</i>)	3	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
<i>prenatal oral tablet 27-1 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (<i>prenatal-feaspgly-methylfol-fa</i>)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fechn-feasp-meth-fa-dha</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	3/4	
TRINATE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<i>prenat-fe poly-methfol-fa-dha</i>)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
<i>cyanocobalamin nasal solution 500 mcg/0.1ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
<i>clopidogrel bisulfate oral tablet 300 mg, 75 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>ft aspirin oral tablet chewable 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	E	H
<i>ticagrelor oral tablet 60 mg, 90 mg</i>	1	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (<i>vorapaxar sulfate</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	1	
THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>ft aspirin oral tablet chewable 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	E	H
VON WILLEBRAND FACTOR-RELATED ANTITHROMB - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (<i>caplacizumab-yhdp</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; QL (0.6 ml per day.); SMCS
CARBONIC ANHYDRASE INHIBITORS (24:36)		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<i>dichlorphenamide oral tablet 50 mg</i>	1	PA; QL (4 tablets per day.)
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
FACTOR XIIA INHIBITORS		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (<i>garadacimab-gxii</i>)	2	PA; QL (1 auto-injector per month.)
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SP; SMCS
LOOP DIURETICS (24:36)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (<i>bumetanide</i>)	3/4	PA; QL (12 nasal sprays per copay.)
<i>ethacrynic acid oral tablet 25 mg</i>	1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (<i>furosemide</i>)	3/4	PA
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (<i>furosemide</i>)	3/4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
OSMOTIC DIURETICS (24:36)		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 II RECEPTOR ANTAGONISTS - Drugs for the Heart		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	1	
ARBLI ORAL SUSPENSION 10 MG/ML (<i>losartan potassium</i>)	3/4	PA
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	1	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (<i>sacubitril-valsartan</i>)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	1	
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	1	PA; QL (2 tablets per day.)
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	1	
<i>valsartan oral solution 4 mg/ml</i>	1	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	
ANGIOTENSIN-CONVERT.ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (<i>benazepril hcl</i>)	3/4	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	1	
QBRELIS ORAL SOLUTION 1 MG/ML (<i>lisinopril</i>)	3/4	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	1	
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	3	
LANOXIN ORAL TABLET 62.5 MCG (<i>digoxin</i>)	3/4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (<i>lomitapide mesylate</i>)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 30 MG (<i>lomitapide mesylate</i>)	3/4	PA; QL (62 capsules per month.)
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; QL (1 tablet per day.)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	1	
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	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		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (5 ml per prescription.)
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	3/4	
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	
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
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, 50 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>prevalite oral powder 4 gm/dose</i>	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (<i>cholestyramine light</i>)	3/4	
QUESTRAN ORAL PACKET 4 GM (<i>cholestyramine</i>)	3/4	
QUESTRAN ORAL POWDER 4 GM/DOSE (<i>cholestyramine</i>)	3/4	
CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	3/4	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	3/4	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	1	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure & Angina		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (<i>acoramidis hcl</i>)	2	PA; QL (124 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>mavacamten</i>)	3/4	PA; QL (1 capsule per day.)
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	3	PA; QL (2 tablets per day.)
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.)
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	1	
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.)
CARDIOTONIC AGENTS - Drugs for Angina		
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	3	PA; QL (2 tablets per day.)
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.)
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	3	
LANOXIN ORAL TABLET 62.5 MCG (<i>digoxin</i>)	3/4	
CENTRAL ALPHA-AGONISTS - Drugs for Abnormal Heart Rhythms		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3/4	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
JAVADIN ORAL SOLUTION 0.02 MG/ML (<i>clonidine hcl</i>)	3/4	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3/4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	1	PA
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	3/4	PA
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
CGMP SYNTHESIS AGENT - Drugs for High Blood Pressure & Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>vericiguat</i>)	3/4	PA; QL (1 tablet per day.)
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
<i>ezetimibe oral tablet 10 mg</i>	1	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; QL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (<i>disopyramide phosphate</i>)	2	
NORPACE ORAL CAPSULE 100 MG, 150 MG (<i>disopyramide phosphate</i>)	3/4	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
CLASS IB ANTIARRHYTHMICS - Drugs for Angina		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (<i>phenytoin sodium extended</i>)	3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (<i>phenytoin</i>)	3	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	1	
<i>phenytek oral capsule 200 mg, 300 mg</i>	1	
<i>phenytoin infatabs oral tablet chewable 50 mg</i>	1	
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin oral tablet chewable 50 mg</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	
CLASS IC ANTIARRHYTHMICS - Drugs for Angina		
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	1	
CLASS II ANTIARRHYTHMICS - Drugs for Angina		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (5 ml per prescription.)
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	
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
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, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	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	PA
timolol hemihydrate ophthalmic solution 0.5 %	1	QL (5 ml per prescription.)
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3/4	
CLASS III ANTIARRHYTHMICS - Drugs for Angina		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3/4	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	1	
MULTAQ ORAL TABLET 400 MG (<i>dronedarone hcl</i>)	3/4	PA
PACERONE ORAL TABLET 100 MG (<i>amiodarone hcl</i>)	3	
PACERONE ORAL TABLET 200 MG (<i>amiodarone hcl</i>)	3/4	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	3/4	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (<i>dofetilide</i>)	3/4	
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (<i>etripamil</i>)	3/4	PA; QL (1 box (2 bottles) per copay.)
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	3/4	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>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</i>	1	
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	1	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg</i>	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	3/4	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	1	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg</i>	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	3/4	
DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	1	
EDEX (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	1	PA
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	1	
DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
FIBRIC ACID DERIVATIVES - Drugs for Cholesterol		
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	1	
<i>fenofibrate oral capsule 134 mg, 200 mg, 67 mg</i>	1	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	1	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	1	
<i>gemfibrozil oral tablet 600 mg</i>	1	
LOPID ORAL TABLET 600 MG (<i>gemfibrozil</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (<i>atorvastatin calcium</i>)	3/4	PA
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1	H-N
<i>atorvastatin calcium oral tablet 40 mg, 80 mg</i>	1	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (<i>rosuvastatin calcium</i>)	3	PA
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	1	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3/4	PA
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	1	
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	1	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	1	H
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	H-N
<i>simvastatin oral tablet 80 mg</i>	1	
LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
<i>ethacrynic acid oral tablet 25 mg</i>	1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (<i>furosemide</i>)	3/4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3/4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KERENDIA ORAL TABLET 10 MG, 20 MG (<i>finerenone</i>)	3/4	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (<i>finerenone</i>)	3/4	PA; QL (30 tablets per month.)
<i>spironolactone oral suspension 25 mg/5ml</i>	1	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3/4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (<i>lomitapide mesylate</i>)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 2 MG (<i>lomitapide mesylate</i>)	3/4	PA
JUXTAPID ORAL CAPSULE 30 MG (<i>lomitapide mesylate</i>)	3/4	PA; QL (62 capsules per month.)
NITRATES AND NITRITES - Drugs for High Blood Pressure & Angina		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3/4	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	1	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3/4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>nitro-bid transdermal ointment 2 %</i>	1	
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 (<i>nitroglycerin</i>)	3	
<i>nitroglycerin rectal ointment 0.4 %</i>	1	QL (30 grams per month.)
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	1	
<i>nitroglycerin transdermal ointment 2 %</i>	1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (<i>nitroglycerin</i>)	3/4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (<i>nitroglycerin</i>)	3	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
RECTIV RECTAL OINTMENT 0.4 % (<i>nitroglycerin</i>)	3/4	QL (30 grams per month.)
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	3/4	PA
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NITRATES AND NITRITES - Drugs for the Heart		
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	1	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	
<i>nitro-bid transdermal ointment 2 %</i>	1	
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 (<i>nitroglycerin</i>)	3	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	1	
<i>nitroglycerin transdermal ointment 2 %</i>	1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (<i>nitroglycerin</i>)	3/4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (<i>nitroglycerin</i>)	3	
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	1	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	2	QL (2 syringes per 28 days.)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	2	QL (2 pens per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
<i>alyq oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
<i>avanafil oral tablet 100 mg, 200 mg, 50 mg</i>	1	PA; QL (3 tablets per month.)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg</i>	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	3/4	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.)
<i>varafenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	QL (3 tablets per month.)
<i>varafenafil hcl oral tablet dispersible 10 mg</i>	1	QL (3 tablets per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
<i>alyq oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>avanafil oral tablet 100 mg, 200 mg, 50 mg</i>	1	PA; QL (3 tablets per month.)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg</i>	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	3/4	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.)
<i>varafenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	QL (3 tablets per month.)
<i>varafenafil hcl oral tablet dispersible 10 mg</i>	1	QL (3 tablets per month.)
POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina		
<i>amiloride hcl oral tablet 5 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3/4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>triamterene oral capsule 100 mg, 50 mg</i>	1	
RENIN INHIBITORS - Drugs for the Heart		
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	1	
TEKTURNA ORAL TABLET 150 MG, 300 MG (<i>aliskiren fumarate</i>)	3	
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (<i>sacubitril-valsartan</i>)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3/4	PA; QL (1 tablet per day.)
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	1	PA; QL (2 tablets per day.)
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3/4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure & Angina		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina		
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	1	
VECAMYL ORAL TABLET 2.5 MG (<i>mecamylamine hcl</i>)	3/4	PA
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); SP; SMCS
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SP; SMCS
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	3	PA; QL (2 tablets per day.)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
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	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (nimodipine)	2	
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, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	3/4	PA; QL (6 tablets per day.)
tiadylt er oral capsule extended release 24 hour 120 mg, 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	3/4	
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X 64MCG, 112 X 48MCG & 112 X 64MCG (<i>treprostinil</i>)	2	PA; QL (224 cartridges per month.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>vericiguat</i>)	3/4	PA; QL (1 tablet per day.)
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (1 starter kit per year.)
<i>riluzole oral tablet 50 mg</i>	1	
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System		
ADAMANTANES (CNS) - Drugs for Parkinson		
<i>amantadine hcl oral capsule 100 mg</i>	1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
ADENOSINE A2A RECEPTOR ANTAGONISTS - Drugs for Parkinson		
NOURIANZ ORAL TABLET 20 MG, 40 MG (<i>istradefylline</i>)	3	PA; QL (1 tablet per day.)
AMPHETAMINES - Drugs for the Nervous System		
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	1	
<i>amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	1	QL (2 capsules per day.)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	1	QL (1 capsule per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	1	QL (5 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	1	QL (4 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	1	QL (10 capsules per day.)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	1	
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	1	QL (2 capsules per day.)
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	1	QL (1 capsule per day)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	1	QL (2 tablets per day.)
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>methamphetamine hcl oral tablet 5 mg</i>	1	
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	PA; QL (1 patch per day.)
ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	NTT
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	NTT
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	NTT
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (Benefit maximum quantity 6 per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg</i>	1	QL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	3/4	QL (6 capsules per day)
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml</i>	1	NTT
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	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	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (gabapentin)	3/4	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (gabapentin)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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
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	
APTOM 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
brivaracetam oral solution 10 mg/ml	1	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	1	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	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	3/4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	3/4	PA
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FELBATOL ORAL TABLET 400 MG, 600 MG (<i>felbamate</i>)	3/4	PA
FINTEPLA ORAL SOLUTION 2.2 MG/ML (<i>fenfluramine hcl</i>)	3/4	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (<i>perampanel</i>)	3/4	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (<i>perampanel</i>)	3	PA
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
KEPPRA ORAL SOLUTION 100 MG/ML (<i>levetiracetam</i>)	3/4	PA
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (<i>levetiracetam</i>)	3/4	PA
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (<i>levetiracetam</i>)	3/4	PA
<i>lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml</i>	1	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (<i>lamotrigine</i>)	3/4	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (<i>lamotrigine</i>)	3/4	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (<i>lamotrigine</i>)	3/4	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (<i>lamotrigine</i>)	3/4	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (<i>lamotrigine</i>)	3/4	PA
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (<i>lamotrigine</i>)	3	PA
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	1	
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	1	PA
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	PA
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	1	
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (pregabalin)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	3/4	PA
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (lacosamide)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (gabapentin)	3/4	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (gabapentin)	3/4	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (gabapentin)	3/4	PA
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
perampanel oral suspension 0.5 mg/ml	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
SUBVENITE ORAL SUSPENSION 10 MG/ML (lamotrigine)	3/4	
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (oxcarbazepine)	3/4	PA
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
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (cenobamate)	3	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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 (<i>cenobamate</i>)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (<i>zonisamide</i>)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	3/4	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	3/4	PA
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (<i>dextromethorphan-bupropion</i>)	3/4	QL (2 tablets per day.)
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	1	H
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	1	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3/4	PA; QL (12 devices (4 kits) per month.)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	2	PA; QL (28 capsules per year.)
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	2	PA; QL (14 capsules per year.)
ANTIMANIC AGENTS - Drugs for Personality Disorder		
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	1	QL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	3/4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	3/4	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	
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	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (lamotrigine)	3/4	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (lamotrigine)	3/4	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (lamotrigine)	3/4	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (lamotrigine)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (<i>lamotrigine</i>)	3	PA
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	1	
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	1	PA
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	1	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	1	PA
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	1	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	1	
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	1	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	
<i>lithium carbonate oral tablet 300 mg</i>	1	
<i>lithium oral solution 8 meq/5ml</i>	1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (<i>lithium carbonate</i>)	3/4	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	1	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg</i>	1	QL (1 capsule per day)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	1	
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>risperidone oral solution 1 mg/ml</i>	1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
SUBVENITE ORAL SUSPENSION 10 MG/ML (<i>lamotrigine</i>)	3/4	
<i>subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>subvenite starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	1	
<i>subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	3/4	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	3/4	
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	QL (7.5 ml (3 bottles) per prescription.)
CAFERGOT ORAL TABLET 1-100 MG (ergotamine-caffeine)	3/4	
caffeine citrate oral solution 60 mg/3ml	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (divalproex sodium)	3/4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	3/4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	3/4	PA
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	QL (8 mL per prescription.)
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	QL (5 tablets per prescription.)
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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	E	H
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (<i>topiramate</i>)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (<i>topiramate</i>)	3/4	PA
<i>topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg</i>	1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (<i>xanomeline-trospium chloride</i>)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (<i>xanomeline-trospium chloride</i>)	3/4	PA; QL (1 starter pack per year.)
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	1	
<i>pimozide oral tablet 1 mg, 2 mg</i>	1	
ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	3/4	QL (1 tablet per day.)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	3/4	PA; QL (1 capsule per day.)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
<i>ramelteon oral tablet 8 mg</i>	1	QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	1	PA; QL (1 capsule per day.)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	1	
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	1	
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	1	
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	1	QL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	1	QL (2 tablets per day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	1	QL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (<i>lumateperone tosylate</i>)	3/4	PA; QL (1 capsule per day.)
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	1	
CLOZARIL ORAL TABLET 100 MG, 25 MG (<i>clozapine</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FANAPT ORAL TABLET 1 MG (<i>iloperidone</i>)	3/4	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (<i>iloperidone</i>)	3/4	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (<i>iloperidone</i>)	3/4	QL (56 tablets per year.)
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG (<i>iloperidone</i>)	3	QL (8 tablets (1 pack) per 365 days.)
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG (<i>iloperidone</i>)	3/4	QL (1 pack (12 tablets) per 365 days.)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (<i>iloperidone</i>)	3/4	QL (2 pack (8 tablets) per 365 days.)
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg</i>	1	QL (1 tablet per day.)
<i>lurasidone hcl oral tablet 40 mg</i>	1	QL (1 tablet per day)
<i>lurasidone hcl oral tablet 80 mg</i>	1	QL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (<i>pimavanserin tartrate</i>)	3/4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (<i>pimavanserin tartrate</i>)	3/4	PA; QL (31 tablets per month.)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	1	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	1	QL (1 capsule per day)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	1	QL (1 tablet per day)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	1	QL (2 tablets per day)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	1	
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	1	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (<i>brexpiprazole</i>)	3/4	QL (1 tablet per day.)
<i>risperidone oral solution 1 mg/ml</i>	1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
VRAYLAR ORAL CAPSULE 0.5 MG (<i>cariprazine hcl</i>)	3/4	QL (60 capsules per month.)
VRAYLAR ORAL CAPSULE 0.75 MG (<i>cariprazine hcl</i>)	3/4	QL (30 capsules per month.)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	3/4	QL (1 capsule per day.)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures		
MYSOLINE ORAL TABLET 250 MG, 50 MG (<i>primidone</i>)	2	PA
<i>phenobarbital oral elixir 20 mg/5ml</i>	1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1	
<i>primidone oral tablet 125 mg</i>	1	PA
<i>primidone oral tablet 250 mg, 50 mg</i>	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (Benefit maximum quantity 6 per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg</i>	1	QL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
FIORICET ORAL CAPSULE 50-300-40 MG (<i>butalbital-apap-caffeine</i>)	3/4	QL (6 capsules per day)
<i>phenobarbital oral elixir 20 mg/5ml</i>	1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1	
TENCON ORAL TABLET 50-325 MG (<i>butalbital-acetaminophen</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
<i>clobazam oral suspension 2.5 mg/ml</i>	1	PA
<i>clobazam oral tablet 10 mg, 20 mg</i>	1	PA
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	1	
<i>diazepam intensol oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	1	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	1	QL (1 box (2 doses/box) per prescription)
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	3	PA; QL (1 box per prescription.)
ONFI ORAL SUSPENSION 2.5 MG/ML (<i>clobazam</i>)	3/4	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	3/4	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	3/4	PA
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
BENZODIAZEPINES (ANXIOLYTIC, SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>alprazolam intensol oral concentrate 1 mg/ml</i>	1	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	1	
<i>clobazam oral suspension 2.5 mg/ml</i>	1	PA
<i>clobazam oral tablet 10 mg, 20 mg</i>	1	PA
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	1	
<i>diazepam intensol oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	1	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	1	QL (1 box (2 doses/box) per prescription)
<i>estazolam oral tablet 1 mg, 2 mg</i>	1	
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	1	
HALCION ORAL TABLET 0.25 MG (<i>triazolam</i>)	3/4	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>midazolam hcl oral syrup 2 mg/ml</i>	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	3	PA; QL (1 box per prescription.)
ONFI ORAL SUSPENSION 2.5 MG/ML (<i>clobazam</i>)	3/4	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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. 8 tablets per prescription.)
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.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (zavegepant hcl)	3/4	PA; QL (6 mg per prescription.)
CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson		
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	1	
entacapone oral tablet 200 mg	1	
tolcapone oral tablet 100 mg	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	1	
ADDYI ORAL TABLET 100 MG (<i>flibanserin</i>)	3/4	PA; QL (1 tablet per day.)
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	1	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	1	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	1	QL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	1	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (<i>trofinetide</i>)	2	PA; QL (120 ml per day.)
DAYBUE STIX ORAL PACKET 5000 MG, 6000 MG, 8000 MG (<i>trofinetide</i>)	2	PA; QL (120 packets per month.)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (<i>sodium oxybate</i>)	3/4	PA; QL (1 packet per day.)
LYNKUET ORAL CAPSULE 60 MG (<i>elinzanetant</i>)	3/4	PA; QL (60 capsules per month.)
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg</i>	1	
NOURIANZ ORAL TABLET 20 MG, 40 MG (<i>istradefylline</i>)	3	PA; QL (1 tablet per day.)
NUEDEXTA ORAL CAPSULE 20-10 MG (<i>dextromethorphan-quinidine</i>)	2	PA; QL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (1 starter kit per year.)
<i>riluzole oral tablet 50 mg</i>	1	
<i>sodium oxybate oral solution 500 mg/ml</i>	3/4	PA; QL (18 ml per day.); SP; SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA
VEOZAH ORAL TABLET 45 MG (<i>fezolinetant</i>)	3/4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (<i>bremelanotide acetate</i>)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.)
XYWAV ORAL SOLUTION 500 MG/ML (<i>ca, mg, k, and na oxybates</i>)	3/4	PA; QL (18 mL per day.); SP; SMCS
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	1	
VYSCOXIA ORAL SUSPENSION 10 MG/ML (<i>celecoxib</i>)	3/4	PA
DIBENZOXAPINES - Drugs for Depression & Psychosis		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
DIHYDROINDOLONES - Drugs for Depression & Psychosis		
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	1	
DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis		
<i>pimozide oral tablet 1 mg, 2 mg</i>	1	
DOPAMINE PRECURSORS - Drugs for Parkinson		
<i>carbidopa oral tablet 25 mg</i>	1	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>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</i>	1	
CREXONT ORAL CAPSULE EXTENDED RELEASE 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG (<i>carbidopa-levodopa</i>)	3/4	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (<i>carbidopa-levodopa</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INBRIJA INHALATION CAPSULE 42 MG (<i>levodopa</i>)	3	PA; QL (10 tablets per day.)
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (<i>carbidopa-levodopa</i>)	3/4	
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson		
<i>bromocriptine mesylate oral capsule 5 mg</i>	1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	1	
<i>cabergoline oral tablet 0.5 mg</i>	1	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (<i>pregabalin</i>)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	3/4	PA
<i>milnacipran hcl oral 12.5 & 25 & 50 mg</i>	1	QL (1 pack per 365 days.)
<i>milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	QL (2 tablets per day)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	1	
<i>pregabalin oral solution 20 mg/ml</i>	1	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	3/4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	3/4	QL (1 pack per 365 days.)
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (<i>cyclobenzaprine hcl (fibromy)</i>)	3/4	PA; QL (60 sublingual tablets per month.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	3/4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	3/4	PA
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (<i>stiripentol</i>)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (<i>stiripentol</i>)	3	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (<i>pregabalin</i>)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	3/4	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (<i>gabapentin</i>)	3/4	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (<i>gabapentin</i>)	3/4	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (<i>gabapentin</i>)	3/4	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	1	
<i>pregabalin oral solution 20 mg/ml</i>	1	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<i>vigabatrin oral packet 500 mg</i>	1	PA; QL (6 packets per day.); SP; SMCS
<i>vigabatrin oral tablet 500 mg</i>	1	PA; QL (6 tablets per day.); SP; SMCS
VIGADRONE ORAL PACKET 500 MG (<i>vigabatrin</i>)	1	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (<i>vigabatrin</i>)	1	PA; QL (6 tablets per day.); SP; SMCS
VIGAFYDE ORAL SOLUTION 100 MG/ML (<i>vigabatrin</i>)	1	PA; QL (900 mL per month.); SP; SMCS
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	3/4	PA
HYDANTOINS - Drugs for Seizures		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ORAL CAPSULE 100 MG, 30 MG (<i>phenytoin sodium extended</i>)	3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (<i>phenytoin</i>)	3	
<i>phenytek oral capsule 200 mg, 300 mg</i>	1	
<i>phenytoin infatabs oral tablet chewable 50 mg</i>	1	
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin oral tablet chewable 50 mg</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	
INHALATION ANESTHETICS - Anesthetics		
FORANE INHALATION SOLUTION (<i>isoflurane</i>)	2	
<i>isoflurane inhalation solution</i>	1	
<i>sevoflurane inhalation solution</i>	1	
<i>terrell inhalation solution</i>	1	
ULTANE INHALATION SOLUTION (<i>sevoflurane</i>)	3	
ION CHANNEL INHIBITION AGENTS - Drugs for Seizures		
APTiom ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (<i>eslicarbazepine acetate</i>)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (<i>rufinamide</i>)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (<i>rufinamide</i>)	3/4	PA
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	1	PA
<i>lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml</i>	1	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (<i>lacosamide</i>)	3	PA
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	1	
<i>rufinamide oral suspension 40 mg/ml</i>	1	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	1	PA
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (<i>oxcarbazepine</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 TABLET 150 MG, 300 MG, 600 MG (<i>oxcarbazepine</i>)	3/4	PA
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>lacosamide</i>)	3/4	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (<i>cenobamate</i>)	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 (<i>cenobamate</i>)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (<i>zonisamide</i>)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	3/4	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
MELATONIN RECEPTOR AGONISTS - Drugs for Anxiety & Sleep Disorder		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	3/4	PA; QL (1 capsule per day.)
<i>ramelteon oral tablet 8 mg</i>	1	QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	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 (<i>selegiline</i>)	3	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	1	
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (<i>selegiline hcl</i>)	3	
MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (<i>selegiline</i>)	3	
MARPLAN ORAL TABLET 10 MG (<i>isocarboxazid</i>)	3	
NARDIL ORAL TABLET 15 MG (<i>phenelzine sulfate</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PARNATE ORAL TABLET 10 MG (<i>tranylcypromine sulfate</i>)	3/4	
<i>phenelzine sulfate oral tablet 15 mg</i>	1	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	1	
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (<i>selegiline hcl</i>)	3	
NMDA ANTAGONISTS - Drugs for Depression & Psychosis		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3/4	PA; QL (12 devices (4 kits) per month.)
NON-BENZODIAZEPINE ANXIOLYTICS - Drugs for Anxiety & Sleep Disorder		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	
NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	1	
<i>zaleplon oral capsule 10 mg, 5 mg</i>	1	
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	1	
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	1	
NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (<i>apomorphine hcl</i>)	3/4	PA; QL (3 ml per day.)
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	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 (<i>rotigotine</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	
NON-OPIOID ANALGESICS - Drugs for Pain		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	NTT
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	NTT
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	NTT
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (Benefit maximum quantity 6 per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg</i>	1	QL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (<i>butalbital-apap-caffeine</i>)	3/4	QL (6 capsules per day)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml</i>	1	NTT
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
TENCON ORAL TABLET 50-325 MG (<i>butalbital-acetaminophen</i>)	3	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (<i>apap-caff-dihydrocodeine</i>)	3	NTT

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC - Drugs for Pain		
<i>diclofenac potassium oral tablet 50 mg</i>	1	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	1	
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	1	
<i>diflunisal oral tablet 500 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	1	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	1	
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	NTT
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>indomethacin er oral capsule extended release 75 mg</i>	1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	1	PA
<i>indomethacin rectal suppository 50 mg</i>	1	PA
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	1	
<i>mefenamic acid oral capsule 250 mg</i>	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>oxaprozin oral tablet 600 mg</i>	1	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3/4	QL (5 bottles per prescription.)
<i>sulindac oral tablet 150 mg, 200 mg</i>	1	
OPIOID AGONISTS (28:08) - Drugs for Pain		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	NTT
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	NTT
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	NTT
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>belladonna alkaloids-opium rectal suppository 16.2-60 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (Benefit maximum quantity 6 per day.)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	1	NTT
<i>diskets oral tablet soluble 40 mg</i>	1	QL (1.5 tablets per day.)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	1	PA; QL (0.34 patches per day.)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	1	PA; QL (15 patches per 31 days.)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	1	PA; QL (2 capsules per day.)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg</i>	1	PA; QL (0 tablets per 100 days, diagnosis review required.)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	1	PA; QL (1 tablet per day.)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml</i>	1	NTT
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	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 100 days, diagnosis review required.)
hydromorphone hcl oral liquid 1 mg/ml	1	NTT
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	NTT
hydromorphone hcl rectal suppository 3 mg	1	NTT
levorphanol tartrate oral tablet 2 mg, 3 mg	1	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.)
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, diagnosis review required.)
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.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg</i>	1	PA; QL (0 capsules per 100 days, diagnosis review required.)
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg</i>	1	PA; QL (93 tablets per 31 days.)
<i>morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml</i>	1	NTT
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	1	NTT
<i>morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i>	1	NTT
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (<i>tapentadol hcl</i>)	3	PA; QL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (<i>tapentadol hcl</i>)	3	PA; QL (0 capsules per 100 days, diagnosis review required.)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (<i>tapentadol hcl</i>)	3/4	QL (6 tablets per day); NTT
<i>opium oral tincture 10 mg/ml (1%)</i>	1	
<i>oxycodone hcl oral capsule 5 mg</i>	1	NTT
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	1	NTT
<i>oxycodone hcl oral solution 5 mg/5ml</i>	1	NTT
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	1	NTT
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg</i>	1	PA; QL (2 tablets per day.)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg</i>	1	PA; QL (0 tablet per 100 days.)
<i>oxymorphone hcl oral tablet 10 mg, 5 mg</i>	1	QL (6 tablets per day.); NTT
<i>tapentadol hcl oral tablet 100 mg, 50 mg, 75 mg</i>	1	QL (6 tablets per day); NTT
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour 200 mg, 300 mg</i>	1	QL (1 tablet per day)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	1	QL (1 tablet per day)
<i>tramadol hcl oral tablet 50 mg</i>	1	NTT

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (<i>apap-caff-dihydrocodeine</i>)	3	NTT
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (<i>oxycodone</i>)	3/4	PA; QL (2 tablets per day.)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (<i>oxycodone</i>)	3/4	PA; QL (0 capsules per 100 days, diagnosis review required.)
<i>xyvona oral tablet 2 mg, 3 mg</i>	1	QL (4 tablets per day.); NTT
OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	1	
<i>ft naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (<i>nalmefene hcl</i>)	1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	1	NTT
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	SM
REZENOPY NASAL LIQUID 10 MG/0.11ML (<i>naloxone hcl</i>)	3/4	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	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 (<i>buprenorphine hcl-naloxone hcl</i>)	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (<i>nalmefene hcl</i>)	1	QL (2 auto-injector pens per copay per prescription.)
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (<i>buprenorphine hcl</i>)	3	PA; QL (2 Films per day.)
BELBUCA BUCCAL FILM 750 MCG (<i>buprenorphine hcl</i>)	3	PA; QL (2 films per day.)
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	1	
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr</i>	1	PA; QL (4 patches per 28 days.)
<i>buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr</i>	1	PA; QL (4 patches per month.)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	1	QL (7.5 ml (3 bottles) per prescription.)
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	1	NTT
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	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 (<i>buprenorphine hcl-naloxone hcl</i>)	1	
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	3/4	QL (1 tablet per day.)
PHENOTHIAZINES - Drugs for Depression & Psychosis		
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	1	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>chlorpromazine hcl oral tablet 10 mg, 25 mg</i>	1	QL (6 tablets per day.)
<i>chlorpromazine hcl oral tablet 100 mg, 50 mg</i>	1	QL (4 tablets per day.)
<i>chlorpromazine hcl oral tablet 200 mg</i>	1	QL (2 tablets per day.)
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	1	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	1	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System		
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	NTT
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	1	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	1	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	1	QL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	1	QL (2 capsules per day)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (<i>serdexmethylphen-dexmethylphen</i>)	3	QL (1 capsule per day.)
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (Benefit maximum quantity 6 per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg</i>	1	QL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
CAFERGOT ORAL TABLET 1-100 MG (<i>ergotamine-caffeine</i>)	3/4	
<i>caffeine citrate oral solution 60 mg/3ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (methylphenidate hcl)	3	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 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.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>methylphenidate hcl er(diffus) oral tablet extended release 27 mg, 36 mg, 54 mg</i>	1	QL (2 tablets per day.)
<i>methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	1	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG (<i>apap-caff-dihydrocodeine</i>)	3	NTT
REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	3/4	
<i>diclofenac sodium external gel 3 %</i>	1	PA; QL (100 grams per prescription.)
<i>diflunisal oral tablet 500 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	1	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	1	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	1	
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	NTT

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>indomethacin er oral capsule extended release 75 mg</i>	1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	1	PA
<i>indomethacin rectal suppository 50 mg</i>	1	PA
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	1	
<i>mefenamic acid oral capsule 250 mg</i>	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>oxaprozin oral tablet 600 mg</i>	1	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3/4	QL (5 bottles per prescription.)
<i>sulindac oral tablet 150 mg, 200 mg</i>	1	
SALICYLATES - Drugs for Pain		
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>ft aspirin oral tablet chewable 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
<i>salsalate oral tablet 500 mg, 750 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	E	H
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (<i>duloxetine hcl</i>)	3/4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (<i>duloxetine hcl</i>)	3/4	QL (1 capsule per day.)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (<i>levomilnacipran hcl</i>)	3/4	QL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (<i>levomilnacipran hcl</i>)	3/4	QL (28 capsules per year.)
<i>milnacipran hcl oral 12.5 & 25 & 50 mg</i>	1	QL (1 pack per 365 days.)
<i>milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	3/4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	3/4	QL (1 pack per 365 days.)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	1	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
SELECTIVE SEROTONIN AGONISTS - Migraine Treatment		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	1	QL (10 tablets per copay.)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	1	QL (10 tablets per copay.)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	1	QL (10 tablets per copay.)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	1	QL (10 per prescription.)
REYVOW ORAL TABLET 100 MG (<i>lasmiditan succinate</i>)	3/4	PA; QL (0.27 tablets per day. 8 tablets per prescription.)
REYVOW ORAL TABLET 50 MG (<i>lasmiditan succinate</i>)	3/4	PA; QL (0.14 tablets per day. Benefit maximum quantity 4 tablets per prescription.)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	1	QL (10 tablets per copay.)
<i>rizatriptan benzoate oral tablet dispersible 10 mg</i>	1	QL (10 per prescription.)
<i>rizatriptan benzoate oral tablet dispersible 5 mg</i>	1	QL (10 tablets per copay.)
<i>sumatriptan nasal solution 20 mg/act, 5 mg/act</i>	1	QL (6 spray bottles per prescription)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	1	QL (10 tablets per prescription.)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	1	QL (2 kits per prescription)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	1	QL (2 kits per prescription)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	1	QL (10 tablets per copay.)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	1	QL (10 tablets per copay.)
ZOMIG NASAL SOLUTION 2.5 MG (<i>zolmitriptan</i>)	3	QL (6 units per prescription.)
ZOMIG NASAL SOLUTION 5 MG (<i>zolmitriptan</i>)	1	QL (1 box per prescription)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	1	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	1	
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	1	QL (4 capsules per 28 days.)
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	1	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg</i>	1	
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	1	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	1	QL (1 capsule per day)
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	1	
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	1	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	1	
SEROTONIN MODULATORS - Drugs for Depression & Psychosis		
EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG (<i>gepirone hcl</i>)	3/4	
EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG (<i>gepirone hcl</i>)	3/4	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	1	
RALDESY ORAL SOLUTION 10 MG/ML (<i>trazodone hcl</i>)	3/4	PA
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (<i>vortioxetine hbr</i>)	3/4	QL (1 tablet per day.)
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (<i>methsuximide</i>)	3/4	
<i>ethosuximide oral capsule 250 mg</i>	1	
<i>ethosuximide oral solution 250 mg/5ml</i>	1	
<i>methsuximide oral capsule 300 mg</i>	1	
ZARONTIN ORAL CAPSULE 250 MG (<i>ethosuximide</i>)	3/4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (<i>ethosuximide</i>)	3/4	
THIOXANTHENES - Drugs for Depression & Psychosis		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	1	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl external cream 5 %</i>	1	PA; QL (45 grams per prescription.)
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (<i>desipramine hcl</i>)	3/4	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	1	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	1	
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (<i>deutetrabenazine</i>)	2	PA; QL (4 tablets per day.)
AUSTEDO ORAL TABLET 6 MG (<i>deutetrabenazine</i>)	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 (<i>deutetrabenazine</i>)	2	PA; QL (30 tablets per month.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (<i>deutetrabenazine</i>)	2	PA; QL (30 Tablets per month.)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (<i>deutetrabenazine</i>)	2	PA; QL (1 kit (28 tablets) per year.)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (1 capsule per day.)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	2	PA; QL (30 tablets per month.)
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (30 capsules per month.)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (1 kit (28 tablets) per year.)
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	1	PA; SP; SMCS
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
<i>armodafinil oral tablet 150 mg, 250 mg</i>	1	QL (1 tablet per day)
<i>armodafinil oral tablet 200 mg</i>	1	QL (1 tablet per day.)
<i>armodafinil oral tablet 50 mg</i>	1	QL (2 tablets per day.)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (<i>sodium oxybate</i>)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	3/4	PA; QL (1 box (28 packets) per year.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>modafinil oral tablet 100 mg, 200 mg</i>	1	QL (3 tablets per day.)
<i>sodium oxybate oral solution 500 mg/ml</i>	3/4	PA; QL (18 ml per day.); SP; SMCS
SUNOSI ORAL TABLET 150 MG, 75 MG (<i>solriamfetol hcl</i>)	2	PA; QL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (<i>pitolisant hcl</i>)	3/4	PA; QL (2 tablets per day.)
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3/4	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (<i>stannous fluoride</i>)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (<i>sodium fluoride-vitamin d</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (<i>stannous fluoride</i>)	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (<i>sodium fluoride</i>)	3	
<i>sf 5000 plus dental cream 1.1 %</i>	1	
<i>sf dental gel 1.1 %</i>	1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	1	
<i>sodium fluoride dental cream 1.1 %</i>	1	
<i>sodium fluoride dental gel 1.1 %</i>	1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	3/4	
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	
FLOTREX ORAL TABLET CHEWABLE 1 MG (pediatric multivitamins-fl)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (stannous fluoride)	3	
FLUORIDEX DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ENAMEL PROTECT DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (<i>sodium fluoride</i>)	3	
<i>sf 5000 plus dental cream 1.1 %</i>	1	
<i>sf dental gel 1.1 %</i>	1	
<i>sod fluoride-potassium nitrate dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 enamel dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental paste 1.1 %</i>	1	
<i>sodium fluoride 5000 sensitive dental gel 1.1-5 %</i>	1	
<i>sodium fluoride dental cream 1.1 %</i>	1	
<i>sodium fluoride dental gel 1.1 %</i>	1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	1	H
<i>sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	1	H
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DEVICES - Medical Supplies and Durable Medical Equipment		
DEVICES - Medical Supplies and Durable Medical Equipment		
ACCU-CHEK AVIVA IN VITRO SOLUTION (<i>blood glucose calibration</i>)	1	
ACCU-CHEK FASTCLIX LANCET KIT KIT (<i>lancets misc.</i>)	1	
ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	
ACCU-CHEK GUIDE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	2	
ACCU-CHEK GUIDE ME KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	2	
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (<i>blood glucose calibration</i>)	1	
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT (<i>lancets misc.</i>)	1	
ADVANTAGE SAFETY LANCETS 28G	3	
ADVOCATE SAFETY LANCETS 21G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 23G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 28G (<i>lancets</i>)	3	
AEROCHAMBER HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
AEROCHAMBER2GO ANTI-STATIC DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ALCOHOL PREP PADS SHEET 70 %	3	
AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	QL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
ASSURE CONTROL SOLUTION 2/3 IN VITRO LIQUID (blood glucose calibration)	2	
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM	2	QL (10 pen needles per day.)
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	QL (10 pen needles per day.)
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	QL (1 device per prescription.)
AUTOLET LITE LANCING DEVICE (lancet devices)	3	QL (1 device per prescription.)
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
BD BLUNT FILL NEEDLE 18G X 1" (needle (disp))	2	
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (needle (disp))	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (needle (disp))	2	
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (insulin pen needle)	2	QL (10 pen needles per day.)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
BD SAFETYGLIDE NEEDLE 23G X 1-1/2" (<i>needle (disp)</i>)	2	
BD SHARPS COLLECTOR (<i>sharps container</i>)	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 (<i>insulin syringe-needle u-100</i>)	2	QL (10 syringes per day.)
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (<i>insulin syringe/needle u-500</i>)	2	QL (10 syringes per day.)
BD ULTRA-FINE PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	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 (<i>insulin syringe-needle u-100</i>)	2	QL (10 syringes per day.)
BIGFOOT UNITY PROGRAM KIT (<i>blood glucose monitoring suppl</i>)	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 1-1/2" , 25G X 5/8"	2	
CAREPOINT POLY HUB NEEDLE 21G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 22G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 27G X 1/2"	2	
CAREPOINT PRECISION POLY HUB 23G X 1" (<i>needle (disp)</i>)	2	
CAREPOINT PRECISION POLY HUB 25G X 5/8"	2	
CAREPOINT SAFETY 1ST NEEDLE 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8"	2	
CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION (<i>blood glucose calibration</i>)	2	
CARESENS LANCETS 30G (<i>lancets</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CARESENS S CONTROL SOLN A/B IN VITRO LIQUID (blood glucose calibration)	3	
CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID (blood glucose calibration)	3	
CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" (needle (disp))	2	
CARETOUCH LANCING/EJECTOR (lancet devices)	3	QL (1 device per prescription.)
CEQUR SIMPLICITY 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	QL (1 device per prescription.)
CHOSEN SAFETY LANCETS 28G (lancets)	3	
CLEVER CHOICE COMFORT EZ (lancets)	3	
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
COMFORT TOUCH TWIST LANCET 30G (lancets)	3	
CONTOUR CONTROL IN VITRO LIQUID HIGH (blood glucose calibration)	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (blood glucose calibration)	2	
CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (blood glucose calibration)	2	
CONTOUR NEXT EZ KIT W/DEVICE (blood glucose monitoring suppl)	1	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CONTOUR NEXT ONE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	SM
CONTOUR PLUS BLUE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	2	
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (3 sensors per month.); SM
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.); SM
DEXCOM G7 15 DAY SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per month.); SM
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	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 (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
DROPSAFE ACTI-LANCE 23G (<i>lancets</i>)	3	
DROPSAFE AUTOPROTECT DUO 31G X 4 MM , 31G X 5 MM , 31G X 8 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
DROPSAFE MEDLANCE LANCET 30G (<i>lancets</i>)	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 (<i>insulin syringe-needle u-100</i>)	2	QL (10 syringes per day.)
DROPSAFE SICURA 25G X 1" , 25G X 5/8" (<i>needle (disp)</i>)	2	
EASIVENT (<i>spacer/aero-holding chambers</i>)	2	SM
EASY COMFORT SHARPS CONTAINER	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (insulin syringe/needle u-500)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBRACE WAVE GLUCOSE CONTROL IN VITRO LIQUID HIGH (blood glucose calibration)	2	
ENLITE GLUCOSE SENSOR (continuous glucose sensor)	3	PA; SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FLEXICHAMBER ADULT MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	2	SM
FLEXICHAMBER CHILD MASK/LARGE (<i>spacer/aero-hold chamber mask</i>)	2	SM
FLEXICHAMBER CHILD MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	2	SM
FLEXICHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	QL (1 device per prescription.)
FONDCIRCLE SINGLE USE LANCETS	3	
FORA TEST N' GO ADVANCE DEVICE (<i>blood glucose/ketone monitor</i>)	3	
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 reader per 999 days.); SM
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
GUARDIAN 4 GLUCOSE SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per month.); SM
GUARDIAN 4 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 transmitter kit per year.); SM
GUARDIAN REAL-TIME CHARGER (<i>continuous glucose monitor sup</i>)	3	PA; SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GUARDIAN REAL-TIME TEST PLUG (<i>continuous glucose monitor sup</i>)	3	PA; SM
GUARDIAN SENSOR 3 (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per 24 days.); SM
HAN-EASE (<i>injection device</i>)	3	
IHEALTH CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	
IHEALTH LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
INPEN 100-BLUE-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-PINK-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INSPIREASE RESERVOIR BAGS (<i>spacer/aero-hold chamber bags</i>)	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 (<i>insulin pen needle</i>)	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 SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 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, 32G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	2	QL (10 syringes per day.)
INSULIN SYRINGES 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 29G X 5/16" 0.5 ML, 29G X 5/16" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	QL (10 syringes per day.)
INSUPEN32G EXTR3ME 32G X 6 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
KT TAPE CGM PATCH (<i>continuous glucose monitor sup</i>)	3	PA; SM
LANCETS (<i>lancets</i>)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (<i>lancets</i>)	3	
MICROLET NEXT LANCETS (<i>lancets</i>)	3	
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
MINIMED INSTINCT GLUC SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per month.); SM
MOBILE LANCETS 30G	3	
NORDIPEN 5 INJECTION DEVICE (<i>injection device</i>)	3	
NOVOFINE PEN NEEDLE 32G X 6 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
NOVOPEN ECHO DEVICE (<i>injection device for insulin</i>)	3	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 180 days.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (10 pods (2 boxes) per copay.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (10 pods per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 LIBRE2 G6 INTRO GEN5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 2 years.)
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	2	PA; QL (10 pods (2 boxes) per copay.)
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	1	QL (1 device per prescription.)
ONETOUCH DELICA SAFETY LANCING (<i>lancets</i>)	1	
ONETOUCH ULTRA IN VITRO LIQUID (<i>blood glucose calibration</i>)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (<i>blood glucose calibration</i>)	1	
PARI VORTEX ADULT MASK (<i>spacer/aero-hold chamber mask</i>)	2	SM
PARI VORTEX PEDIATRIC MASK (<i>spacer/aero-hold chamber mask</i>)	2	SM
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (RX)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (RX)	2	QL (10 pen needles per day.)
PERFECT POINT SAFETY LANCETS (<i>lancets</i>)	3	
PERFECT POINT SAFETY NEEDLE 25G X 1" (<i>needle (disp)</i>)	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	
PURE COMFORT SAFETY LANCET 30G	3	
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 33G X 8 MM (<i>insulin pen needle</i>)	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 (<i>lancets</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SENSILANCE SAFETY LANCETS 26G (<i>lancets</i>)	3	
SENSILANCE SAFETY LANCETS 28G (<i>lancets</i>)	3	
SHARPS COLLECTOR	3	
SHARPS CONTAINER	3	
SIMPLERA SYNC SENSOR (<i>continuous glucose sensor</i>)	3	PA; SM
SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)	2	QL (10 pen needles per day.)
TECHLITE LANCETS 26G (<i>lancets</i>)	3	
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	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 (<i>blood glucose calibration</i>)	2	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (<i>blood glucose calibration</i>)	2	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (<i>blood glucose calibration</i>)	2	
TWIST REFILL KIT KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per copay.)
TWIST REFILL KIT/INFUSION SET KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per copay.)
TWIST STARTER KIT KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 730 days.)
ULTRA-CARE SAFETY LANCETS 30G	3	
UNIFINE OTC PEN NEEDLES 31G X 5 MM , 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
UNISTRIIP CONTROL IN VITRO SOLUTION LOW (<i>blood glucose calibration</i>)	3	
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (<i>insulin pen needle</i>)	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 (<i>insulin syringe-needle u-100</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G (<i>lancets</i>)	3	
VERIFINE SAFE LANCET MINI 23G (<i>lancets</i>)	3	
VERIFINE SAFE LANCET MINI 28G (<i>lancets</i>)	3	
VERIFINE SAFE LANCET MINI 30G (<i>lancets</i>)	3	
VERIFINE SHARPS CONTAINER (<i>sharps container</i>)	3	
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (<i>needle (disp)</i>)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (<i>blood glucose calibration</i>)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (<i>blood glucose calibration</i>)	3	
VIVAGUARD LANCETS 30G (<i>lancets</i>)	3	
VIVAGUARD LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
VIVAGUARD SAFETY LANCETS 28G (<i>lancets</i>)	3	
VORTEX VALVE CHAMBER-PEDI MASK DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	2	SM
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (<i>corticotropin</i>)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; SP; SMCS
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (<i>cosyntropin</i>)	3/4	
<i>cosyntropin injection solution reconstituted 0.25 mg</i>	1	
CARDIAC FUNCTION		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
DIABETES MELLITUS		
ACCU-CHEK GUIDE TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR NEXT TEST IN VITRO STRIP (<i>glucose blood</i>)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR PLUS TEST IN VITRO STRIP (<i>glucose blood</i>)	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 (<i>ketone blood test</i>)	3	
RELION GLUCOSE TEST STRIPS IN VITRO STRIP (<i>glucose blood</i>)	3/4	QL (51 strips per prescription without history 204 strips per prescription with history.)
KETONES		
CHEMSTRIP K IN VITRO STRIP (<i>acetone (urine) test</i>)	2	
KETOSTIX IN VITRO STRIP (<i>acetone (urine) test</i>)	2	
PHEOCHROMOCYTOMA		
<i>metyrosine oral capsule 250 mg</i>	1	PA
PITUITARY FUNCTION		
METOPIRONE ORAL CAPSULE 250 MG (<i>metyrapone</i>)	3	
SUGAR		
DIASTIX REAGENT IN VITRO STRIP (<i>glucose urine test-glucose ox</i>)	3	
URINE AND FECES CONTENTS		
CHEMSTRIP UGK IN VITRO STRIP (<i>urine glucose-ketones test</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KETO-DIASTIX IN VITRO STRIP (<i>urine glucose-ketones test</i>)	3	
KETONE CARE IN VITRO STRIP (<i>urine glucose-ketones test</i>)	2	
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
<i>formaldehyde external solution 37 %</i>	1	
<i>glutaraldehyde external solution 25 %</i>	1	
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
ACIDIFYING AGENTS		
K-PHOS NO 2 ORAL TABLET 305-700 MG (<i>pot & sod ac phosphates</i>)	2	
ALKALINIZING AGENTS		
<i>cytra k crystals oral packet 3300-1002 mg</i>	1	
ORACIT ORAL SOLUTION 490-640 MG/5ML (<i>sod citrate-citric acid</i>)	2	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	1	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	1	
<i>sod citrate-citric acid oral solution 500-334 mg/5ml</i>	1	
<i>tricitrates oral solution 550-500-334 mg/5ml</i>	1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (<i>potassium citrate</i>)	3/4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (<i>potassium citrate</i>)	3/4	
AMMONIA DETOXICANTS		
<i>carglumic acid oral tablet soluble 200 mg</i>	1	PA; SP; SMCS
<i>constulose oral solution 10 gm/15ml</i>	1	
<i>enulose oral solution 10 gm/15ml</i>	1	
<i>generlac oral solution 10 gm/15ml</i>	1	
<i>glycerol phenylbutyrate oral liquid 1.1 gm/ml</i>	1	PA; QL (17.5 ml per day.)
KRISTALOSE ORAL PACKET 10 GM, 20 GM (<i>lactulose</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	
<i>lactulose oral packet 20 gm</i>	1	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	1	
LITHOSTAT ORAL TABLET 250 MG (<i>acetohydroxamic acid</i>)	3	
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	1	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	1	PA
CALORIC AGENTS - Drugs for Nutrition		
DOJOLVI ORAL LIQUID 100 % (<i>triheptanoin</i>)	3/4	PA
CARBONIC ANHYDRASE INHIBITORS (40:28) - Drugs for Water Balance		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
DIURETICS, MISCELLANEOUS - Drugs for Water Balance		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
LOOP DIURETICS (40:28) - Drugs for Water Balance		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (<i>bumetanide</i>)	3/4	PA; QL (12 nasal sprays per copay.)
<i>ethacrynic acid oral tablet 25 mg</i>	1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (<i>furosemide</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (<i>furosemide</i>)	3/4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
OSMOTIC DIURETICS (40:28) - Drugs for Water Balance		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %</i>	1	
<i>urea external lotion 40 %</i>	1	
OTHER ION-REMOVING AGENTS		
RADIOGARDASE ORAL CAPSULE 0.5 GM (<i>prussian blue insoluble</i>)	3	
PHOSPHATE-REMOVING AGENTS		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	1	
<i>calcium acetate oral tablet 667 mg</i>	1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (<i>lanthanum carbonate</i>)	3	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	1	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	1	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	1	
VELPHORO ORAL TABLET CHEWABLE 500 MG (<i>sucroferric oxyhydroxide</i>)	3/4	
XPHOZAH ORAL TABLET 20 MG, 30 MG (<i>tenapanor hcl (ckd)</i>)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-REMOVING AGENTS		
LOKELMA ORAL PACKET 10 GM (<i>sodium zirconium cyclosilicate</i>)	3	PA; QL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM (<i>sodium zirconium cyclosilicate</i>)	3	PA; QL (3 packets per day.)
<i>sodium polystyrene sulfonate oral powder</i>	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (<i>sodium polystyrene sulfonate</i>)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (<i>sodium polystyrene sulfonate</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VELTASSA ORAL PACKET 1 GM (<i>patiromer sorbitex calcium</i>)	3	PA; QL (124 packets per month.)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (<i>patiromer sorbitex calcium</i>)	3	PA; QL (1 Packet per day.)
XPHOZAH ORAL TABLET 30 MG (<i>tenapanor hcl (ckd)</i>)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance		
<i>amiloride hcl oral tablet 5 mg</i>	1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3/4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	
REPLACEMENT PREPARATIONS		
CALCIFOL ORAL WAFER 1342-1.6 MG (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	3	
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	1	
<i>calcium acetate oral tablet 667 mg</i>	1	
EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (<i>potassium bicarb-citric acid</i>)	2	
<i>effer-k oral tablet effervescent 25 meq</i>	1	
GALZIN ORAL CAPSULE 25 MG, 50 MG (<i>zinc acetate (oral)</i>)	3	
<i>klor-con 10 oral tablet extended release 10 meq</i>	1	
<i>klor-con m10 oral tablet extended release 10 meq</i>	1	
<i>klor-con m15 oral tablet extended release 15 meq</i>	1	
<i>klor-con m20 oral tablet extended release 20 meq</i>	1	
<i>klor-con oral packet 20 meq</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fecbn-feasp-meth-fa-dha</i>)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (<i>prenat mv-min-methylfolate-fa</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION 22-4 MEQ/L (<i>bicarb-dextrose-k (crrt)</i>)	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION 32-2.5 MEQ/L (<i>bicarb-dextrose-ca (crrt)</i>)	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION 32-2 MEQ/L (<i>bicarb-dextrose-k (crrt)</i>)	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION 32-2-3.5 MEQ/L (<i>bicarb-dextrose-k-ca (crrt)</i>)	3	
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION 32-4-1.2 MEQ/L (<i>bicarb-dextrose-k-mg (crrt)</i>)	3	
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5 MEQ/L (<i>bicarb-dextrose-k-ca (crrt)</i>)	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION 32-1.2 MEQ/L (<i>bicarb-mg (crrt)</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<i>prenat-fe poly-methfol-fa-dha</i>)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (<i>copper histidinate</i>)	3/4	
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (hydrochlorothiazide)	3/4	PA
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (benazepril-hydrochlorothiazide)	3/4	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
THIAZIDE-LIKE DIURETICS (40:28) - Drugs for Water Balance		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
URICOSURIC AGENTS		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
ORLYNVAH ORAL TABLET 500-500 MG (<i>sulopenem etzadrox-probenecid</i>)	3/4	QL (10 tablets per course of therapy.)
<i>probenecid oral tablet 500 mg</i>	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (<i>tolvaptan (hyponatremia)</i>)	3/4	PA; QL (90 tablets per 365 days.); SP; SMCS
SAMSCA ORAL TABLET 30 MG (<i>tolvaptan (hyponatremia)</i>)	3/4	PA; QL (60 tablets per 365 days.); SP; SMCS
<i>tolvaptan (hyponatremia) oral tablet 15 mg</i>	1	PA; QL (90 tablets per 365 days.); SMCS
<i>tolvaptan (hyponatremia) oral tablet 30 mg</i>	1	PA; QL (60 tablets per 365 days.); SMCS
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	1	PA; SMCS
<i>tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg</i>	1	PA; QL (2 tablets per day.)
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	3/4	PA; QL (14 capsules per 21 days.)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (<i>arimoclomol citrate</i>)	3/4	PA; QL (90 capsules per month.)
<i>sapropterin dihydrochloride oral packet 100 mg</i>	1	PA; QL (16 packets per day.)
<i>sapropterin dihydrochloride oral packet 500 mg</i>	1	PA; QL (4 packets per day.)
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	1	PA; QL (16 tablets per day)
SEPHIENCE ORAL PACKET 1000 MG (<i>sepiapterin</i>)	3/4	PA; QL (186 packets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 250 MG (<i>sepiapterin</i>)	3/4	PA; QL (682 packets per month.)
<i>zelvysia oral packet 100 mg</i>	1	PA; QL (589 packets per month.)
<i>zelvysia oral packet 500 mg</i>	1	PA; QL (4 packets per day.)
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	2	PA
HARLIKU ORAL TABLET 2 MG (<i>nitisinone (aku)</i>)	3/4	PA; QL (31 tablets per month.)
<i>miglustat oral capsule 100 mg</i>	1	
OPFOLDA ORAL CAPSULE 65 MG (<i>miglustat (gaa deficiency)</i>)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	2	PA
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (<i>lonafarnib</i>)	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 (<i>pancrelipase (lip-prot-amyl)</i>)	2	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (<i>pegvaliase-pqpz</i>)	3	PA; QL (7 mL per year.); SP; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (<i>pegvaliase-pqpz</i>)	3	PA; QL (6 syringes per 365 days.); SP; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (<i>pegvaliase-pqpz</i>)	3	PA; 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 (<i>pancrelipase (lip-prot-amyl)</i>)	3	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>dornase alfa</i>)	2	PA; QL (5 ml per day.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	3	QL (90 grams per prescription.)
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML (<i>asfotase alfa</i>)	2	PA; QL (5.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (<i>asfotase alfa</i>)	2	PA; QL (8.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (<i>asfotase alfa</i>)	2	PA; QL (12 ml tablets per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (<i>asfotase alfa</i>)	2	PA; QL (9.6 ml (12 vials) per month.); SP; SMCS
SUCRAID ORAL SOLUTION 8500 UNIT/ML (<i>sacrosidase</i>)	2	PA; SP; SMCS
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	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 (<i>pancrelipase (lip-prot-amyl)</i>)	2	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
ALPHA-ADRENERGIC AGONISTS (52:40) - Drugs for the Eye		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (<i>brimonidine tartrate</i>)	1	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	3/4	QL (10 ml per prescription)
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	1	
<i>brimonidine tartrate external gel 0.33 %</i>	1	PA; QL (30 grams per prescription.)
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	1	QL (10 ml per prescription)
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (<i>brimonidine tartrate-timolol</i>)	1	QL (5 ml per prescription)
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ERY EXTERNAL PAD 2 %	3	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	1	H-N
<i>gatifloxacin ophthalmic solution 0.5 %</i>	1	
<i>gentamicin sulfate external cream 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate external ointment 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	QL (15 ml per prescription.)
<i>levofloxacin ophthalmic solution 0.5 %, 1.5 %</i>	1	
<i>loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %</i>	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (<i>neomycin-polymyxin-dexameth</i>)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (<i>neomycin-polymyxin-dexameth</i>)	3/4	
<i>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</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
MITOSOL OPHTHALMIC KIT 0.2 MG (<i>mitomycin</i>)	3	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	1	
<i>neomycin sulfate oral tablet 500 mg</i>	1	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (tobramycin)	3	QL (3.5 grams per prescription.)
XTORO OTIC SUSPENSION 0.3 % (finafloxacin)	3	
ZILXI EXTERNAL FOAM 1.5 % (minocycline hcl micronized)	3/4	PA; QL (30 grams per prescription.)
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (loteprednol-tobramycin)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (natamycin)	3	
ANTI-INFECTIVES, MISCELLANEOUS (52:04) - Drugs for Infections		
ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % (silver nitrate-pot nitrate)	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (povidone-iodine)	3	
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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (<i>chlorhexidine gluconate</i>)	3/4	
<i>periogard mouth/throat solution 0.12 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (<i>pramoxine-chloroxylonol</i>)	3	
<i>silver nitrate external solution 0.5 %</i>	1	
XDEMVI OPTHALMIC SOLUTION 0.25 % (<i>lotilaner</i>)	3/4	PA; QL (10 ml per 63 days.)
ANTI-INFLAMMATORY AGENTS (EENT) - Drugs for Inflammation		
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
MIEBO OPTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	3/4	PA; QL (1 bottle per month.)
OXERVATE OPTHALMIC SOLUTION 0.002 % (<i>cenegermin-bkbj</i>)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
RESTASIS OPTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	1	PA; QL (60 vials per month.)
VERKAZIA OPTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	3/4	PA; QL (4 vials per day.)
XIIDRA OPTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	3/4	PA; QL (60 vials per month.)
ANTIVIRALS (EENT) - Drugs for Infections		
<i>trifluridine ophthalmic solution 1 %</i>	1	
ZIRGAN OPTHALMIC GEL 0.15 % (<i>ganciclovir</i>)	3	
ASTRINGENTS (52:04) - Drugs for Infections		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	3/4	
<i>periogard mouth/throat solution 0.12 %</i>	1	
BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
BETIMOL OPTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3/4	QL (5 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	3	
<i>carteolol hcl ophthalmic solution 1 %</i>	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (<i>brimonidine tartrate-timolol</i>)	1	QL (5 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	3/4	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	3/4	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	1	QL (5 ml per prescription.)
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ocudose ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3/4	
CARBONIC ANHYDRASE INHIBITORS (52:40) - Drugs for the Eye		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<i>brinzolamide ophthalmic suspension 1 %</i>	1	QL (10 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	3/4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	3/4	
<i>dorzolamide hcl solution 2 % ophthalmic</i>	1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (<i>fluticasone-salmeterol</i>)	3	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	QL (10.7 grams per prescription.); SM
ALREX OPHTHALMIC SUSPENSION 0.2 % (loteprednol etabonate)	3/4	QL (5 ml per prescription)
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	
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, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.); SM
CIPRO HC OTIC SUSPENSION 0.2-1 % (ciprofloxacin-hydrocortisone)	3/4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	3/4	QL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	3/4	
DERMOTIC OTIC OIL 0.01 % (<i>fluocinolone acetonide</i>)	3/4	
<i>dexamethasone intensol oral concentrate 1 mg/ml</i>	1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	1	
<i>dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)</i>	1	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	1	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	1	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (<i>loteprednol etabonate</i>)	3/4	QL (8.3 mL per prescription)
FLAREX OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone acetate</i>)	2	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluocinolone acetonide body external oil 0.01 %</i>	1	QL (118.28 ml per prescription.)
<i>fluocinolone acetonide external cream 0.01 %</i>	1	QL (15 grams per prescription.)
<i>fluocinolone acetonide external cream 0.025 %</i>	1	QL (120 grams per copay.)
<i>fluocinolone acetonide external ointment 0.025 %</i>	1	QL (120 grams per copay.)
<i>fluocinolone acetonide external solution 0.01 %</i>	1	
<i>fluocinolone acetonide otic oil 0.01 %</i>	1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	1	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
FML FORTE OPHTHALMIC SUSPENSION 0.25 % <i>(fluorometholone)</i>	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % <i>(fluorometholone)</i>	3/4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG <i>(hydrocortisone acetate)</i>	3	
<i>hydrocortisone (perianal) external cream 2.5 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	1	
<i>hydrocortisone butyrate external ointment 0.1 %</i>	1	
<i>hydrocortisone butyrate external solution 0.1 %</i>	1	
<i>hydrocortisone external cream 2.5 %</i>	1	
<i>hydrocortisone external lotion 2.5 %</i>	1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	1	
<i>hydrocortisone valerate external cream 0.2 %</i>	1	QL (15 grams per prescription.)
<i>hydrocortisone valerate external ointment 0.2 %</i>	1	QL (15 grams per prescription.)
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (<i>loteprednol etabonate</i>)	3	
KHINDIVI ORAL SOLUTION 1 MG/ML (<i>hydrocortisone</i>)	3/4	PA
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (<i>loteprednol etabonate</i>)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (<i>loteprednol etabonate</i>)	3	QL (5 grams per prescription.)
<i>loteprednol etabonate ophthalmic suspension 0.2 %</i>	1	QL (5 ml per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	1	QL (5 ml per prescription.)
<i>loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %</i>	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % <i>(dexamethasone)</i>	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 <i>(neomycin-polymyxin-dexameth)</i>	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % <i>(neomycin-polymyxin-dexameth)</i>	3/4	
<i>mometasone furoate external cream 0.1 %</i>	1	
<i>mometasone furoate external ointment 0.1 %</i>	1	
<i>mometasone furoate external solution 0.1 %</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	1	QL (34 grams (2 bottles) per copay.)
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	1	
NUCORT EXTERNAL LOTION 2 % <i>(hydrocortisone acetate)</i>	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG <i>(prednisolone sodium phosphate)</i>	3/4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % <i>(prednisolone acetate)</i>	3	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	1	
<i>prednisolone oral solution 15 mg/5ml</i>	1	
<i>prednisolone oral tablet 5 mg</i>	1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml</i>	1	
<i>prednisolone sodium phosphate oral tablet dispersible 30 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (<i>hydrocortisone ace-pramoxine</i>)	2	
<i>procto-med hc external cream 2.5 %</i>	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	1	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (<i>dexamethasone</i>)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (<i>dexamethasone</i>)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (<i>dexamethasone</i>)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (<i>dexamethasone</i>)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	3	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	QL (2 blisters per day.); SM
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (<i>loteprednol-tobramycin</i>)	3	
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	3/4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	3/4	PA; QL (60 vials per month.)
EENT DRUGS, MISCELLANEOUS		
<i>acetic acid otic solution 2 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	1	
AQUORAL MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	3	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	SM
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (<i>cysteamine hcl</i>)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	2	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	3	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	3/4	PA; QL (1 bottle per month.)
MUCOSITISRX MOUTH/THROAT PACKET (<i>artificial saliva</i>)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (<i>cenegermin-bkbj</i>)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
TRYPTYR OPHTHALMIC SOLUTION 0.003 % (<i>acoltremon</i>)	3/4	PA; QL (60 vials per month.)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	3/4	PA; QL (0.28 ml per day.)
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	3/4	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	1	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	1	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	1	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	1	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (<i>nepafenac</i>)	3/4	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3/4	QL (5 bottles per prescription.)
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (<i>lidocaine hcl</i>)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (<i>proparacaine hcl</i>)	3	
ALTACAIN OPHTHALMIC SOLUTION 0.5 % (<i>tetracaine hcl</i>)	3	
<i>lidocaine hcl mouth/throat solution 4 %</i>	1	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (<i>pramoxine-chloroxylonol</i>)	3	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	1	
MACULAR DEGENERATION AGENTS		
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (<i>cysteamine hcl</i>)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (<i>echothiophate iodide</i>)	2	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (<i>pilocarpine hcl</i>)	3/4	
MYDRIATICS - Drugs for the Eye		
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (<i>cyclopentolate hcl</i>)	3/4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	3	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OSMOTIC AGENTS - Drugs for the Eye		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %</i>	1	
<i>urea external lotion 40 %</i>	1	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
<i>bimatoprost ophthalmic solution 0.03 %</i>	1	QL (2.5 ml per prescription.)
<i>bimatoprost solution 0.01 % ophthalmic</i>	1	QL (2.5 mL per copay.)
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	2	QL (2.5 mL per copay.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per prescription.)
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	1	QL (30 unit of use droppers per prescription.)
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	1	QL (2.5 ml per prescription)
XELPROS OPHTHALMIC EMULSION 0.005 % (<i>latanoprost</i>)	3	QL (2.5 ml per prescription.)
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (<i>tafluprost</i>)	3	QL (30 unit of use droppers per prescription.)
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (<i>netarsudil dimesylate</i>)	3	QL (2.5 ml per prescription.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per prescription.)
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	3	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	3/4	PA; QL (30 grams per prescription.)
UPNEEQ OPHTHALMIC SOLUTION 0.1 % (<i>oxymetazoline hcl</i>)	3/4	PA; QL (30 single-use vials per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GASTROINTESTINAL DRUGS		
CHLORIDE CHANNEL ACTIVATORS		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	1	PA; QL (2 capsules per day.)
GUANYLATE CYCLASE C (GCC) RECEPT AGONIST		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (<i>linaclotide</i>)	2	PA; QL (1 capsule per day.)
IMMUNOMODULATORY AGENTS (56:44)		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (<i>vedolizumab</i>)	2	PA; QL (0.05 ml per day.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (<i>mirikizumab-mrkz</i>)	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 (<i>mirikizumab-mrkz</i>)	2	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>mirikizumab-mrkz</i>)	2	PA; QL (2 ml (1 auto-injector) per month.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>mirikizumab-mrkz</i>)	2	PA; QL (2 ml (1 prefilled syringe) per month.)
OPIOID ANTAGONISTS (56:18)		
<i>alvimopan oral capsule 12 mg</i>	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	3/4	PA; QL (0.4 ml per day.)
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	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 (<i>netupitant-palonosetron</i>)	3/4	QL (1 capsule per prescription.)
ANZEMET ORAL TABLET 50 MG (<i>dolasetron mesylate</i>)	3	QL (6 tablets per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
granisetron hcl oral tablet 1 mg	1	
GRANISOL ORAL SOLUTION 2 MG/10ML (granisetron hcl)	3	
ondansetron hcl oral solution 4 mg/5ml	1	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	
ondansetron odt oral tablet dispersible 4 mg, 8 mg	1	
ANTIDIARRHEA AGENTS - Drugs for Diarrhea		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	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	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	1	
SYNDROS ORAL SOLUTION 5 MG/ML (<i>dronabinol</i>)	3/4	PA; QL (4 ml per day.)
ANTI-HISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	1	
ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation		
<i>alosetron hcl oral tablet 0.5 mg, 1 mg</i>	1	PA; QL (2 tablets per day)
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (<i>mesalamine</i>)	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3/4	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3/4	
<i>balsalazide disodium oral capsule 750 mg</i>	1	
DIPENTUM ORAL CAPSULE 250 MG (<i>olsalazine sodium</i>)	3	
<i>mesalamine oral capsule delayed release 400 mg</i>	1	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	1	
<i>mesalamine rectal enema 4 gm</i>	1	QL (28 bottles per month.)
<i>mesalamine rectal suppository 1000 mg</i>	1	QL (1 suppository per day.)
<i>mesalamine-cleanser rectal kit 4 gm</i>	1	QL (4 kits per month.)
ROWASA RECTAL KIT 4 GM (<i>mesalamine-cleanser</i>)	3/4	QL (4 kits per month.)
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
ANTI-ULCER AGENTS AND ACID SUPPRESS., MISC - Drugs for Ulcers and Stomach Acid		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>bis subcit-metronid-tetracyc</i>)	3/4	QL (120 capsules per 180 days.)
ANTIULCER AGENTS AND ACID SUPPRESSANTS - Drugs for Ulcers and Stomach Acid		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	3/4	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
CATHARTICS AND LAXATIVES - Drugs for Constipation		
<i>bisacodyl ec oral tablet delayed release 5 mg</i>	E	H
<i>clearlax oral powder 17 gm/scoop</i>	E	H
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (<i>sod picosulfate-mag ox-cit acid</i>)	3	QL (350 ml per prescription.)
<i>ft clearlax oral powder 17 gm/scoop</i>	E	H
<i>ft laxative oral tablet delayed release 5 mg</i>	E	H
<i>ft magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
<i>gavilax oral powder 17 gm/scoop</i>	E	H
<i>gavilyte-c oral solution reconstituted 240 gm</i>	1	H
<i>gavilyte-g oral solution reconstituted 236 gm</i>	1	QL (4000 mL per prescription.); H
<i>gavilyte-n with flavor pack oral solution reconstituted 420 gm</i>	1	QL (4000 ml per prescription.); H
<i>gentle laxative oral tablet delayed release 5 mg</i>	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
glycolax oral powder 17 gm/scoop	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (peg 3350-kcl-nabcb-nacl-nasulf)	1	QL (4000 mL per prescription.); H
goodsense clearlax oral powder 17 gm/scoop	E	H
laxative osmotic oral powder 17 gm/scoop	E	H
magnesium citrate oral solution 1.745 gm/30ml	E	H
mm clearlax oral powder 17 gm/scoop	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (peg-kcl-nacl-nasulf-na asc-c)	3/4	QL (1 kit per prescription.)
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	1	QL (354 ml per prescription.)
peg 3350 oral powder 17 gm/scoop	E	H
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	QL (4000 ml per prescription.); H
peg-3350/electrolytes oral solution reconstituted 236 gm	1	QL (4000 mL per prescription.); H
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	QL (1 kit per prescription.)
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	QL (1 kit per prescription.)
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)	3	QL (3 cartons per prescription.)
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	QL (2 doses (1 box) per prescription.)
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (na sulfate-k sulfate-mg sulf)	3	QL (354 ml per prescription.)
SUTAB ORAL TABLET 1479-225-188 MG (sodium sulfate-mag sulfate-kcl)	3	QL (2 doses (24 tablets) per copay.)
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (odevixibat)	3/4	PA; QL (2 capsules per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (<i>odevixibat</i>)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (<i>odevixibat</i>)	3/4	PA; QL (2 capsules per day.)
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (<i>cholic acid</i>)	2	PA; QL (4 capsules per day.)
CTEXLI ORAL TABLET 250 MG (<i>chenodiol (basds)</i>)	3/4	PA; QL (93 tablets per month.)
IQIRVO ORAL TABLET 80 MG (<i>elafibranor</i>)	3/4	PA; QL (31 tablets per month.)
LIVDELZI ORAL CAPSULE 10 MG (<i>seladelpar lysine</i>)	3/4	PA; QL (30 capsules per month.)
LIVMARLI ORAL SOLUTION 19 MG/ML (<i>maralixibat chloride</i>)	3/4	PA; QL (60 mL (1140 mg) per month.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (<i>maralixibat chloride</i>)	3/4	PA; QL (4 mL per day.)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (<i>maralixibat chloride</i>)	3/4	PA; QL (60 tablets per month.)
LIVMARLI ORAL TABLET 30 MG (<i>maralixibat chloride</i>)	3/4	PA; QL (30 tablets per month.)
<i>ursodiol oral capsule 300 mg</i>	1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	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 (<i>pancrelipase (lip-prot-amyl)</i>)	2	
GATTEX SUBCUTANEOUS KIT 5 MG (<i>teduglutide (rdna)</i>)	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 (<i>pancrelipase (lip-prot-amyl)</i>)	3	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3/4	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 (<i>pancrelipase (lip-prot-amyl)</i>)	2	
DOPAMINE RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	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; QL (1.6 mL (2 auto-injectors) per month.)
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.)
<i>alvimopan oral capsule 12 mg</i>	1	
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	2	PA
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (<i>odevixibat</i>)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (<i>odevixibat</i>)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (<i>odevixibat</i>)	3/4	PA; QL (2 capsules per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 syringe per month.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (<i>risankizumab-rzaa</i>)	2	PA; QL (1.2 ml per 42 days.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (<i>risankizumab-rzaa</i>)	2	PA; QL (2.4 mL per 42 days.)
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	2	PA; QL (1 tablet per day.)
SYNDROS ORAL SOLUTION 5 MG/ML (<i>dronabinol</i>)	3/4	PA; QL (4 ml per day.)
VIBERZI ORAL TABLET 100 MG, 75 MG (<i>eluxadoline</i>)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (<i>fecal microb spores, live-brpk</i>)	3/4	PA; QL (12 capsules per 365 days.)
XPHOZAH ORAL TABLET 30 MG (<i>tenapanor hcl (ckd)</i>)	3/4	PA; QL (2 tablets per day.)
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	3/4	QL (1 capsule per prescription.)
<i>aprepitant oral capsule 125 mg, 40 mg</i>	1	QL (1 capsule per prescription)
<i>aprepitant oral capsule 80 mg</i>	1	QL (2 capsules per prescription)
<i>aprepitant oral capsule therapy pack 80 & 125 mg</i>	1	QL (3 capsules per prescription)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (<i>aprepitant</i>)	2	QL (3 pouches per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (<i>vonoprazan fumarate</i>)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	3/4	PA; QL (60 tablets per month and 120 tablets per year.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	3/4	QL (112 tablets per 180 days.)
PROKINETIC AGENTS - Drugs for the Stomach		
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
REGLAN ORAL TABLET 10 MG, 5 MG (<i>metoclopramide hcl</i>)	3/4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (<i>misoprostol</i>)	3/4	SM
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	1	
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	1	SM
PROTECTANTS - Drugs for Ulcers and Stomach Acid		
<i>sucralfate oral suspension 1 gm/10ml</i>	1	
<i>sucralfate oral tablet 1 gm</i>	1	
PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid		
<i>esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	PA; QL (1 packet per day.)
<i>esomeprazole magnesium oral packet 40 mg</i>	1	PA; QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (<i>lansoprazole</i>)	3	PA
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	1	PA; QL (1 tablet per day.)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	1	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (<i>vonoprazan fumarate</i>)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	3/4	PA; QL (60 tablets per month and 120 tablets per year.)
GOLD COMPOUNDS		
GOLD COMPOUNDS		
AURANOFIN ORAL CAPSULE 3 MG	3	
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
CHEMET ORAL CAPSULE 100 MG (<i>succimer</i>)	2	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	1	PA
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	1	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	1	PA
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	1	PA
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	1	PA
DEPEN TITRATABS ORAL TABLET 250 MG (<i>penicillamine</i>)	2	
FERRIPROX ORAL SOLUTION 100 MG/ML (<i>deferiprone</i>)	2	PA
FERRIPROX ORAL TABLET 1000 MG (<i>deferiprone</i>)	3/4	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (<i>deferiprone</i>)	3/4	PA
<i>penicillamine oral tablet 250 mg</i>	1	
<i>trientine hcl oral capsule 250 mg, 500 mg</i>	1	PA
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (<i>bremelanotide acetate</i>)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (<i>fluticasone-salmeterol</i>)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 packet per day.); SM
<i>betamethasone dipropionate aug external cream 0.05 %</i>	1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	1	
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	1	
<i>betamethasone dipropionate external cream 0.05 %</i>	1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	1	
<i>betamethasone valerate external cream 0.1 %</i>	1	
<i>betamethasone valerate external lotion 0.1 %</i>	1	
<i>betamethasone valerate external ointment 0.1 %</i>	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (<i>fluticasone furoate-vilanterol</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	3	QL (0.36 grams per day.); SM
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	1	SM
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	1	QL (120 ml (2 boxes) per 30 days.); SM
<i>budesonide inhalation suspension 1 mg/2ml</i>	1	QL (60 ml (1 box) per 30 days.); SM
<i>budesonide oral capsule delayed release particles 3 mg</i>	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (<i>hydrocortisone</i>)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (<i>hydrocortisone</i>)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	2	
<i>dexamethasone intensol oral concentrate 1 mg/ml</i>	1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	1	
<i>dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)</i>	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (<i>betamethasone dipropionate aug</i>)	3/4	
EOHILIA ORAL SUSPENSION 2 MG/10ML (<i>budesonide</i>)	3/4	PA; QL (20 grams per day.)
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external lotion 0.05 %</i>	1	QL (60 ml per prescription.)
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (<i>hydrocortisone acetate</i>)	3	
<i>hydrocortisone (perianal) external cream 2.5 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	1	
<i>hydrocortisone butyrate external ointment 0.1 %</i>	1	
<i>hydrocortisone butyrate external solution 0.1 %</i>	1	
<i>hydrocortisone external cream 2.5 %</i>	1	
<i>hydrocortisone external lotion 2.5 %</i>	1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	1	
<i>hydrocortisone valerate external cream 0.2 %</i>	1	QL (15 grams per prescription.)
<i>hydrocortisone valerate external ointment 0.2 %</i>	1	QL (15 grams per prescription.)
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
INTRAROSA VAGINAL INSERT 6.5 MG (<i>prasterone</i>)	3/4	PA; QL (1 insert per day.)
ISTURISA ORAL TABLET 1 MG (<i>osilodrostat phosphate</i>)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (<i>osilodrostat phosphate</i>)	3/4	PA; QL (372 tablets per month.)
KHINDIVI ORAL SOLUTION 1 MG/ML (<i>hydrocortisone</i>)	3/4	PA
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (<i>methylprednisolone</i>)	3/4	
MEDROL ORAL TABLET 2 MG (<i>methylprednisolone</i>)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (<i>methylprednisolone</i>)	3/4	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	1	
<i>mometasone furoate external cream 0.1 %</i>	1	
<i>mometasone furoate external ointment 0.1 %</i>	1	
<i>mometasone furoate external solution 0.1 %</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	1	QL (34 grams (2 bottles) per copay.)
NUCORT EXTERNAL LOTION 2 % (<i>hydrocortisone acetate</i>)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (<i>prednisolone sodium phosphate</i>)	3/4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (<i>prednisolone acetate</i>)	3	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	1	
<i>prednisolone oral solution 15 mg/5ml</i>	1	
<i>prednisolone oral tablet 5 mg</i>	1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml</i>	1	
<i>prednisolone sodium phosphate oral tablet dispersible 30 mg</i>	1	
<i>prednisone intensol oral concentrate 5 mg/ml</i>	1	
<i>prednisone oral solution 5 mg/5ml</i>	1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	2	
<i>procto-med hc external cream 2.5 %</i>	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (10.6 grams per month.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (42.4 grams per month.); SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (<i>budesonide-formoterol fumarate</i>)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (<i>budesonide-formoterol fumarate</i>)	1	SM
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (<i>dexamethasone</i>)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (<i>dexamethasone</i>)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (<i>dexamethasone</i>)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (<i>dexamethasone</i>)	3	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (<i>budesonide</i>)	3/4	PA; QL (4 capsules per day.)
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	1	QL (63 grams per prescription.)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external cream 0.5 %</i>	1	QL (15 grams per prescription.)
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triderm external cream 0.5 %</i>	1	QL (15 grams per prescription.)
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (<i>budesonide</i>)	1	
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-GLUCOSIDASE INHIBITORS - Drugs for Diabetes		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ANDROGENS - Hormones		
COVARYX HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	
COVARYX ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	2	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (<i>testosterone cypionate</i>)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (<i>testosterone cypionate</i>)	3/4	SM
EEMT HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	
EEMT ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	2	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	1	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	
KYZATREX ORAL CAPSULE 150 MG, 200 MG (<i>testosterone undecanoate</i>)	3/4	PA; QL (4 capsules per day.); SM
METHITEST ORAL TABLET 10 MG	2	SM
<i>methyltestosterone oral capsule 10 mg</i>	1	SM
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	SM
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	SM
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	1	PA; QL (150 grams (2 pumps) per month.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>testosterone transdermal gel 1.62 %</i>	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
<i>colesevelam hcl oral packet 3.75 gm</i>	1	
<i>colesevelam hcl oral tablet 625 mg</i>	1	
CYCLOSET ORAL TABLET 0.8 MG (<i>bromocriptine mesylate</i>)	3	
<i>mifepristone oral tablet 300 mg</i>	1	PA; QL (4 tablets per day.); SP; SMCS
ANTIESTROGENS - Drugs for Women		
<i>anastrozole oral tablet 1 mg</i>	1	H-N
<i>exemestane oral tablet 25 mg</i>	1	H-N
<i>letrozole oral tablet 2.5 mg</i>	1	H-N
ANTIGONADTROPINS - Hormones		
<i>aftera oral tablet 1.5 mg</i>	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (<i>cetorelix acetate</i>)	3/4	PA; QL (14 cartons per 21 days.)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (<i>testosterone cypionate</i>)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (<i>testosterone cypionate</i>)	3/4	SM
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (<i>degarelix acetate</i>)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	3	
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>ganirelix acetate</i>)	3	QL (7 ml per 21 days.)
<i>ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml</i>	1	QL (7 ml per 21 days.)
<i>her style oral tablet 1.5 mg</i>	1	H
KYZATREX ORAL CAPSULE 150 MG, 200 MG (<i>testosterone undecanoate</i>)	3/4	PA; QL (4 capsules per day.); SM
<i>levonorgestrel oral tablet 1.5 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>my choice oral tablet 1.5 mg</i>	1	H
<i>my way oral tablet 1.5 mg</i>	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (<i>relugolix-estradiol-norethind</i>)	2	PA; QL (1 tablet day.)
<i>new day oral tablet 1.5 mg</i>	1	H
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
<i>option 2 oral tablet 1.5 mg</i>	1	H
ORGOVYX ORAL TABLET 120 MG (<i>relugolix</i>)	3	PA; QL (1 tablet per day); CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (<i>elagolix-estradiol-norethind</i>)	2	PA; QL (2 capsules per day.)
ORILISSA ORAL TABLET 150 MG (<i>elagolix sodium</i>)	2	PA; QL (1 tablet per day.)
ORILISSA ORAL TABLET 200 MG (<i>elagolix sodium</i>)	2	PA; QL (2 tablets per day.)
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	1	H
<i>shewise oral tablet 1.5 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	3/4	H
<i>take action oral tablet 1.5 mg</i>	1	H
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	SM
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	SM
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	1	PA; QL (150 grams (2 pumps) per month.); SM
<i>testosterone transdermal gel 1.62 %</i>	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
<i>diazoxide oral suspension 50 mg/ml</i>	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (<i>diazoxide</i>)	3/4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	1	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg</i>	1	
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (<i>calcitonin (salmon)</i>)	3	
ANTITHYROID AGENTS - Drugs for the Thyroid		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	1	
BIGUANIDES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (<i>pioglitazone hcl-metformin hcl</i>)	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.)
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (<i>linagliptin-metformin hcl</i>)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (<i>linagliptin-metformin hcl</i>)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (<i>linagliptin-metformin hcl</i>)	2	QL (1 tablet per day.)
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	
<i>metformin hcl oral solution 500 mg/5ml</i>	1	
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	1	
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	QL (3 tablets per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	1	QL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	1	QL (31 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linaglip-metform</i>)	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 (<i>empagliflozin-linaglip-metform</i>)	2	QL (2 tablets per day.)
CONTRACEPTIVES - Drugs for Women		
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aftera oral tablet 1.5 mg</i>	1	H
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	3	QL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	3/4	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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)	E	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
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
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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	1	H
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	1	QL (1 tablet per 21 days.); H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>emzahh oral tablet 0.35 mg</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H
<i>errin oral tablet 0.35 mg</i>	1	H
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>feirza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>feirza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	3/4	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>galbriela oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>heather oral tablet 0.35 mg</i>	1	H
<i>her style oral tablet 1.5 mg</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 & 0.01 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>jasmiel oral tablet 3-0.02 mg</i>	1	H
<i>jencycla oral tablet 0.35 mg</i>	1	H
<i>jolessa oral tablet 0.15-0.03 mg</i>	1	H
<i>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg</i>	1	H
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>levonorgestrel oral tablet 1.5 mg</i>	1	H
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg</i>	1	H
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>lojaimiess oral tablet 0.1-0.02 & 0.01 mg</i>	1	H
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lyleq oral tablet 0.35 mg</i>	1	H
<i>lyza oral tablet 0.35 mg</i>	1	H
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	1	QL (5 ml per year.); H; SM
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	QL (5 mL per 365 days.); H; SM
<i>meleya oral tablet 0.35 mg</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
<i>my choice oral tablet 1.5 mg</i>	1	H
<i>my way oral tablet 1.5 mg</i>	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>new day oral tablet 1.5 mg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	3/4	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>nora-be oral tablet 0.35 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 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
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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>shewise oral tablet 1.5 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	3/4	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	1	H
<i>take action oral tablet 1.5 mg</i>	1	H
<i>tarina 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	1	H
<i>taysofy oral capsule 1-20 mg-mcg(24)</i>	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-lynyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>valtya 1/50 oral tablet 1-50 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	1	H
<i>wera oral tablet 0.5-35 mg-mcg</i>	1	H
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xarah fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>xelria fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (<i>drospirenone-ethinyl estradiol</i>)	3	
YAZ ORAL TABLET 3-0.02 MG (<i>drospirenone-ethinyl estradiol</i>)	3	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	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 (<i>sitagliptin hydrochloride</i>)	3/4	PA
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	QL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (<i>linagliptin-metformin hcl</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (<i>linagliptin-metformin hcl</i>)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (<i>linagliptin-metformin hcl</i>)	2	QL (1 tablet per day.)
<i>saxagliptin hcl oral tablet 2.5 mg, 5 mg</i>	1	QL (1 tablet per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	1	QL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	1	QL (31 tablets per month.)
TRADJENTA ORAL TABLET 5 MG (<i>linagliptin</i>)	2	QL (1 tablet per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linaglip-metform</i>)	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 (<i>empagliflozin-linaglip-metform</i>)	2	QL (2 tablets per day.)
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
<i>clomid oral tablet 50 mg</i>	1	
<i>clomiphene citrate oral tablet 50 mg</i>	1	
DUAVEE ORAL TABLET 0.45-20 MG (<i>conj estrogens-bazedoxifene</i>)	3	QL (1 tablet per day.)
<i>milophene oral tablet 50 mg</i>	1	
OSPHEA ORAL TABLET 60 MG (<i>ospemifene</i>)	3	PA; QL (1 tablet per day.)
<i>raloxifene hcl oral tablet 60 mg</i>	1	H-N
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H-N
<i>toremifene citrate oral tablet 60 mg</i>	1	CM
ESTROGENS - Drugs for Women		
<i>abigale lo oral tablet 0.5-0.1 mg</i>	1	
<i>abigale oral tablet 1-0.5 mg</i>	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (<i>estradiol-norethindrone acet</i>)	3/4	
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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)	E	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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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 (37.5 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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (<i>estrogens-methyltest</i>)	3	
ESTRING VAGINAL RING 7.5 MCG/24HR (<i>estradiol</i>)	2	QL (1 ring per 90 days.)
<i>estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg</i>	1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (<i>estradiol</i>)	2	SM
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>feirza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>feirza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	3/4	H
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	3	QL (1 ring per 3 months.)
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>galbriela oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG (<i>estradiol</i>)	2	QL (0.29 vaginal insert per day.)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (<i>estradiol</i>)	2	QL (0.29 insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (<i>estradiol</i>)	2	QL (18 inserts per year.)
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 & 0.01 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>jasmiel oral tablet 3-0.02 mg</i>	1	H
<i>jinteli oral tablet 1-5 mg-mcg</i>	1	
<i>jolessa oral tablet 0.15-0.03 mg</i>	1	H
<i>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg</i>	1	H
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg</i>	1	H
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)	1	H
<i>lojaimiess oral tablet 0.1-0.02 & 0.01 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>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</i>	1	QL (8 patches (1 box) per 28 days.); SM
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (<i>estradiol</i>)	3	QL (4 patches (1 carton) per 28 days.); SM
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-linyah oral tablet 0.25-35 mg-mcg</i>	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (<i>relugolix-estradiol-norethind</i>)	2	PA; QL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	3/4	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
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
pimtreea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens conjugated)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (estrogens, conjugated)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (conj estrog-medroxyprogest ace)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (conj estrog-medroxyprogest ace)	3	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>syeda oral tablet 3-0.03 mg</i>	1	H
<i>tarina 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	1	H
<i>taysofy oral capsule 1-20 mg-mcg(24)</i>	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>valtya 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	2	QL (2 prefilled syringes per copay.)
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (<i>follitropin beta</i>)	2	PA; QL (5.4 mL per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML, 900 UNT/1.08ML (<i>follitropin beta</i>)	2	PA; QL (8.64 mL per 21 days.)
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>follitropin alfa</i>)	3/4	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (<i>follitropin alfa</i>)	3/4	PA
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SM
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>menotropins</i>)	3/4	PA; QL (6 vials per day.)
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>chorionic gonadotropin</i>)	3	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>choriogonadotropin alfa</i>)	3/4	
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (<i>chorionic gonadotropin</i>)	3	
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	2	SM
INCRETIN MIMETICS - Drugs for Diabetes		
<i>liraglutide subcutaneous solution pen-injector 18 mg/3ml</i>	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 (<i>tirzepatide</i>)	2	PA; QL (0.08 ml per day.)
OZEMPIC ORAL TABLET 1.5 MG, 9 MG (<i>semaglutide</i>)	2	PA; QL (30 tablets per month.)
OZEMPIC ORAL TABLET 4 MG (<i>semaglutide</i>)	2	PA; QL (30 Tablets per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>semaglutide</i>)	2	PA; QL (1 Pen-injector per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (<i>semaglutide</i>)	2	PA; QL (3 ml per month.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</i>)	2	PA; QL (1 tablet per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	2	QL (18 ml per month.); SM
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	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 (<i>insulin nph isophane & regular</i>)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	1	QL (70 ml per prescription.); SM
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	2	QL (75 ml per prescription.); SM
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	1	QL (70 ml per prescription.); SM
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (<i>metreleptin</i>)	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 (<i>insulin glargine</i>)	1	QL (75 ml per prescription.); SM
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	1	QL (70 ml per prescription.); SM
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	2	QL (18 ml per month.); SM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	2	QL (75 ml per prescription.); SM
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	2	QL (37.5 ml per prescription.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MEGLITINIDES - Drugs for Diabetes		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	1	QL (3 tablets per day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	1	QL (4 tablets per day)
<i>repaglinide oral tablet 2 mg</i>	1	QL (8 tablets per day)
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	3	PA
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (<i>palopegteriparatide</i>)	3/4	PA; QL (2 pens (1.12 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (<i>palopegteriparatide</i>)	3/4	PA; QL (2 pens (1.96 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (<i>palopegteriparatide</i>)	3/4	PA; QL (2 pens (2.8 mL) per 28 days.)
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (<i>corticotropin</i>)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; SP; SMCS
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>crinecerfont</i>)	3/4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (<i>crinecerfont</i>)	3/4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>desmopressin acetate injection solution 4 mcg/ml</i>	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	1	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	1	
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (<i>somatrogon-ghla</i>)	3/4	PA; QL (0.172 ml per day.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (9 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (<i>somatropin</i>)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	3/4	PA; QL (1 vial per day.)
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (<i>lonapegsomatropin-tcgd</i>)	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 (<i>lonapegsomatropin-tcgd</i>)	3/4	PA; QL (0.143 cartridge per day.)
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (<i>somapacitan-beco</i>)	3/4	
PROGESTINS - Drugs for Women		
<i>abigale lo oral tablet 0.5-0.1 mg</i>	1	
<i>abigale oral tablet 1-0.5 mg</i>	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (<i>estradiol-norethindrone acet</i>)	3/4	
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>aftera oral tablet 1.5 mg</i>	1	H
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (<i>drospirenone-estradiol</i>)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	3	QL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	3/4	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (<i>levonorgest-eth estrad-fe bisg</i>)	E	H
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (<i>drospiren-eth estrad-levomefol</i>)	E	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (<i>estradiol-progesterone</i>)	3	
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	1	QL (1 tablet per 21 days.); H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>emzahh oral tablet 0.35 mg</i>	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (<i>progesterone</i>)	2	
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H
<i>errin oral tablet 0.35 mg</i>	1	H
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>feirza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>feirza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	3/4	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>galbriela oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>gallifrey oral tablet 5 mg</i>	1	
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>heather oral tablet 0.35 mg</i>	1	H
<i>her style oral tablet 1.5 mg</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 & 0.01 mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphase</i>)	1	H
<i>lojaimiess oral tablet 0.1-0.02 & 0.01 mg</i>	1	H
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lyleq oral tablet 0.35 mg</i>	1	H
<i>lyza oral tablet 0.35 mg</i>	1	H
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	1	QL (5 ml per year.); H; SM
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	QL (5 mL per 365 days.); H; SM
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	SM
<i>megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml</i>	1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
<i>meleya oral tablet 0.35 mg</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
<i>my choice oral tablet 1.5 mg</i>	1	H
<i>my way oral tablet 1.5 mg</i>	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (<i>relugolix-estradiol-norethind</i>)	2	PA; QL (1 tablet day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>new day oral tablet 1.5 mg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	3/4	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>nora-be oral tablet 0.35 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>norethindrone acetate oral tablet 5 mg</i>	1	
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg</i>	1	H
<i>norethindrone oral tablet 0.35 mg</i>	1	H
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>norlyroc oral tablet 0.35 mg</i>	1	H
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nylia 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
OPIII ORAL TABLET 0.075 MG (<i>norgestrel</i>)	1	H
<i>option 2 oral tablet 1.5 mg</i>	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (<i>elagolix-estradiol-norethind</i>)	2	PA; QL (2 capsules per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>orquidea oral tablet 0.35 mg</i>	1	H
<i>philith oral tablet 0.4-35 mg-mcg</i>	1	H
<i>pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	1	H
<i>portia-28 oral tablet 0.15-30 mg-mcg</i>	1	H
PREMPHASE ORAL TABLET 0.625-5 MG (<i>conj estrogen-medroxyprogesterone</i>)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (<i>conj estrogen-medroxyprogesterone</i>)	3	
<i>progesterone intramuscular oil 50 mg/ml</i>	1	SM
<i>progesterone oral capsule 100 mg, 200 mg</i>	1	SM
<i>progesterone vaginal insert 100 mg</i>	1	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>medroxyprogesterone acetate</i>)	3/4	SM
<i>reclipsen oral tablet 0.15-30 mg-mcg</i>	1	H
<i>rivelsa oral tablet 42-21-21-7 days</i>	1	H
<i>rosyrah oral tablet 42-21-21-7 days</i>	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (<i>drospiren-eth estrad-levomefol</i>)	E	H
<i>setlakin oral tablet 0.15-0.03 mg</i>	1	H
<i>sharobel oral tablet 0.35 mg</i>	1	H
<i>shewise oral tablet 1.5 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	3/4	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	1	H
<i>take action oral tablet 1.5 mg</i>	1	H
<i>tarina 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	1	H
<i>taysofy oral capsule 1-20 mg-mcg(24)</i>	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>valtya 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	1	H
<i>wera oral tablet 0.5-35 mg-mcg</i>	1	H
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xarah fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>xelria fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
YASMIN 28 ORAL TABLET 3-0.03 MG (<i>drospirenone-ethinyl estradiol</i>)	3	
YAZ ORAL TABLET 3-0.02 MG (<i>drospirenone-ethinyl estradiol</i>)	3	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	1	H
RAPID-ACTING INSULINS - Drugs for Diabetes		
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml (25 pens) per prescription.); SM
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	1	QL (70 ml per prescription.); SM
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.); SM
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	QL (70 ml per prescription.); SM
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.); SM
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	QL (75 ml per prescription.); SM
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin lispro-aabc</i>)	2	QL (75 ml per prescription.); SM
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro-aabc</i>)	1	QL (70 ml per prescription.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	1	QL (70 ml per prescription.); SM
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	2	QL (75 mL per prescription.); SM
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	1	QL (70 ml per prescription.); SM
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (<i>insulin regular(human) in nacl</i>)	3	SM
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (<i>bexagliflozin</i>)	3	QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	QL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG (<i>empagliflozin</i>)	2	QL (30 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	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 (<i>empagliflozin-linagliptin-metformin</i>)	2	QL (2 tablets per day.)
SOMATOSTATIN AGONISTS - Hormones		
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (pasireotide diaspertate)	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
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (somatropin)	2	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (somatropin)	2	PA; QL (9 mL per month.)
NORDITROPIN FLEXPOR 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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	1	
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (<i>glipizide</i>)	3/4	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	QL (1 tablet per day)
THIAZOLIDINEDIONES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (<i>pioglitazone hcl-metformin hcl</i>)	3/4	QL (3 tablets per day)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (<i>pioglitazone hcl-glimepiride</i>)	3	QL (1 tablet per day)
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	1	QL (1 tablet per day)
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	QL (1 tablet per day)
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	QL (3 tablets per day)
THYROID AGENTS - Drugs for the Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (<i>thyroid</i>)	3	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	3	
<i>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</i>	1	
<i>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</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (levothyroxine sodium)	2	PA
unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
IMMUNOMODULATORY AGENTS (90:00)		
AMINO ACID POLYMERS		
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	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; QL (40 tablets per 720 days.); SP; SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>teriflunomide oral tablet 14 mg</i>	1	PA; QL (1 tablet per day.)
<i>teriflunomide oral tablet 7 mg</i>	1	PA; QL (31 tablets per month.)
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3/4	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	1	
APRIL OR BAFF INHIBITOR AGENTS		
VOYXACT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 400 MG/2ML (<i>sibeprenlimab-szsi</i>)	3/4	
CALCINEURIN INHIBITORS, MISC (90:28)		
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3/4	PA
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	1	PA; QL (60 vials per month.)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	QL (30 grams per prescription.)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (<i>cyclosporine</i>)	3/4	PA; QL (4 vials per day.)
COMPLEMENT INHIBITOR AGENTS (90:20)		
FABHALTA ORAL CAPSULE 200 MG (<i>iptacopan hcl</i>)	2	PA; QL (2 capsules per day.)
TAVNEOS ORAL CAPSULE 10 MG (<i>avacopan</i>)	3/4	PA; QL (6 capsules per day.); SP; SMCS
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (<i>zilucoplan sodium</i>)	3/4	PA; QL (0.416 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (<i>zilucoplan sodium</i>)	3/4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (<i>zilucoplan sodium</i>)	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 (<i>vedolizumab</i>)	2	PA; QL (0.05 ml per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (<i>abatacept</i>)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (<i>abatacept</i>)	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 (<i>sulfasalazine</i>)	3/4	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3/4	
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (methotrexate (anti-rheumatic))	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (methotrexate (anti-rheumatic))	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (auranofin)	3	
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 (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (guselkumab)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (guselkumab)	2	PA; QL (4 ml (2 pens/1 box) per month.)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	3/4	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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	2	PA; QL (14 vials per month.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	
INTERLEUKIN INHIBITOR AGENTS, MISC		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.)
INTERLEUKIN-MEDIATED AGENTS, MISC		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	3	PA; QL (4 prefilled syringes per month.)
AVTOZMA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab-anoh</i>)	3	PA; QL (4 autoinjectors per month.)
AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab-anoh</i>)	3	PA; QL (4 syringes per month.)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	2	PA; QL (0.036 ml per day.)
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
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (ustekinumab-hmny)	2	PA; QL (1 single-dose vial every 3 months.)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (ustekinumab-hmny)	2	PA; QL (1 prefilled syringe every 3 months.)
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (ustekinumab-stba)	2	
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (ustekinumab-stba)	2	PA; QL (1 syringe every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (ustekinumab-auub)	2	PA; QL (1 single-dose vial every 3 months.)
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; 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.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	2	PA; QL (8 mL per day.)
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	2	PA; QL (2 tablets per day.)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.)
MONOCARBOXYLIC ACID AMIDE AGENTS		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
MONOCLONAL ANTIBODIES (90:04)		
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (<i>ofatumumab</i>)	2	PA; QL (0.02 ml per day.)
MONOCLONAL ANTIBODIES (90:10)		
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (<i>lecanemab-irmb</i>)	3/4	PA; QL (7.2 mL (4 autoinjectors) per month.)
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>satralizumab-mwge</i>)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3/4	PA; QL (10 g per 23 days.)
<i>sirolimus oral solution 1 mg/ml</i>	1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
NEONATAL FC RECEPTOR BLOCKERS		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (<i>efgartigimod alfa-hyalur-qvfc</i>)	3/4	PA; QL (4 syringes every 50 days.)
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack per year.)
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (<i>apremilast</i>)	2	PA; QL (30 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack (41 tablets) per 365 days.)
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.)
GILENYA ORAL CAPSULE 0.25 MG (<i>fingolimod hcl</i>)	3/4	PA; QL (1 capsule per day.)
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (7 tablets per 365 days.)
T-CELL BLOCKERS (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG (<i>voclosporin</i>)	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; QL (1.6 mL (2 auto-injectors) per month.)
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 (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	2	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 syringe per month.)
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (<i>tetracaine hcl</i>)	3	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	1	
ZTLIDO EXTERNAL PATCH 1.8 % (<i>lidocaine</i>)	3	PA; QL (3 patches per day.)
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
<i>dutasteride oral capsule 0.5 mg</i>	1	
<i>finasteride oral tablet 5 mg</i>	1	
5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	1	
<i>dutasteride oral capsule 0.5 mg</i>	1	
<i>finasteride oral tablet 5 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>naltrexone hcl oral tablet 50 mg</i>	1	
ANTIDOTES (92:12) - Drugs for Overdose or Poisoning		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE <i>(glucagon)</i>	2	QL (2 intranasal devices per prescription.)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE <i>(glucagon)</i>	2	QL (2 intranasal devices per prescription.)
CHEMET ORAL CAPSULE 100 MG <i>(succimer)</i>	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG <i>(lanthanum carbonate)</i>	3	
<i>glucagon emergency kit injection solution reconstituted 1 mg</i>	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML <i>(glucagon)</i>	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML <i>(glucagon)</i>	2	QL (0.4 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML <i>(glucagon)</i>	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML <i>(glucagon)</i>	2	QL (0.4 ml per prescription.)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML <i>(glucagon)</i>	2	QL (2 vials per copay.)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML <i>(glucagon)</i>	2	QL (2 prefilled syringes per copay.)
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	1	
<i>lederle leucovorin oral tablet 5 mg</i>	1	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
phytonadione oral tablet 5 mg	1	QL (5 tablets per prescription.)
RADIOGARDASE ORAL CAPSULE 0.5 GM (prussian blue insoluble)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
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	QL (20 packets per prescription.)
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 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	PA
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	PA
MITIGARE ORAL CAPSULE 0.6 MG (colchicine)	2	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (sulopenem etzadrox-probenecid)	3/4	QL (10 tablets per course of therapy.)
probenecid oral tablet 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (<i>sodium oxybate</i>)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	3/4	PA; QL (1 box (28 packets) per year.)
<i>sodium oxybate oral solution 500 mg/ml</i>	3/4	PA; QL (18 ml per day.); SP; SMCS
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (<i>eplontersen sodium</i>)	2	PA; QL (0.029 ml per day.)
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	3	PA
BONE RESORPTION INHIBITORS - Drugs for Bone Loss		
<i>alendronate sodium oral solution 70 mg/75ml</i>	1	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	1	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (<i>estradiol</i>)	3	QL (8 patches (1 box) per 28 days.); SM
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (<i>estradiol valerate</i>)	3/4	SM
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	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 (<i>estradiol</i>)	3	SM
<i>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</i>	1	QL (8 patches (1 box) per 28 days.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 (37.5 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.)
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	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	3	
<i>raloxifene hcl oral tablet 60 mg</i>	1	H-N
<i>risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg</i>	1	
<i>yuvaferm vaginal tablet 10 mcg</i>	1	
BRADYKININ RECEPTOR ANTAGONISTS		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; QL (0.6 ml per day.); SMCS
CARBONIC ANHYDRASE INHIBITORS (92:26)		
<i>dichlorphenamide oral tablet 50 mg</i>	1	PA; QL (4 tablets per day.)
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3/4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (<i>stannous fluoride</i>)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (<i>sodium fluoride-vitamin d</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (<i>stannous fluoride</i>)	3	
FLUORIDEX DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (<i>sodium fluoride</i>)	3	
<i>sf 5000 plus dental cream 1.1 %</i>	1	
<i>sf dental gel 1.1 %</i>	1	
<i>sod fluoride-potassium nitrate dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 enamel dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental paste 1.1 %</i>	1	
<i>sodium fluoride 5000 sensitive dental gel 1.1-5 %</i>	1	
<i>sodium fluoride dental cream 1.1 %</i>	1	
<i>sodium fluoride dental gel 1.1 %</i>	1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	1	H
<i>sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	1	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
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; QL (16 vials per month.); 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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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; QL (16 vials per month.); SP; SMCS
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.); 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
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (tocilizumab)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (tocilizumab)	3	PA; QL (4 prefilled syringes 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; QL (1.6 mL (2 auto-injectors) per month.)
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3/4	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3/4	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3/4	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	2	PA; QL (1 tablet per day.); CM
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.)
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
DEPEN TITRATABS ORAL TABLET 250 MG (<i>penicillamine</i>)	2	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
gengraf oral capsule 100 mg, 25 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (methotrexate)	3/4	PA; CM
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; QL (1 tablet per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	3	PA; 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.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 15 MG/0.3ML (methotrexate (anti-rheumatic))	2	QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (methotrexate (anti-rheumatic))	2	QL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (methotrexate (anti-rheumatic))	2	QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (methotrexate (anti-rheumatic))	2	QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (methotrexate (anti-rheumatic))	2	QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (methotrexate (anti-rheumatic))	2	QL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (methotrexate (anti-rheumatic))	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (auranofin)	3	
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, 5 MG (tofacitinib citrate)	2	PA; QL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.)
ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)		
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3/4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	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 (<i>tocilizumab</i>)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	3	PA; QL (4 prefilled syringes per month.)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (<i>interferon gamma-1b</i>)	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; QL (1.6 mL (2 auto-injectors) per month.)
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 (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	2	PA; QL (4 pens (1 box) per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	2	PA; QL (4 syringes (1 box) per month.)
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3/4	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3/4	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3/4	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	2	PA; QL (4 capsules per day.)
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	2	PA; QL (14 vials per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; QL (56 capsules per year.); SP; SMCS
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; QL (2 capsules per day.); SP; SMCS
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SP; SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>satralizumab-mwge</i>)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.)
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
GILENYA ORAL CAPSULE 0.25 MG (<i>fingolimod hcl</i>)	3/4	PA; QL (1 capsule per day.)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	1	PA; QL (30 ml per month.)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	1	PA; QL (12 ml per 21 days.)
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	1	PA; QL (30 ml per month.)
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	1	PA; QL (12 ml per 21 days.)
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
JOENJA ORAL TABLET 70 MG (<i>leniolisib phosphate</i>)	2	PA; QL (2 tablets per day.)
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (<i>ofatumumab</i>)	2	PA; QL (0.02 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg</i>	1	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
<i>lenalidomide oral capsule 20 mg, 25 mg</i>	1	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; QL (40 tablets per 720 days.); SP; SMCS
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (7 tablets per 365 days.)
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (<i>abatacept</i>)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (<i>abatacept</i>)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack per year.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	3	PA; QL (1 ml per month.); SP; SMCS
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	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 (<i>peginterferon beta-1a</i>)	3	PA; QL (2 ml per year without additional quantity notification.); SP; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	3	PA; QL (1 ml per month.); SP; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	3	PA; QL (1 ml per month.); SP; SMCS
<i>pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg</i>	1	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
RHAPSIDO ORAL TABLET 25 MG (<i>remibrutinib</i>)	2	PA; QL (60 tablets per month.)
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (1 syringe per month.)
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<i>teriflunomide oral tablet 14 mg</i>	1	PA; QL (1 tablet per day.)
<i>teriflunomide oral tablet 7 mg</i>	1	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	2	PA; QL (28 capsules per prescription.); SP; CM; SMCS
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (<i>ozanimod hcl</i>)	3	PA; QL (7 capsules per year.)
ZEPOSIA ORAL CAPSULE 0.92 MG (<i>ozanimod hcl</i>)	3	PA; QL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) (<i>ozanimod hcl</i>)	3	PA
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3/4	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.)
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	1	
<i>engraft oral capsule 100 mg, 25 mg</i>	1	
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3/4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
LUPKYNIS ORAL CAPSULE 7.9 MG (<i>voclosporin</i>)	3/4	PA; QL (6 capsules per day.); SP; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	1	CM
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
<i>mycophenolate mofetil oral capsule 250 mg</i>	1	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	1	
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	1	
<i>mycophenolic acid oral tablet delayed release 180 mg, 360 mg</i>	1	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (<i>mycophenolate mofetil</i>)	1	
<i>pimecrolimus external cream 1 %</i>	1	QL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3/4	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	3	CM
<i>sirolimus oral solution 1 mg/ml</i>	1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	QL (30 grams per prescription.)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	3/4	PA; CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SP; SMCS
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (<i>levacetylleucine</i>)	3/4	PA; QL (112 packets per month.)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	2	PA; QL (4 vials per 21 days.); SP; SMCS
<i>betaine oral powder</i>	1	
CARNITOR ORAL SOLUTION 1 GM/10ML (<i>levocarnitine</i>)	3/4	
CARNITOR ORAL TABLET 330 MG (<i>levocarnitine</i>)	3/4	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (<i>levocarnitine</i>)	3/4	
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	2	PA
CYSTADANE ORAL POWDER (<i>betaine</i>)	3/4	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (<i>cysteamine bitartrate</i>)	2	
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	1	PA; QL (2 tablets per day)
DIABETES MONITOR DIGIT ADD-ON KIT	3	
DIABETES MONITOR DIGIT SOLN KIT	3	
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (<i>givinostat hcl</i>)	3/4	PA; QL (420 mL per month.)
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (<i>prasterone (dhea)</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ELMIRON ORAL CAPSULE 100 MG (<i>pentosan polysulfate sodium</i>)	3/4	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
ENDARI ORAL PACKET 5 GM (<i>glutamine (sickle cell)</i>)	3/4	PA; QL (6 packets per day.)
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (<i>risdiplam</i>)	2	PA; QL (6.7 ml per day, 1280 ml per 180 days.); SP; SMCS
EVRYSDI ORAL TABLET 5 MG (<i>risdiplam</i>)	2	PA; QL (30 tablets per month.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3/4	PA; QL (1 tablet per day.)
FIRDAPSE ORAL TABLET 10 MG (<i>amifampridine phosphate</i>)	2	PA; QL (300 tablets per month.)
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	3/4	PA; QL (14 capsules per 21 days.)
ISTURISA ORAL TABLET 1 MG (<i>osilodrostat phosphate</i>)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (<i>osilodrostat phosphate</i>)	3/4	PA; QL (372 tablets per month.)
KYGEVVI ORAL PACKET 2-2 GM (<i>doxecitine-doxribtimine</i>)	3/4	
<i>levocarnitine oral solution 1 gm/10ml</i>	1	
<i>levocarnitine oral tablet 330 mg</i>	1	
<i>levocarnitine sf oral solution 1 gm/10ml</i>	1	
<i>l-glutamine oral packet 5 gm</i>	1	PA; QL (6 packets per day.)
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	3/4	QL (1 tablet per day.)
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>metirosine oral capsule 250 mg</i>	1	PA
<i>miglustat oral capsule 100 mg</i>	1	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
OPFOLDA ORAL CAPSULE 65 MG (<i>miglustat (gaa deficiency)</i>)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	2	PA

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PREMESISR _X ORAL TABLET 1 MG (<i>prenatal ca-b6-b12-fa-ginger</i>)	3	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fecbn-feasp-meth-fa-dha</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	2	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (<i>cysteamine bitartrate</i>)	3/4	PA; SP; SMCS
PROCYSBI ORAL PACKET 300 MG, 75 MG (<i>cysteamine bitartrate</i>)	3/4	SP; SMCS
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (<i>belumosudil mesylate</i>)	3/4	PA; QL (1 tablet per day.); SP; SMCS
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (<i>nedosiran sodium</i>)	3/4	PA; QL (0.04 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (<i>nedosiran sodium</i>)	3/4	PA; QL (0.03 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>nedosiran sodium</i>)	3/4	PA; QL (0.04 ml per day.)
<i>sapropterin dihydrochloride oral packet 100 mg</i>	1	PA; QL (16 packets per day.)
<i>sapropterin dihydrochloride oral packet 500 mg</i>	1	PA; QL (4 packets per day.)
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	1	PA; QL (16 tablets per day)
SKYCLARYS ORAL CAPSULE 50 MG (<i>omaveloxolone</i>)	2	PA; QL (3 capsules per day.)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (<i>palovarotene</i>)	3/4	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	3/4	QL (1 tablet per day.); SM
<i>tiopronin oral tablet 100 mg</i>	1	CM
<i>tiopronin oral tablet delayed release 100 mg, 300 mg</i>	1	CM
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (<i>methen-hyosc-meth blue-na phos</i>)	2	
VIJOICE ORAL PACKET 50 MG (<i>alpelisib</i>)	3/4	PA; QL (28 packets (1 carton) per month.)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (<i>alpelisib</i>)	3/4	PA; QL (28 tablets (1 blister pack) per month.)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (<i>alpelisib</i>)	3/4	PA; QL (56 tablets (2 blister packs) per month.)
VILEVEV MB ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<i>prenat-fe poly-methfol-fa-dha</i>)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	
VOWST ORAL CAPSULE (<i>fecal microb spores, live-brpk</i>)	3/4	PA; QL (12 capsules per 365 days.)
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (<i>vosoritide</i>)	3/4	PA; QL (1 vial per day.); SP; SMCS
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.)
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<i>zelvysia oral packet 100 mg</i>	1	PA; QL (589 packets per month.)
<i>zelvysia oral packet 500 mg</i>	1	PA; QL (4 packets per day.)
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	2	PA; QL (5 capsules per day.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZOKINVY ORAL CAPSULE 75 MG (<i>lonafarnib</i>)	2	PA; QL (1 tablet per day.)
PROTECTIVE AGENTS		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1	QL (45 grams per prescription)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	1	PA; QL (2 tablets per day)
<i>mesna oral tablet 400 mg</i>	1	CM
MESNEX ORAL TABLET 400 MG (<i>mesna</i>)	3/4	CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	3	H
CONDOMS	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN (<i>condoms latex lubricated</i>)	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	3	QL (12 condoms per month.); H
DUREX TROPICAL (<i>condoms latex lubricated</i>)	3	QL (12 condoms per month.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (<i>nonoxynol-9</i>)	E	H
FC2 FEMALE CONDOM (<i>condoms - female</i>)	3	QL (12 condoms per month.); H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (<i>cervical caps</i>)	3	H
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (<i>diaphragms</i>)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (<i>nonoxynol-9</i>)	E	H
PHEXX VAGINAL GEL 1.8-1-0.4 % (<i>lactic ac-citric ac-pot bitart</i>)	3/4	H
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	E	H
TRUE COVER DEVICE	3	QL (12 condoms per month.); H
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (<i>nonoxynol-9</i>)	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (<i>nonoxynol-9</i>)	E	H
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	2	H
OXYTOCICS - Drugs for Women		
OXYTOCICS - Drugs for Women		
CERVIDIL VAGINAL INSERT 10 MG (<i>dinoprostone</i>)	3	
METHERGINE ORAL TABLET 0.2 MG (<i>methylergonovine maleate</i>)	3/4	QL (28 tablets per year.)
<i>methylergonovine maleate oral tablet 0.2 mg</i>	1	QL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG (<i>mifepristone</i>)	3	SM
<i>mifepristone oral tablet 200 mg</i>	1	SM
PREPIDIL VAGINAL GEL 0.5 MG/3GM (<i>dinoprostone</i>)	3	
PHARMACEUTICAL AIDS		
PHARMACEUTICAL AIDS		
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AG) ANHYDROUS TRANSDERMAL GEL (<i>transdermal base</i>)	3	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (<i>transdermal base</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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		
DUAL PHOSPHODIESTERASE INHIBITOR (48:34)		
OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (<i>ensifentrine</i>)	3/4	PA; QL (150 mL per month.); SM
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (<i>epinephrine</i>)	2	QL (2 pens per prescription.); SM
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	2	QL (2 injections per prescription.); SM
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml</i>	1	QL (2 injections per prescription.); SM
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.); SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD		
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	3/4	QL (0.87 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	3	QL (0.28 grams per day.); SM
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
<i>ipratropium bromide hfa inhalation aerosol solution 17 mcg/act</i>	1	QL (0.87 grams per day.); SM
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	SM
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	SM
LEVVID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN ORAL TABLET 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (<i>hyoscyamine sulfate</i>)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	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 (<i>tiotropium bromide</i>)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (<i>tiotropium bromide</i>)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>tiotropium bromide</i>)	2	SM
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (<i>revefenacin</i>)	3/4	PA; QL (3 ml per day.); SM
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (<i>nerandomilast</i>)	3/4	PA; QL (60 tablets per month.)
<i>nintedanib esylate oral capsule 100 mg, 150 mg</i>	1	PA; QL (2 capsules per day.)
<i>pirfenidone oral capsule 267 mg</i>	1	PA; QL (9 capsules per day.)
<i>pirfenidone oral tablet 267 mg</i>	1	PA; QL (9 tablets per day.)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	1	PA; 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (<i>brensocatib</i>)	3/4	PA; QL (31 tablets per month.)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	3/4	PA; QL (0.015 ml per day.)
ANTITUSSIVES - Drugs for Cough and Cold		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	1	
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	1	NTT
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	1	PA; QL (120 mL per prescription and 360 ml per month.)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	1	PA
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (<i>phenylephrine-chlorphen-dm</i>)	3	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	1	PA; QL (360 ml per month.)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1	
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (fluticasone-salmeterol)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	QL (10.7 grams per prescription.); 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, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (fluticasone furoate-vilanterol)	3	QL (2 blisters 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
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
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	3	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	QL (34 grams (2 bottles) per copay.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	1	QL (10.6 grams per month.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (42.4 grams per month.); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	QL (2 blisters per day.); SM
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (<i>vanzacraft-tezacraft-deutivacraft</i>)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (<i>vanzacraft-tezacraft-deutivacraft</i>)	3/4	PA; QL (84 tablets per month.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	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 (<i>elexacaftor-tezacaftor-ivacaft</i>)	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 (<i>elexacaftor-tezacaftor-ivacaft</i>)	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 (<i>vanzacraft-tezacraft-deutivacraft</i>)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (<i>vanzacraft-tezacraft-deutivacraft</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>ivacaftor</i>)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (<i>ivacaftor</i>)	2	PA; QL (728 packets per 356 days.)
KALYDECO ORAL PACKET 5.8 MG (<i>ivacaftor</i>)	2	PA; QL (2 packets per day and 728 packets per 365 days.)
KALYDECO ORAL TABLET 150 MG (<i>ivacaftor</i>)	2	PA; QL (780 tablets per 356 days.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	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 (<i>elexacaftor-tezacaftor-ivacaft</i>)	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 (<i>elexacaftor-tezacaftor-ivacaft</i>)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); SP; SMCS
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3/4	PA; QL (1 tablet per day.)
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 SOLUBLE 32 MG (<i>bosentan</i>)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TRYVIO ORAL TABLET 12.5 MG (<i>aproцитentan</i>)	3/4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	3/4	PA; QL (30 tablets per month.)
EXPECTORANTS - Drugs for the Lungs		
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	1	
<i>potassium iodide (expectorant) oral solution 1 gm/ml</i>	1	
SSKI ORAL SOLUTION 1 GM/ML (<i>potassium iodide (expectorant)</i>)	3	
FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	2	PA; QL (4 vials per 21 days.); SP; SMCS
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	3/4	PA; QL (1 pen every 2 months.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	3/4	PA; QL (0.07 ml per day.)
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
<i>montelukast sodium oral packet 4 mg</i>	1	
<i>montelukast sodium oral tablet 10 mg</i>	1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	1	
SINGULAIR ORAL PACKET 4 MG (<i>montelukast sodium</i>)	3	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	1	
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	1	
MAST-CELL STABILIZERS - Drugs for Inflammation		
ALOCRILOPHthalmic SOLUTION 2 % (<i>nedocromil sodium</i>)	3	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	SM
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
MUCOLYTIC AGENTS - Drugs for the Lungs		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (<i>sodium chloride</i>)	2	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>sodium chloride</i>)	3	
PULMOSAL INHALATION NEBULIZATION SOLUTION 7 % (<i>sodium chloride</i>)	2	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	2	PA; QL (5 ml per day.)
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %</i>	1	
NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	1	QL (34 grams (2 bottles) per copay.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEUTROPHIL SERINE PROTEASE INHIBITORS - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (<i>brensocatib</i>)	3/4	PA; QL (31 tablets per month.)
ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 packet per day.); SM
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	1	SM
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	1	QL (120 ml (2 boxes) per 30 days.); SM
<i>budesonide inhalation suspension 1 mg/2ml</i>	1	QL (60 ml (1 box) per 30 days.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (42.4 grams per month.); SM
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (<i>nerandomilast</i>)	3/4	PA; QL (60 tablets per month.)
<i>roflumilast oral tablet 250 mcg</i>	1	QL (31 tablets per year.)
<i>roflumilast oral tablet 500 mcg</i>	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.05 % (<i>roflumilast</i>)	3/4	PA; QL (60 Grams per prescription.)
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
<i>alyq oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg</i>	1	QL (0.5 tablet per day.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	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 (<i>treprostinil diolamine</i>)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (6 tablets per day.)
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X 64MCG, 112 X 48MCG & 112 X 64MCG (<i>treprostinil</i>)	2	PA; QL (224 cartridges per month.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (<i>mannitol (cystic fibrosis)</i>)	3	PA; QL (20 capsules per day.); CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (<i>mannitol (cystic fibrosis)</i>)	3	PA; QL (20 capsules per day.); CM
<i>pirfenidone oral capsule 267 mg</i>	1	PA; QL (9 capsules per day.)
<i>pirfenidone oral tablet 267 mg</i>	1	PA; QL (9 tablets per day.)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	1	PA; QL (3 tablets per day.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	3/4	PA; QL (0.07 ml per day.)
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (<i>sotatercept-csrk</i>)	3/4	PA; QL (1 kit every 3 weeks.); SP; SMCS
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.)
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (1 inhaler per copay.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (1 inhaler per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (18 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (6.7 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	QL (8.5 grams per prescription.); SM
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1	SM
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	1	PA
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	1	QL (2 nebules per day); SM
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	1	QL (2 vials per day.); SM
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	1	QL (90 ml per prescription.); SM
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	1	QL (30 vials per prescription); SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.); SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (<i>formoterol fumarate</i>)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>salmeterol xinafoate</i>)	2	QL (1 diskus (60 blisters) per month.); SM

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>olodaterol hcl</i>)	2	SM
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (<i>levalbuterol tartrate</i>)	3	QL (15 grams per prescription.); 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 (<i>riociguat</i>)	2	PA; QL (3 tablets per day.)
<i>alyq oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; QL (1 tablet per day.); SP; SMCS
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SP; SMCS
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	2	PA; QL (1 tablet per day.); SP; SMCS
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	3/4	PA; QL (6 tablets per day.)
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg</i>	1	QL (0.5 tablet per day.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.)
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	3/4	PA; QL (4 tablets 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per month.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SP; SMCS
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	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 (<i>riociguat</i>)	2	PA; QL (3 tablets per day.)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	3/4	PA; QL (200 tablets per year.)
XANTHINE DERIVATIVES - Drugs for Asthma/COPD		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
SKIN AND MUCOUS MEMBRANE AGENTS		
ANTIPROLIFERANTS		
AMELUZ EXTERNAL GEL 10 % (<i>aminolevulinic acid hcl</i>)	3	
<i>bexarotene external gel 1 %</i>	1	QL (60 grams per prescription.)
<i>bexarotene oral capsule 75 mg</i>	1	CM
<i>fluorouracil external cream 5 %</i>	1	
<i>fluorouracil external solution 2 %, 5 %</i>	1	
<i>imiquimod external cream 5 %</i>	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3/4	QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3/4	QL (5 units per prescription)
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (<i>aminolevulinic acid hcl</i>)	3	
PANRETIN EXTERNAL GEL 0.1 % (<i>alitretinoin</i>)	3	
VALCHLOR EXTERNAL GEL 0.016 % (<i>mechlorethamine hcl (topical)</i>)	2	PA; QL (120 grams per prescription.); SP; SMCS
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ADRENERGIC AGONISTS - Drugs for the Skin		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (<i>brimonidine tartrate</i>)	1	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	3/4	QL (10 ml per prescription)
<i>brimonidine tartrate external gel 0.33 %</i>	1	PA; QL (30 grams per prescription.)
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	1	QL (10 ml per prescription)
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (<i>brimonidine tartrate-timolol</i>)	1	QL (5 ml per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MIRVASO EXTERNAL GEL 0.33 % (<i>brimonidine tartrate</i>)	2	PA; QL (30 grams per prescription.)
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	3/4	PA; QL (30 grams per prescription.)
ANTIBACTERIALS (84:04) - Drugs for the Skin		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3/4	QL (30 grams per prescription.)
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	3/4	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
<i>azelaic acid external gel 15 %</i>	1	
AZELEX EXTERNAL CREAM 20 % (<i>azelaic acid</i>)	3	QL (30 grams per prescription.)
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (<i>benzoyl peroxide-erythromycin</i>)	2	QL (23.3 grams per prescription.)
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	1	QL (23.3 grams per prescription.)
<i>bp 10-1 external emulsion 10-1 %</i>	1	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (<i>clindamycin hcl</i>)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (<i>clindamycin hcl</i>)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (<i>clindamycin palmitate hcl</i>)	3/4	
CLEOCIN VAGINAL CREAM 2 % (<i>clindamycin phosphate</i>)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (<i>clindamycin phosphate</i>)	3/4	
<i>clindacin etz external swab 1 %</i>	1	
<i>clindacin external foam 1 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>clindacin-p external swab 1 %</i>	1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	1	
<i>clindamycin phos (twice-daily) external gel 1 %</i>	1	QL (75 grams per prescription.)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
<i>clindamycin phosphate external foam 1 %</i>	1	
<i>clindamycin phosphate external lotion 1 %</i>	1	
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>clindamycin phosphate vaginal cream 2 %</i>	1	
CLINDESSE VAGINAL CREAM 2 % (<i>clindamycin phosphate (1 dose)</i>)	2	
<i>dapsone external gel 5 %, 7.5 %</i>	1	QL (60 grams per prescription.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
ERY EXTERNAL PAD 2 %	3	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	3/4	
<i>gentamicin sulfate external cream 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate external ointment 0.1 %</i>	1	QL (30 grams per prescription.)
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	QL (15 ml per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KLARON EXTERNAL LOTION 10 % (<i>sulfacetamide sodium (acne)</i>)	3/4	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	3/4	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	3/4	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	
<i>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</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	1	
<i>mupirocin calcium external cream 2 %</i>	1	QL (15 grams per prescription)
<i>mupirocin external ointment 2 %</i>	1	QL (22 grams per prescription.)
<i>neomycin sulfate oral tablet 500 mg</i>	1	
<i>neuac external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	
<i>sodium sulfacetamide external shampoo 10 %</i>	1	
<i>sodium sulfacetamide wash external liquid 10 %</i>	1	
<i>sss 10-5 external cream 10-5 %</i>	1	
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	1	
<i>sulfacetamide sodium (cleans) external gel 10 %</i>	1	
<i>sulfacetamide sodium external liquid 10 %</i>	1	
<i>sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %</i>	1	
<i>sulfacetamide sodium-sulfur external emulsion 10-1 %</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (mafenide acetate)	3	
SUMAXIN EXTERNAL PAD 10-4 % (sulfacetamide sodium-sulfur)	3/4	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	3/4	
XACIATO VAGINAL GEL 2 % (clindamycin phosphate)	2	QL (1 gel tube (8 grams) per prescription.)
XEPI EXTERNAL CREAM 1 % (ozenoxacin)	3	QL (30 g per prescription.)
ZILXI EXTERNAL FOAM 1.5 % (minocycline hcl micronized)	3/4	PA; QL (30 grams per prescription.)
ANTIFULGALS (SKIN, MUCOUS MEMBRANE), MISC - Drugs for the Skin		
EXODERM EXTERNAL LOTION 25-1 % (sod thiosulfate-salicylic acid)	3	
ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (crisaborole)	3	QL (60 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (tapinarof)	3/4	PA; QL (60 grams per prescription.)
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (hydrocortisone ace-pramoxine)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (<i>lidocaine-benzalkonium (pod)</i>)	3	
<i>doxepin hcl external cream 5 %</i>	1	PA; QL (45 grams per prescription.)
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	
DYCLOPRO EXTERNAL SOLUTION 0.5 %	3/4	
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	2	
<i>glydo external prefilled syringe 2 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
<i>lidocaine external ointment 5 %</i>	1	QL (1.19 grams per day.)
<i>lidocaine external patch 5 %</i>	1	PA; QL (3 patches per day)
<i>lidocaine hcl external solution 4 %</i>	1	
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	1	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	1	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	1	
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	2	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	2	
PYRIDIDIUM ORAL TABLET 100 MG, 200 MG (<i>phenazopyridine hcl</i>)	3	
ZTLIDO EXTERNAL PATCH 1.8 % (<i>lidocaine</i>)	3	PA; QL (3 patches per day.)
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
<i>acyclovir external ointment 5 %</i>	1	
<i>acyclovir oral capsule 200 mg</i>	1	
<i>acyclovir oral suspension 200 mg/5ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	
ZELSUVMI EXTERNAL GEL 10.3 % (<i>berdazimer sodium</i>)	3/4	QL (31 grams (1 box) per copay)
ASTRINGENTS (84:12) - Drugs for the Skin		
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	2	QL (0.36 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (<i>glycopyrrolate</i>)	3/4	
DRYSOL EXTERNAL SOLUTION 20 % (<i>aluminum chloride</i>)	3/4	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
ASTRINGENTS, ANTI-INFECTIVE - Drugs for the Skin		
<i>benzalkonium chloride external solution</i>	2	
<i>benzalkonium chloride external solution 50 %</i>	1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
<i>iodine tincture external tincture 2 %</i>	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	3/4	
<i>perio gard mouth/throat solution 0.12 %</i>	1	
<i>selenium sulfide external lotion 2.5 %</i>	1	
SILVADENE EXTERNAL CREAM 1 % (<i>silver sulfadiazine</i>)	3/4	
<i>silver sulfadiazine external cream 1 %</i>	1	
<i>ssd external cream 1 %</i>	1	
AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
<i>clotrimazole mouth/throat troche 10 mg</i>	1	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	1	
<i>econazole nitrate external cream 1 %</i>	1	
EXELDERM EXTERNAL CREAM 1 % (<i>sulconazole nitrate</i>)	3	
EXELDERM EXTERNAL SOLUTION 1 % (<i>sulconazole nitrate</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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 lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
budesonide rectal foam 2 mg, 2 mg/act	1	
clobetasol prop emollient base external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate e external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external gel 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external liquid 0.05 %	1	QL (59 ml per prescription)
clobetasol propionate external ointment 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external solution 0.05 %	1	QL (25 ml per prescription.)
clocortolone pivalate external cream 0.1 %	1	QL (75 grams per prescription.)
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (flurandrenolide)	3	QL (1 packet per prescription.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-chloroxyleneol)	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-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (fluocinolone acetonide)	3/4	QL (118.28 ml per prescription.)
DERMA-SMOOTH/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	QL (15 grams per prescription.)
desonide external gel 0.05 %	1	QL (60 grams per prescription)
desonide external lotion 0.05 %	1	QL (60 ml per prescription.)
desonide external ointment 0.05 %	1	QL (15 grams per prescription.)
desoximetasone external cream 0.05 %	1	QL (60 gm per prescription.)
desoximetasone external cream 0.25 %	1	QL (15 grams per prescription.)
desoximetasone external gel 0.05 %	1	QL (15 grams per prescription.)
desoximetasone external ointment 0.05 %	1	QL (60 grams per prescription.)
desoximetasone external ointment 0.25 %	1	QL (15 grams per prescription.)
diflorasone diacetate external cream 0.05 %	1	QL (30 grams per prescription.)
DIPROLENE EXTERNAL OINTMENT 0.05 % (betamethasone dipropionate aug)	3/4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (calcipotriene-betameth diprop)	3/4	QL (60 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 2.5 %	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	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocortisone-iodoquinol external cream 1-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
KHINDIVI ORAL SOLUTION 1 MG/ML (hydrocortisone)	3/4	PA
KOURZEQ MOUTH/THROAT PASTE 0.1 % (triamcinolone acetonide)	2	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	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	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (pramoxine-hc)	2	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3/4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (<i>hc & sal acid-sulfur & shampoo</i>)	3	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	1	
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	2	
TOPICORT EXTERNAL OINTMENT 0.05 % (<i>desoximetasone</i>)	3/4	QL (60 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.25 % (<i>desoximetasone</i>)	3/4	QL (15 grams per prescription.)
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	1	QL (63 grams per prescription.)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external cream 0.5 %</i>	1	QL (15 grams per prescription.)
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	1	
<i>triderm external cream 0.5 %</i>	1	QL (15 grams per prescription.)
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
<i>ciclodan external solution 8 %</i>	1	
<i>ciclopirox external gel 0.77 %</i>	1	
<i>ciclopirox external shampoo 1 %</i>	1	
<i>ciclopirox external solution 8 %</i>	1	
<i>ciclopirox olamine external cream 0.77 %</i>	1	
<i>ciclopirox olamine external suspension 0.77 %</i>	1	
IMMUNOMODULATORY AGENTS (84:06) - Drugs for the Skin		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>tralokinumab-ldrm</i>)	2	PA; QL (2 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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	2	PA; QL (0.15 ml per day.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (2 ml (1 syringe) per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (1 syringe per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (2 ml (1 syringe) per month.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	2	PA; QL (1 pen (2 ml) per month.)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	2	PA; QL (1 pen (2 ml) per month.)
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3/4	PA; QL (10 g per 23 days.)
ICOTYDE ORAL TABLET 200 MG (<i>icotrokinra hcl</i>)	2	PA; QL (30 tablets per month.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (<i>nemolizumab-ilto</i>)	2	PA; QL (2 pens every 4 weeks.)
<i>pimecrolimus external cream 1 %</i>	1	QL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3/4	PA
RHAPSIDO ORAL TABLET 25 MG (<i>remibrutinib</i>)	2	PA; QL (60 tablets per month.)
<i>sirolimus oral solution 1 mg/ml</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (guselkumab)	2	PA; QL (1 mL (1 device) every 8 weeks.)
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 (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (guselkumab)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (guselkumab)	2	PA; QL (4 ml (2 pens/1 box) per month.)
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
ANZUPGO EXTERNAL CREAM 20 MG/GM (delgocitinib)	3/4	PA; QL (60 Grams per Month.)
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
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (ruxolitinib phosphate)	2	PA; CM
LITFULO ORAL CAPSULE 50 MG (ritlecitinib tosylate)	3	PA; QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (<i>ruxolitinib phosphate</i>)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
<i>roflumilast oral tablet 250 mcg</i>	1	QL (31 tablets per year.)
<i>roflumilast oral tablet 500 mcg</i>	1	QL (1 tablet per day)
SOTYKTU ORAL TABLET 6 MG (<i>deucravacitinib</i>)	2	PA; QL (1 tablet per day.)
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per prescription.)
KERATOLYTIC AGENTS - Drugs for the Skin		
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1	QL (45 grams per prescription)
AKLIEF EXTERNAL CREAM 0.005 % (<i>trifarotene</i>)	3/4	PA; QL (45 grams per prescription.)
<i>amnestem oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	3/4	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	3	
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	3	
<i>bp 10-1 external emulsion 10-1 %</i>	1	
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	3/4	
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (<i>salicylic acid-lactic acid</i>)	2	
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
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	
SALICATE EXTERNAL LIQUID 10 % (salicylic acid)	3	
salicylic acid external solution 26 %	1	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (salicylic acid-urea in lactac)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (hc & sal acid-sulfur & shampoo)	3	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SUMAXIN EXTERNAL PAD 10-4 % (sulfacetamide sodium-sulfur)	3/4	
tazarotene external cream 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (tazarotene)	3/4	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (tazarotene)	3/4	PA; QL (30 grams per prescription.)
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VEREGEN EXTERNAL OINTMENT 15 % (<i>sinecatechins</i>)	3	QL (30 grams per prescription.)
XIRUN EXTERNAL GEL 40-10 %	3	
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
KERATOPLASTIC AGENTS - Drugs for the Skin		
<i>coal tar external solution 20 %</i>	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1	QL (45 grams per prescription)
<i>benzalkonium chloride external solution</i>	2	
<i>benzalkonium chloride external solution 50 %</i>	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (<i>benzoyl peroxide-erythromycin</i>)	2	QL (23.3 grams per prescription.)
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	1	QL (23.3 grams per prescription.)
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxyleneol</i>)	3/4	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	2	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (<i>lidocaine-benzalkonium (pod)</i>)	3	
FEM PH VAGINAL GEL 0.9-0.025 % (<i>acetic acid-oxyquinoline</i>)	3/4	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
<i>iodine tincture external tincture 2 %</i>	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
<i>neuac external gel 1.2-5 %</i>	1	QL (1 bottle (45 grams) per month.)
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	3/4	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>periogard mouth/throat solution 0.12 %</i>	1	
<i>selenium sulfide external lotion 2.5 %</i>	1	
SILVADENE EXTERNAL CREAM 1 % (<i>silver sulfadiazine</i>)	3/4	
<i>silver sulfadiazine external cream 1 %</i>	1	
<i>ssd external cream 1 %</i>	1	
SULFAMYLLON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (<i>benzoyl peroxide-hyaluronate</i>)	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
<i>diclofenac sodium external gel 3 %</i>	1	PA; QL (100 grams per prescription.)
OXABOROLES - Drugs for the Skin		
<i>tavaborole external solution 5 %</i>	1	PA; QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	3	QL (60 grams per prescription.)
JASCAYD ORAL TABLET 18 MG, 9 MG (<i>nerandomilast</i>)	3/4	PA; QL (60 tablets per month.)
<i>roflumilast oral tablet 250 mcg</i>	1	QL (31 tablets per year.)
<i>roflumilast oral tablet 500 mcg</i>	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.05 % (<i>roflumilast</i>)	3/4	PA; QL (60 Grams per prescription.)
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per 30 days.)
PIGMENTING AGENTS - Drugs for the Skin		
<i>methoxsalen rapid oral capsule 10 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
<i>klayesta external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
<i>nystatin external cream 100000 unit/gm</i>	1	QL (90 grams per prescription.)
<i>nystatin external ointment 100000 unit/gm</i>	1	QL (90 grams per prescription.)
<i>nystatin external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	1	
<i>nystop external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
SCABICIDES AND PEDICULICIDES - Drugs for the Skin		
CROTAN EXTERNAL LOTION 10 % (<i>crotamiton</i>)	3	
EURAX EXTERNAL CREAM 10 % (<i>crotamiton</i>)	2	
<i>malathion external lotion 0.5 %</i>	1	
OVIDE EXTERNAL LOTION 0.5 % (<i>malathion</i>)	3/4	
<i>permethrin external cream 5 %</i>	1	
PRURADIK EXTERNAL LOTION 10 % (<i>crotamiton</i>)	3	
SOOLANTRA EXTERNAL CREAM 1 % (<i>ivermectin</i>)	1	QL (45 grams per prescription.)
<i>spinosad external suspension 0.9 %</i>	1	
<i>sulfurated lime external solution</i>	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1	QL (45 grams per prescription)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	2	PA; QL (0.15 ml per day.)
AKLIEF EXTERNAL CREAM 0.005 % (<i>trifarotene</i>)	3/4	PA; QL (45 grams per prescription.)
AMELUZ EXTERNAL GEL 10 % (<i>aminolevulinic acid hcl</i>)	3	
<i>amnestem oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
<i>azelaic acid external gel 15 %</i>	1	
AZELEX EXTERNAL CREAM 20 % (<i>azelaic acid</i>)	3	QL (30 grams per prescription.)
B & C EXTERNAL OINTMENT	3	
<i>balsam peru-castor oil external ointment</i>	1	
<i>bexarotene external gel 1 %</i>	1	QL (60 grams per prescription.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; QL (1 syringe per month.)
<i>brimonidine tartrate external gel 0.33 %</i>	1	PA; QL (30 grams per prescription.)
<i>calcipotriene external cream 0.005 %</i>	1	QL (60 grams per prescription)
<i>calcipotriene external ointment 0.005 %</i>	1	
<i>calcipotriene external solution 0.005 %</i>	1	QL (60 mL per prescription)
CALCITRENE EXTERNAL OINTMENT 0.005 % (<i>calcipotriene</i>)	3	
<i>calcitriol external ointment 3 mcg/gm</i>	1	QL (100 grams per prescription)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	2	PA; QL (1 tablet per day.); CM
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	3/4	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	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 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (60 grams per prescription.)
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.)
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	PA; QL (6 packets per day.)
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (calcipotriene-betameth diprop)	3/4	QL (60 grams per prescription.)
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid-oxyquinoline)	3/4	
FILSUEVZ EXTERNAL GEL 10 % (birch triterpenes)	3/4	PA; QL (14.4 grams per day.)
FINACEA EXTERNAL FOAM 15 % (azelaic acid)	3/4	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (dermatological products, misc.)	3	PA
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	3/4	PA; QL (10 g per 23 days.)
imiquimod external cream 5 %	1	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (tirbanibulin)	3/4	QL (5 units per prescription)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3/4	QL (5 units per prescription)
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (<i>aminolevulinic acid hcl</i>)	3	
<i>l-glutamine oral packet 5 gm</i>	1	PA; QL (6 packets per day.)
LITFULO ORAL CAPSULE 50 MG (<i>ritlecitinib tosylate</i>)	3	PA; QL (1 capsule per day.)
<i>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</i>	1	
MIRVASO EXTERNAL GEL 0.33 % (<i>brimonidine tartrate</i>)	2	PA; QL (30 grams per prescription.)
<i>nitroglycerin rectal ointment 0.4 %</i>	1	QL (30 grams per month.)
OPZELURA EXTERNAL CREAM 1.5 % (<i>ruxolitinib phosphate</i>)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack per year.)
PANRETIN EXTERNAL GEL 0.1 % (<i>alitretinoin</i>)	3	
<i>pimecrolimus external cream 1 %</i>	1	QL (30 grams per prescription.)
PODOCON-25 EXTERNAL SOLUTION 25 % (<i>podophyllum resin</i>)	3	
<i>podofilox external gel 0.5 %</i>	1	
<i>podofilox external solution 0.5 %</i>	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % (<i>nitroglycerin</i>)	3/4	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	3/4	PA; QL (30 grams per prescription.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	3	QL (90 grams per prescription.)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>risankizumab-rzaa</i>)	2	PA; QL (1 ml per 63 days.)

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>risankizumab-rzaa</i>)	2	PA; QL (1 ml per 63 days.)
SOTYKTU ORAL TABLET 6 MG (<i>deucravacitinib</i>)	2	PA; QL (1 tablet per day.)
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	QL (30 grams per prescription.)
<i>tazarotene external cream 0.05 %, 0.1 %</i>	1	PA; QL (30 grams per prescription.)
<i>tazarotene external gel 0.05 %, 0.1 %</i>	1	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (<i>tazarotene</i>)	3/4	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (<i>tazarotene</i>)	3/4	PA; QL (30 grams per prescription.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 syringe) every 8 weeks.)
VALCHLOR EXTERNAL GEL 0.016 % (<i>mechlorethamine hcl (topical)</i>)	2	PA; QL (120 grams per prescription.); SP; SMCS
VENELEX EXTERNAL OINTMENT (<i>balsam peru-castor oil</i>)	3	
VEREGEN EXTERNAL OINTMENT 15 % (<i>sinecatechins</i>)	3	QL (30 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	3/4	PA; QL (60 grams per prescription.)
ZELSUVMI EXTERNAL GEL 10.3 % (<i>berdazimer sodium</i>)	3/4	QL (31 grams (1 box) per copay)
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	3/4	PA; QL (60 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	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 (<i>xanomeline-trospium chloride</i>)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (<i>xanomeline-trospium chloride</i>)	3/4	PA; QL (1 starter pack per year.)
<i>flavoxate hcl oral tablet 100 mg</i>	1	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	1	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride oral tablet 2.5 mg, 5 mg</i>	1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	1	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	1	
<i>trospium chloride oral tablet 20 mg</i>	1	
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
<i>mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VITAMINS		
MULTIVITAMIN PREPARATIONS		
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	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 (<i>prenatal vit-fe fumarate-fa</i>)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
NESTABS ORAL TABLET 32-1 MG (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (<i>prenatal multivit-min-fe-fa</i>)	3	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
PREMESISRX ORAL TABLET 1 MG (<i>prenatal ca-b6-b12-fa-ginger</i>)	3	
<i>prenatal oral tablet 27-1 mg</i>	1	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DHA ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (<i>prenatal-feaspgly-methylfol-fa</i>)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fecbn-feasp-meth-fa-dha</i>)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (<i>prenat mv-min-methylfolate-fa</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	3/4	
TRINATE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOOR ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<i>prenat-fe poly-methfol-fa-dha</i>)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
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-FLOOR ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
VITAMIN B COMPLEX		
BEYAZ ORAL TABLET 3-0.02-0.451 MG (<i>drospiren-eth estrad-levomefol</i>)	E	H
CALCIFOL ORAL WAFER 1342-1.6 MG (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	3	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
<i>cyanocobalamin nasal solution 500 mcg/0.1ml</i>	1	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	1	H
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	E	H
<i>folic acid tablet 1 mg oral (rx)</i>	1	
<i>ft folic acid oral tablet 400 mcg, 800 mcg</i>	E	H
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	3/4	
<i>lederle leucovorin oral tablet 5 mg</i>	1	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (<i>cyanocobalamin</i>)	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 (<i>prenatal vit-fe fumarate-fa</i>)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
NESTABS ORAL TABLET 32-1 MG (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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	QL (1 kit per prescription.)
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	QL (1 kit per prescription.)
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	QL (1 kit per prescription.)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (peg-kcl-nacl-nasulf-na asc-c)	3	QL (3 cartons per prescription.)
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAMIN D		
CALCIFOL ORAL WAFER 1342-1.6 MG (ca carb-fa-d-b6-b12-boron-mg)	3	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	
calcitriol oral solution 1 mcg/ml	1	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	1	
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	

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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	1	
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG (<i>calcitriol</i>)	3/4	
ROCALTROL ORAL SOLUTION 1 MCG/ML (<i>calcitriol</i>)	3/4	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)</i>	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (<i>paricalcitol</i>)	3/4	
VITAMIN E		
<i>wheat germ oil oral oil</i>	1	
VITAMIN K ACTIVITY		
<i>phytonadione oral tablet 5 mg</i>	1	QL (5 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range 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 with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Index of Drugs

abacavir sulfate	33	ADDYI	136	aliskiren fumarate	113
abacavir sulfate-lamivudine ...	33	adefovir dipivoxil	38	allopurinol	263
abigale	226, 239	ADEMPAS	298, 299	almotriptan malate	155
abigale lo	226, 239	ADRENALIN	64, 197, 286	ALOCRIL	185, 293
abiraterone acetate	44	ADVAIR HFA ... 72, 189, 209, 289		ALOGLIPTIN BENZOATE	225
abirtega	44	ADVANTAGE SAFETY		ALOGLIPTIN-METFORMIN	
ABRYSVO	59	LANCETS 28G	162	HCL	217, 225
acamprosate calcium	15, 136	ADVATE	80	ALOGLIPTIN-PIOGLITAZONE	
acarbose	214	ADVOCATE SAFETY		.....	225, 251
ACCU-CHEK AVIVA	162	LANCETS 21G	162	ALORA	227, 264
ACCU-CHEK FASTCLIX		ADVOCATE SAFETY		alose tron hcl	200
LANCET KIT	162	LANCETS 23G	162	ALPHAGAN P	184, 300
ACCU-CHEK GUIDE	162	ADVOCATE SAFETY		ALPHANATE	80
ACCU-CHEK GUIDE		LANCETS 28G	162	ALPHANINE SD	80
CONTROL	162	ADYNOVATE	80	alprazolam	134
ACCU-CHEK GUIDE ME	162	AEROCHAMBER HOLDING		alprazolam er	133
ACCU-CHEK GUIDE TEST	174	CHAMBER	162	alprazolam intensol	134
ACCU-CHEK SMARTVIEW		AEROCHAMBER PLS FLOVU		alprazolam xr	134
CONTROL	162	MTHPIECE	162	ALPROLIX	80
ACCU-CHEK SOFTCLIX		AEROCHAMBER PLUS FLO-		ALREX	190
LANCET DEVICE KIT	162	VU INTERM	162	ALTACAIN	196, 261
accutane	316, 320	AEROCHAMBER PLUS FLO-		altavera	218, 227, 240
ACD-A NOCLOT-50	76	VU LARGE	162	ALTUVIII	80
acebutolol hcl		AEROCHAMBER PLUS FLO-		ALUNBRIG	45
.....	74, 94, 100, 102, 109	VU MEDIUM	162	ALVAIZ	78
acetaminophen-codeine		AEROCHAMBER PLUS FLO-		alvimopan	198, 204
.....	118, 143, 145	VU SMALL	162	alyacen 1/35	218, 227, 240
acetazolamide		AEROCHAMBER2GO ANTI-		alyacen 7/7/7	218, 227, 240
.....	89, 99, 119, 176, 189	STATIC	162	ALYFTREK	290
acetazolamide er		afirmelle	218, 226, 239	alyq	111, 112, 295, 298
.....	89, 99, 119, 176, 189	AFLURIA	60	amantadine hcl	20, 21, 117
acetic acid	194	AFLURIA PRESERVATIVE		ambrisentan	114, 291, 298
acetylcysteine	15, 262, 293	FREE	60	amcinonide	308
acitretin	316, 320	AFSTYLA	80	AMELUZ	300, 321
ACTEMRA	257, 269, 273	aftera	215, 218, 240	amethyst	218, 227, 240
ACTEMRA ACTPEN		AIMOVIG	135	amiloride hcl	90, 112, 178
.....	257, 269, 273	AIRSUPRA		amiloride-	
ACTHAR	173, 238	.....	72, 190, 209, 289, 294, 297	hydrochlorothiazide	178, 180
ACTHAR GEL	173, 238	AKEEGA	45	aminocaproic acid	80
ACTHIB	59	AKLIEF	316, 321	amiodarone hcl	104
ACTIMMUNE	273	AKTEN	196	amitriptyline hcl	157
ACTIVELLA	226, 239	AKYNZEO	198, 206	AMJEVITA	204, 260, 269, 273
ACTOPLUS MET	217, 251	albendazole	22	AMJEVITA-PED 15KG TO	
ACULAR	152, 195	albuterol sulfate	73, 297	<30KG	204, 260, 269, 273
ACULAR LS	152, 195	ALBUTEROL SULFATE ... 73, 297		amlodipine besylate	
acyclovir	38, 305, 306	albuterol sulfate hfa .. 72, 73, 297		.....	105, 106, 114
ADACEL	59, 60	ALCAINE	196	amlodipine besylate-	
ADALIMUMAB-ADAZ		alclometasone dipropionate 308		benazepril hcl	93, 105
.....	204, 260, 269, 273	ALCOHOL PREP PADS	163	amlodipine besylate-	
adapalene-benzoyl peroxide		ALECENSA	45	valsartan	92, 105
.....	284, 316, 318, 320	alendronate sodium	264	amnestem	316, 321
ADBRY	313, 314, 321	alfuzosin hcl er	72	amoxapine	157

amoxicillin	22, 201	ARNUITY ELLIPTA	190, 209, 289, 294	AUM READYGARD DUO PEN	NEEDLE	163
amoxicillin-potassium		ARTISS	307, 321	AUM SAFETY PEN NEEDLE		163
clavulanate	22	ARZOL SILVER NIT		AURANOFIN ...	208, 254, 269, 273	
amphetamine sulfate	117	APPLICATORS	187	aurovela 1.5/30	218, 227, 240	
amphetamine-		ascomp-codeine	132, 145, 150, 153	aurovela 1/20	218, 227, 240	
dextroamphetamine	117	asenapine maleate	124, 125, 130	aurovela 24 fe	218, 227, 240	
dextroamphetamine er	117	ashlyna	218, 227, 240	aurovela fe 1.5/30 ..	218, 227, 240	
amphet-dextroamphet 3-		aspirin	87, 88, 127, 154	aurovela fe 1/20	218, 227, 240	
bead er	117	aspirin 81	87, 88, 127, 153	AUSTEDO	158	
ampicillin	22	aspirin adult low dose	87, 88, 127, 153	AUSTEDO XR	158	
AMZEEQ	23, 43, 185, 301	aspirin adult low strength	87, 88, 127, 153	AUSTEDO XR PATIENT		
anagrelide hcl	88	aspirin childrens	87, 88, 127, 153	TITRATION	158	
ANALPRAM HC		aspirin ec adult low dose	87, 88, 127, 153	AUTOLET LANCING DEVICE	163	
.....	190, 209, 304, 308, 309	aspirin ec low dose	87, 88, 127, 153	AUTOLET LITE LANCING		
anastrozole	45, 215	aspirin low dose	87, 88, 127, 153, 154	DEVICE	163	
ANCOBON	41	aspirin regimen	87, 88, 127, 154	AUVELITY	124	
ANDEMBRY	89	aspirin-dipyridamole er	87, 111, 154, 174	AUVI-Q	64, 286	
ANGELIQ	227, 240	ASSURE CONTROL		avanafil	111, 112	
ANNOVERA	218, 227, 240	SOLUTION 2/3	163	AVAR CLEANSER	301, 316	
ANORO ELLIPTA	65, 73	ASSURE ID DUO PRO PEN		AVAR-E EMOLLIENT	301, 316	
ANTICOAGULANT SODIUM		NEEDLES	163	AVERI	218, 227, 240	
CITRATE	76	ASSURE ID PRO PEN		aviane	218, 227, 240	
ANUCORT-HC	190, 209, 309	NEEDLES	163	AVIDOXY	23, 43, 301	
ANUSOL-HC	190, 209, 309	ASTRINGYN	80	AVIDOXY DK	43, 316, 325	
ANZEMET	198	atazanavir sulfate	35	AVMAPKI FAKZYNJA CO-		
ANZUPGO	315	atenolol	74, 95, 100, 102, 109	PACK	45	
apap-caff-dihydrocodeine	118, 143, 145, 150	atenolol-chlorthalidone	95, 100, 182	AVONEX PEN	256, 273	
.....		atomoxetine hcl	136, 150	AVONEX PREFILLED ...	256, 274	
APOKYN	142	ATORVALIQ	108	AVTOZMA	257	
apomorphine hcl	142	atorvastatin calcium	108	ayuna	218, 227, 240	
apraclonidine hcl	184, 195	atovaquone	25	AYVAKIT	45	
aprepitant	206	atovaquone-proguanil hcl	23	AZASAN	253, 270, 274, 278	
apri	218, 227, 240	atropine sulfate	15, 65, 196, 286	AZASITE	185	
APRISO	200	ATROVENT HFA	65, 286	azathioprine ...	253, 270, 274, 278	
APTIOM	119, 140	ATTRUBY	99	azelaic acid	301, 321	
APTIVUS	35	aubra eq	218, 227, 240	azelastine hcl	185, 296	
AQ INSULIN SYRINGE	163	AUGTYRO	45	AZELEX	301, 321	
AQINJECT PEN NEEDLE	163	AUM INSULIN SAFETY PEN		azithromycin	39, 40	
AQNEURSA	280	NEEDLE	163	AZSTARYS	150	
AQUORAL	195	AUM MINI INSULIN PEN		AZULFIDINE		
ARAKODA	23	NEEDLE	163	.....	42, 200, 254, 270, 274	
aranelle	218, 227, 240	AUM PEN NEEDLE	163	AZULFIDINE EN-TABS		
ARANESP (ALBUMIN FREE)				.....	42, 200, 254, 270, 274	
.....	75, 76, 78, 79			azurette	219, 227, 240	
ARBLI	92			B & C	321	
ARCALYST	280, 292			bac (butalbital-acetamin-		
AREXVY	60			caff)	118, 132, 143, 150	
arformoterol tartrate	73, 297			bacitracin-polymyxin b		
ARIKAYCE	21			.....	28, 185, 301	
aripiprazole	124, 130			bacitra-neomycin-		
armodafinil	158			polymyxin-hc ...	28, 185, 190, 301	
ARMOUR THYROID	251			baclofen	69, 70	

BACTRIM.....	25, 42, 43	benzoyl peroxide-		BOSULIF.....	45, 46
BACTRIM DS.....	25, 42, 43	erythromycin	301, 318	bp 10-1	301, 316
BAFIERTAM.....	255, 274	benztropine mesylate	68, 119	BRAFTOVI.....	46
BALCOLTRA.....	219, 227, 240	BERINERT.....	268	BREATHE COMFORT	
balsalazide disodium	200	BESIFLOXACIN HCL.....	185	CHAMBER/ADULT.....	164
balsam peru-castor oil	321	BESIVANCE.....	185	BREATHE COMFORT	
BALVERSA.....	45	BESREMI.....	36, 45, 274	CHAMBER/CHILD.....	164
balziva	219, 227, 240	BETADINE OPHTHALMIC		BRENZAVVY.....	249
BANZEL.....	119, 140	PREP.....	187	BREO ELLIPTA 73, 190, 209, 289	
BAQSIMI ONE PACK15, 235, 262		betaine	280	BREZTRI AEROSPHERE	
BAQSIMI TWO PACK		betamethasone dipropionate		.....	66, 73, 210
.....	15, 235, 262	.....	209, 309	briellyn	219, 228, 241
BARACLUDE.....	38	betamethasone dipropionate		brimonidine tartrate	
BAXDELA.....	41	aug	209, 309	.....	184, 300, 321
BAXFENDY.....	90	betamethasone valerate		BRINSUPRI.....	288, 294
BD AUTOSHIELD DUO PEN		.....	209, 309	brinzolamide	189
NEEDLES.....	163	BETAPACE AF		brivaracetam	119, 120
BD BLUNT FILL NEEDLE.....	163	.....	70, 95, 100, 102, 104, 109	BRIVIACT.....	120
BD ECLIPSE LUER-LOK		BETASERON.....	257, 274	bromfenac sodium (once-	
NEEDLE.....	163	betaxolol hcl		daily)	195
BD ECLIPSE NEEDLE.....	163	.....	75, 95, 100, 103, 109, 188	bromocriptine mesylate	138
BD PEN NEEDLE MICRO		bethanechol chloride	71	BRONCHITOL.....	296
ULTRAFINE.....	163	BETIMOL.....	70, 95, 103, 188	BRONCHITOL TOLERANCE	
BD PEN NEEDLE MINI		BETOPTIC-S.....	75, 103, 189	TEST.....	296
ULTRAFINE.....	163	BEVESPI AEROSPHERE		BRUKINSA.....	46
BD PEN NEEDLE NANO		.....	66, 73, 306	BRYNOVIN.....	225
ULTRAFINE.....	164	bexarotene	45, 300, 321	budesonide	210, 289, 294, 309
BD PEN NEEDLE ORIG		BEXSERO.....	60	bumetanide	89, 108, 176
ULTRAFINE.....	164	BEYAZ.....	219, 227, 240, 328	BUMEX.....	89, 108, 176
BD PEN NEEDLE SHORT		BEYFORTUS.....	37	buprenorphine	149
ULTRAFINE.....	164	bicalutamide	45	buprenorphine hcl	149
BD SAFETYGLIDE NEEDLE..	164	BIGFOOT UNITY PROGRAM	164	buprenorphine hcl-naloxone	
BD SHARPS COLLECTOR....	164	BIJUVA.....	227, 240	hcl	148, 149
BD ULTRA-FINE INSULIN		BIKTARVY.....	32, 33	bupropion hcl	124
SYRINGES.....	164	BILTRICIDE.....	22	bupropion hcl er (smoking	
BD ULTRA-FINE PEN		bimatoprost	197	det)	63, 124
NEEDLES.....	164	BIMZELX.....	314, 321	bupropion hcl er (sr)	124
BD VEO INSULIN SYR		bis subcit-metronid-tetracyc		bupropion hcl er (xl)	124
ULTRAFINE.....	164	.....	23, 25, 43, 199, 200	buspirone hcl	129, 142
BELBUCA.....	149	bisacodyl ec	201	butalbital-acetaminophen	
belladonna alkaloids-opium		bismuth/metronidaz/tetracyc		.....	118, 132, 143
.....	65, 145	lin	23, 25, 43, 199, 200	butalbital-apap-caff-cod	
BELSOMRA.....	129, 149	bisoprolol fumarate		.....	118, 132, 143, 145, 150
benazepril hcl	92, 93	.....	75, 95, 100, 103, 109	butalbital-apap-caffeine	
benazepril-		bisoprolol-		.....	118, 132, 143, 150
hydrochlorothiazide	93, 180	hydrochlorothiazide	95, 100, 181	butalbital-asa-caff-codeine	
BENEFIX.....	81	blisovi 24 fe	219, 227, 240	.....	132, 145, 150, 154
BENLYSTA.....	256, 278	blisovi fe 1.5/30	219, 227, 240	butalbital-aspirin-caffeine	
benzalkonium chloride	306, 318	blisovi fe 1/20	219, 228, 240	.....	132, 150, 154
BENZAMYCIN.....	301, 318	BLUJEPa.....	43	butorphanol tartrate	128, 149
BENZNIDAZOLE.....	25, 37, 38	BONSITY.....	238, 264	BYLVAY.....	203, 204
benzoin	308	BOOSTRIX.....	59, 60		
benzonatate	288	bosentan	114, 291, 298		

BYLVAY (PELLETS)		
.....	202, 203, 204	
cabergoline	.....	138
CABLIVI	.....	76, 88
CABOMETYX	.....	46
CAFERGOT	.....	71, 128, 150
caffeine citrate	.....	128, 150
CALCIFOL	.....	178, 328, 330
calcipotriene	.....	307, 308, 321
calcitonin (salmon)	.....	216, 217, 264
CALCITRENE	.....	308, 321
calcitriol	.....	321, 330
calcium acetate	.....	177, 178
calcium acetate (phos binder)	.....	177, 178
CALQUENCE	.....	46
camila	.....	219, 241
camrese	.....	219, 228, 241
camrese lo	.....	219, 228, 241
CAMZYOS	.....	100
candesartan cilexetil	.....	91, 92
candesartan cilexetil-hctz	.....	92, 181
capecitabine	.....	46
CAPLYTA	.....	130
CAPRELSA	.....	46
captopril	.....	92, 93
captopril- hydrochlorothiazide	.....	93, 181
CAPVAXIVE	.....	60
carbamazepine	.....	120, 125
carbamazepine er	.....	120, 125
CARBATROL	.....	120, 125
carbidopa	.....	137
carbidopa-levodopa	.....	137
carbidopa-levodopa er	.....	137
carbidopa-levodopa- entacapone	.....	135, 137
carbinoxamine maleate	.....	17, 18, 292
CARBZAH	.....	17, 18, 292
CARDAMYST	.....	104
CARDURA	.....	71, 90, 91, 95
CARDURA XL	.....	71, 91, 95
CAREPOINT POLY HUB NEEDLE	.....	164
CAREPOINT PRECISION POLY HUB	.....	164
CAREPOINT SAFETY 1ST NEEDLE	.....	164
CARESENS CONTROL SOLUTION A/B	.....	164
CARESENS LANCETS 30G	.....	164
CARESENS S CONTROL SOLN A/B	.....	165
CARETOUCH CONTROL SOL LEVEL 2	.....	165
CARETOUCH HYPODERMIC NEEDLE	.....	165
CARETOUCH LANCING/EJECTOR	.....	165
carglumic acid	.....	175
carisoprodol	.....	69
CARNITOR	.....	280
CARNITOR SF	.....	280
CAROSPIR	.....	90, 108, 109, 112, 113, 178
carteolol hcl	.....	189
cartia xt	.....	97, 98, 104, 114
carvedilol	.....	70, 72, 91, 95, 100, 103, 109
CAVERJECT	.....	106, 114
CAVERJECT IMPULSE	.....	106, 114
CAYA	.....	284
CAYSTON	.....	37
cefaclor	.....	20
cefaclor er	.....	20
cefadroxil	.....	20
cefdinir	.....	20
cefixime	.....	20
CEFIXIME	.....	20
cefpodoxime proxetil	.....	20
cefprozil	.....	20
cefuroxime axetil	.....	20
celecoxib	.....	137
CELONTIN	.....	157
cephalexin	.....	20
CEQUR SIMPLICITY 2U	.....	165
CERDELGA	.....	183, 280
CERVIDIL	.....	285
CETRAXAL	.....	185
CETROTIDE	.....	215
cevimeline hcl	.....	71
CHANTIX	.....	63, 68
CHANTIX CONTINUING MONTH PAK	.....	63, 68
CHANTIX STARTING MONTH PAK	.....	63, 68
charlotte 24 fe	.....	219, 228, 241
chateal eq	.....	219, 228, 241
CHEMET	.....	15, 208, 262
CHEMSTRIP BG LOG BOOK	.....	165
CHEMSTRIP K	.....	174
CHEMSTRIP UGK	.....	174
chlordiazepoxide hcl	.....	134
chlordiazepoxide- amitriptyline	.....	134, 157
chlordiazepoxide-clidinium	.....	66, 134
chlorhexidine gluconate	.....	21, 187, 188, 306, 318
chloroquine phosphate	.....	23
chlorpromazine hcl	.....	149, 150
chlorthalidone	.....	90, 113, 182
chlorzoxazone	.....	69
CHOLBAM	.....	203, 205
cholestyramine	.....	96
cholestyramine light	.....	96
CHORIONIC GONADOTROPIN	.....	236
CHOSEN LANCETS 30G	.....	165
CHOSEN LANCING DEVICE	.....	165
CHOSEN SAFETY LANCETS 28G	.....	165
CIBINQO	.....	258, 270, 315, 321
ciclodan	.....	313
ciclopirox	.....	313
ciclopirox olamine	.....	313
cilostazol	.....	87, 111, 112
CILOXAN	.....	185
CIMDUO	.....	33
cimetidine	.....	19, 206
cimetidine hcl	.....	19, 206
CIMZIA (2 SYRINGE)	.....	205, 254, 261, 270, 274
CIMZIA-STARTER	.....	205, 254, 261, 270, 274
cinacalcet hcl	.....	217
CIPRO	.....	26, 41
CIPRO HC	.....	185, 190
ciprofloxacin hcl	.....	26, 41, 185
ciprofloxacin- dexamethasone	.....	185, 190
ciprofloxacin-hydrocortisone	.....	185, 190
citalopram hydrobromide	.....	156
cladribine (10 tabs)	.....	46, 252, 274, 278
cladribine (4 tabs)	.....	46, 252, 274, 278
cladribine (5 tabs)	.....	46, 253, 274, 278
cladribine (6 tabs)	.....	46, 253, 274, 278
cladribine (7 tabs)	.....	46, 253, 274, 278

cladribine (8 tabs)	COBENFY	129, 325	COSENTYX (300 MG DOSE)	.....	257, 270, 321
.....	COBENFY STARTER PACK	.....	.....	257, 270, 322	
cladribine (9 tabs)	.....	129, 325	COSENTYX 150 MG/ML	.....	257, 270, 322
.....	codeine sulfate	145, 288	.....	257, 270, 322	
claravis	colchicine	263	COSENTYX SENSOREADY	.....	257, 270, 322
clarithromycin	colchicine-probenecid ..	182, 263	(300 MG).....	257, 270, 322	
clarithromycin er ..	colesevelam hcl	96, 215	COSENTYX SENSOREADY	.....	258, 270, 322
clearlax	COLESTID	96	PEN	258, 270, 322	
clemastine fumarate ..	colestipol hcl	96	COSENTYX UNOREADY	.....	258, 270, 322
CLEMSZA	colistimethate sodium (cba) ..	41	.....	258, 270, 322	
CLENPIQ	COLY-MYCIN M	41	COSOPT	189	
CLEOCIN	COMBIGAN	184, 189, 300	cosyntropin	174	
CLEOCIN-T	COMBIPATCH	228, 241	COTELIC	47	
CLEVER CHOICE COMFORT	COMBIVENT RESPIMAT	.....	COVARYX	214, 228	
EZ .....	.....	66, 73, 286	COVARYX HS	214, 228	
CLIMARA PRO	COMETRIQ	46, 47	CRENESSITY	81, 238	
clindacin	COMFORT EZ PRO PEN	.....	CREON	183, 203	
clindacin etz	NEEDLES	165	CRESEMBA	27	
clindacin-p	COMFORT TOUCH TWIST	.....	CREXONT	137	
clindamycin hcl	LANCET 30G	165	CRINONE	241	
clindamycin palmitate hcl	COMIRNATY	60	cromolyn sodium ..	185, 195, 293	
.....	COMIRNATY 5-11 YEARS	60	CROTAN	320	
clindamycin phos (twice-	COMPLERA	32, 33, 38	cryselle	219, 228, 241	
daily)	CONDOMS	284	CTEXLI	203	
clindamycin phos-benzoyl	CONDYLOX	316, 321	CUVPOSA	66, 306	
perox	constulose	175	cyanocobalamin	86, 328	
clindamycin phosphate ..	CONTOUR CONTROL	165	CYANOCOBALAMIN	86, 328	
CLINDESSE	CONTOUR NEXT CONTROL ..	165	cyclobenzaprine hcl	69	
CLINPRO 5000	CONTOUR NEXT EZ	165	CYCLOGYL	196	
clobazam	CONTOUR NEXT GEN	.....	CYCLOMYDRIL	196, 197	
clobetasol prop emollient	MONITOR	165	cyclopentolate hcl	196	
base	CONTOUR NEXT MONITOR ..	165	cyclophosphamide ..	47, 256, 278	
clobetasol propionate	CONTOUR NEXT ONE ..	165, 166	.....	47, 256, 278	
clobetasol propionate e	CONTOUR NEXT TEST	174	cycloserine	26	
clocortolone pivalate	CONTOUR PLUS BLUE	166	CYCLOSET	215	
clomid	CONTOUR PLUS CONTROL	.....	cyclosporine	.....	188, 253, 270, 274, 279
clomiphene citrate	SOLUTION	166	.....	188, 253, 270, 274, 278, 279	
clomipramine hcl	CONTOUR PLUS TEST	174	cyproheptadine hcl	18, 292	
clonazepam	COPIKTRA	47	cyred eq	219, 228, 241	
clonidine	CORDRAN	309	CYSTADANE	280	
clonidine hcl	CORIFACT	81	CYSTADROPS	195, 196	
clonidine hcl er	CORLANOR	100, 114	CYSTAGON	280	
clopidogrel bisulfate	CORTANE-B	.....	CYSTARAN	195, 196	
clorazepate dipotassium	.....	190, 210, 304, 310, 318	CYTOTEC	207	
.....	CORTEF	190, 210, 310	cytra k crystals	175	
clotrimazole	CORTENEMA	190, 210, 310	dabigatran etexilate	.....	78
clotrimazole-betamethasone	CORTIFOAM	190, 210, 310	mesylate .....	.....	280, 284
.....	CORTISPORIN-TC	185, 190	danazol	214	
clozapine	CORTROPHIN	173, 238	DANTRIUM	69	
CLOZARIL	CORTROPHIN GEL	173, 238			
COAGADEX	CORTROSYN	174			
coal tar					
COARTEM					

dantrolene sodium	69	desoximetasone	310	diltiazem hcl er coated	
dapsone	23, 24, 25, 302, 322	desvenlafaxine succinate er	154	beads	97, 98, 99, 104, 114
DAPTACEL	59, 60	dexamethasone	191, 210	dilt-xr	97, 98, 99, 105, 114
DARAPRIM	24	dexamethasone intensol		dimethyl fumarate	255, 275
darunavir	35	.....	191, 210	dimethyl fumarate starter	
dasatinib	47	dexamethasone sodium		pack	256, 275
dasetta 1/35 (28)	219, 228, 241	phosphate	191	DIPENTUM	200
dasetta 7/7/7	219, 228, 241	DEXCOM G6 RECEIVER	166	diphenhydramine hcl	
DAURISMO	47	DEXCOM G6 SENSOR	166	.....	17, 18, 68, 119, 129, 288, 292
DAYBUE	136	DEXCOM G6 TRANSMITTER	166	diphenoxylate-atropine ..	66, 199
DAYBUE STIX	136	DEXCOM G7 15 DAY		DIPROLENE	210, 310
daysee	219, 228, 241	SENSOR	166	dipyridamole	87, 112, 115, 174
DEBACTEROL	195, 318	DEXCOM G7 RECEIVER	166	diskets	145
deblitane	219, 241	DEXCOM G7 SENSOR	166	disopyramide phosphate	102
deferasirox	208	dexmethylphenidate hcl	151	disulfiram	15, 261
deferasirox granules	208	dexmethylphenidate hcl er ..	151	divalproex sodium	
deferiprone	208	dextroamphetamine sulfate ..	117	.....	120, 125, 128, 139
DELESTROGEN	228, 264	dextroamphetamine sulfate		divalproex sodium er	
DELSTRIGO	32, 33	er	117	.....	120, 125, 128, 139
delyla	219, 228, 241	DIABECIN HR	305, 318	DIVIGEL	228, 264
demeclocycline hcl	43	DIABETES MONITOR DIGIT		dofetilide	104
DENG VAXIA	60	ADD-ON	166, 280	DOJOLVI	176
DENTA 5000 PLUS	159, 160, 266	DIABETES MONITOR DIGIT		dolishale	219, 228, 241
DENTA 5000 PLUS		SOLN	166, 280	donepezil hcl	71
SENSITIVE	160, 266	DIACOMIT	120, 138	DOPTelet	79
DENTAGEL	159, 160, 266	DIASTIX REAGENT	174	DOPTelet SPRINKLE	79
DEPAKOTE	120, 125, 128, 138	diazepam	133, 134	DORZOLAMIDE HCL	189
DEPAKOTE ER		diazepam intensol	133, 134	dorzolamide hcl	189
.....	120, 125, 128, 138	diazoxide	216	dorzolamide hcl-timolol mal	189
DEPAKOTE SPRINKLES		dichlorphenamide	89, 266	dotti	228, 264
.....	120, 125, 128	diclofenac potassium	144	DOVATO	32, 34
DEPEN TITRATABS ..	15, 208, 270	diclofenac sodium		doxazosin mesylate	
DEPO-ESTRADIOL	228, 264	.....	144, 152, 158, 195, 319	.....	71, 90, 91, 95
DEPO-PROVERA	219, 241	diclofenac sodium er	144	doxepin hcl	157, 305
DEPO-SUBQ PROVERA	104	diclofenac-misoprostol	144, 207	doxercalciferol	330
.....	219, 241	dicloxacin sodium	40	doxycycline hyclate ..	24, 43, 302
DEPO-TESTOSTERONE	214, 215	dicyclomine hcl	66	doxycycline monohydrate	
DERMA-SMOOTH/FS BODY		DIFICID	39, 40	.....	24, 43, 302
.....	191, 310	diflorasone diacetate	310	DRISDOL	330
DERMA-SMOOTH/FS		diflunisal	144, 152	DRIZALMA SPRINKLE	154
SCALP	191, 310	difluprednate	191	dronabinol	199, 205
DERMOTIC	191, 310	digoxin	94, 100	DROPLET MICRON	166
DESCOVY	34, 38	dihydroergotamine mesylate		DROPSAFE ACTI-LANCE	
desipramine hcl	157	.....	71, 128	23G	166
desmopressin ace spray		DILANTIN	102, 140	DROPSAFE AUTOPROTECT	
refrig	81, 238	DILANTIN INFATABS	102, 139	DUO	166
desmopressin acetate	81, 239	DILANTIN-125	102, 140	DROPSAFE MEDLANCE	
DESMOPRESSIN ACETATE		diltiazem hcl 97, 98, 99, 105, 114		LANCET 30G	166
.....	81, 239	diltiazem hcl er		DROPSAFE SAFETY	
desmopressin acetate pf	81, 239	.....	97, 98, 99, 104, 105, 114	SYRINGE/NEEDLE	166
desmopressin acetate spray		diltiazem hcl er beads		DROPSAFE SICURA	166
.....	81, 239	.....	97, 98, 104, 114	drospiren-eth estrad-	
desonide	310			levomefol	219, 228, 241, 328

drospirenone-ethinyl		
estradiol	220, 229, 241	
DROXIA.....	47	
droxidopa	64	
DRYSOL.....	306	
DUAVEE.....	226, 229	
DUETACT.....	250, 251	
duloxetine hcl	138, 154	
DUOPA.....	137	
DUPIXENT.....	292, 314, 322	
DUREX EXTRA SENSITIVE THIN.....	284	
DUREX TROPICAL.....	284	
dutasteride	261	
DUVYZAT.....	280	
DYCLOPRO.....	305	
E.E.S. GRANULES.....	28	
EASIVENT.....	166	
EASY COMFORT SHARPS CONTAINER.....	166	
EASY TOUCH HEALTHPRO HIGH/LOW.....	167	
EASYGEL.....	159, 160, 266	
EASYMAX 15 LEVEL 2-3 CONTROL.....	167	
EASYMAX CONTROL.....	167	
EASYMAX CONTROL NORMAL/HIGH.....	167	
EBGLYSS.....	314	
econazole nitrate	306	
econtra one-step	215, 220, 241	
EC-RX DHEA.....	280	
EDEX (2 CARTRIDGE) ...	107, 115	
EDEX (6 CARTRIDGE) ...	107, 115	
EDURANT.....	32	
EDURANT PED.....	33	
EEMT.....	214, 229	
EEMT HS.....	214, 229	
efavirenz	33	
efavirenz-emtricitab-tenofo df	33, 34	
efavirenz-lamivudine- tenofovir	33, 34	
EFFER-K.....	178	
effer-k	178	
EGATEN.....	22	
EGRIFTA SV.....	250	
EGRIFTA WR.....	250	
ELESTRIN.....	229, 265	
eletriptan hydrobromide	155	
elinest	220, 229, 241	
ELIQUIS.....	77	
ELIQUIS (1.5 MG PACK).....	77	
ELIQUIS (2 MG PACK).....	77	
ELIQUIS DVT/PE STARTER PACK.....	77	
ELITE-OB.....	85, 326, 328	
elixophyllin	107, 151, 176, 299, 325	
ELLA.....	220, 242	
ELMIRON.....	281	
ELOCTATE.....	81	
eltrombopag olamine	79	
eluryng	220, 229, 242	
EMBECTA AUTOSHIELD DUO.....	167	
EMBECTA INS SYR U/F 1/2 UNIT.....	167	
EMBECTA INSULIN SYR ULTRAFINE.....	167	
EMBECTA INSULIN SYRINGE	167	
EMBECTA INSULIN SYRINGE U-100.....	167	
EMBECTA INSULIN SYRINGE U-500.....	167	
EMBECTA PEN NEEDLE NANO.....	167	
EMBECTA PEN NEEDLE NANO 2 GEN.....	167	
EMBECTA PEN NEEDLE ULTRAFINE.....	167	
EMBRACE PEN NEEDLES....	167	
EMBRACE WAVE GLUCOSE CONTROL.....	167	
EMEND.....	206	
EMGALITY.....	135	
EMPAVELI.....	268	
EMSAM.....	141	
emtricitabine	34	
emtricitabine-tenofovir df	34, 38	
emtricitab- rilpivir-tenofov df	33, 34, 38	
EMTRIVA.....	34	
EMVERM.....	23	
emzahh	220, 242	
enalapril maleate	93	
enalapril- hydrochlorothiazide	93, 181	
ENBRACE HR ..	85, 281, 326, 328	
ENBREL.....	261, 270, 275	
ENBREL MINI.....	261, 270, 275	
ENBREL SURECLICK	261, 270, 275	
ENBUMYST.....	89, 176	
ENCARE.....	284	
ENDARI.....	281, 322	
endocet	118, 143, 145	
ENDOMETRIN.....	242	
ENFLONIA.....	37	
ENGERIX-B.....	60	
enilloring	220, 229, 242	
ENLITE GLUCOSE SENSOR.....	167	
enoxaparin sodium	83, 84	
ENSACOVE.....	47	
enskyce	220, 229, 242	
ENSPRYNG.....	259, 275	
ENSTILAR.....	308, 310, 322	
entacapone	135	
entecavir	38	
ENTRESTO.....	91, 92, 113	
ENTYVIO PEN.....	198, 205, 254	
enulose	175	
EOHILIA.....	210	
EPCLUSA.....	29, 30, 31	
EPIDIOLEX.....	120	
EPIFOAM.....	305, 311	
epinastine hcl	19, 185	
epinephrine	65, 286	
EPINEPHRINE.....	65, 286	
EPIVIR.....	34	
eplerenone	90, 108, 109, 112, 113, 178	
EQUETRO.....	120, 125	
ergocalciferol	330	
ERGOMAR.....	71, 128	
ergotamine-caffeine	71, 128, 151	
ERIVEDGE.....	47	
ERLEADA.....	47	
erlotinib hcl	47	
errin	220, 242	
ERY.....	29, 186, 302	
ERYPED 400.....	29	
erythromycin	29, 186, 302	
erythromycin base	29	
erythromycin ethylsuccinate	29	
escitalopram oxalate	156	
eslicarbazepine acetate	120, 140	
esomeprazole magnesium	207	
est estrogens-methyltest	214, 229	
est estrogens-methyltest ds	214, 229	
est estrogens-methyltest hs	214, 229	
estarylla	220, 229, 242	
estazolam	134	
estradiol	229, 265	
estradiol valerate	229, 265	

estradiol-norethindrone acet	229, 242	fenofibrate micronized	107	FLUORIDEX DAILY	
ESTRATEST H.S.	214, 230	fenofibric acid	107	RENEWAL	159, 160, 266
ESTRING	230, 265	fentanyl	145	FLUORIDEX ENHANCED	
estrogens conjugated	230, 265	FERRIPROX	208	WHITENING	160, 266
eszopiclone	130, 142	FERRIPROX TWICE-A-DAY	208	FLUORIMAX 5000	160, 266
ethacrynic acid	89, 108, 176	FETZIMA	154	FLUORIMAX 5000 SENSITIVE	160, 266
ethambutol hcl	26	FETZIMA TITRATION	154	fluorometholone	191
ethosuximide	157	fidaxomicin	39, 40	fluorouracil	48, 300, 322
etodolac	144, 152	FILSPARI	113, 273, 281, 291	fluoxetine hcl	156
etodolac er	144, 152	FILSUVEZ	322	fluphenazine hcl	150
etonogestrel-ethinyl		FINACEA	302, 322	flurandrenolide	311
estradiol	220, 230, 242	finasteride	261, 308	flurazepam hcl	134
etoposide	47	finlimod hcl	260, 275	flurbiprofen	144, 152, 195
etravirine	33	FINTEPLA	121	flurbiprofen sodium	152, 195
EUCRISA	304, 319	finzala	220, 230, 242	fluticasone propionate	191, 210, 289, 293, 311
EURAX	320	FIORICET	118, 132, 143, 151	fluticasone-salmeterol	73, 191, 210, 289
EVAMIST	230, 265	FIRDAPSE	71, 281	FLUTICASONE-	
everolimus	47, 256, 279	FIRMAGON	48, 215	SALMETEROL	74, 192, 211, 289
EVEXITHROID	251	FIRMAGON (240 MG DOSE)	48, 215	fluvastatin sodium	108
EVOTAZ	35, 281	FIRST-LANSOPRAZOLE	207	fluvastatin sodium er	108
EVRYSDI	281	FIRVANQ	29	fluvoxamine maleate	156
EXELDERM	306	FLAREX	191	fluvoxamine maleate er	156
exemestane	48, 215	flavoxate hcl	325	FLUZONE	61
EXODERM	17, 304, 316	flecainide acetate	102	FLUZONE HIGH-DOSE	61
EXXUA	156	FLEXICHAMBER	168	FML FORTE	192
EXXUA TITRATION PACK	156	FLEXICHAMBER ADULT		FML LIQUIFILM	192
EYSUVIS	191	MASK/SMALL	168	FOCALIN	151
EZALLOR SPRINKLE	108	FLEXICHAMBER CHILD		folic acid	328
ezetimibe	101	MASK/LARGE	168	FOLLISTIM AQ	236
ezetimibe-simvastatin	101, 108	FLEXICHAMBER CHILD		fondaparinux sodium	76, 85
FABHALTA	254, 268	MASK/SMALL	168	FONDCIRCLE CONTROL	
falmina	220, 230, 242	FLOLIPID	108	SOLUTION	168
famciclovir	38	FLORIVA	159, 160, 266, 330	FONDCIRCLE LANCING	
famotidine	19, 206	FLOTREX	159, 160, 266, 326	DEVICE	168
FANAPT	131	FLUAD	60	FONDCIRCLE SINGLE USE	
FANAPT TITRATION PACK A	131	FLUARIX	60	LANCETS	168
FANAPT TITRATION PACK B	131	FLUCELVAX	60	FORA TEST N' GO ADVANCE	168
FANAPT TITRATION PACK C	131	fluconazole	27	FORA TEST N'GO ADV-	
FASENRA PEN	292	flucytosine	41	VOICE-6 CON	174
FC2 FEMALE CONDOM	284	fludrocortisone acetate	210	FORANE	140
febuxostat	263	FLULAVAL	61	formaldehyde	175
FEIBA	81	FLUMIST	61	formoterol fumarate	74, 297
feirza 1.5/30	220, 230, 242	flunisolid	191, 210, 289, 293	FOSAMAX	265
feirza 1/20	220, 230, 242	fluocinolone acetonide	191, 311	FOSAMAX PLUS D	265, 330
felbamate	120	fluocinolone acetonide body	191, 311	fosamprenavir calcium	35
FELBATOL	121	fluocinolone acetonide scalp	191, 311	fosfomycin tromethamine	44
felodipine er	105, 106	fluocinonide	311	fosinopril sodium	93
FEM PH	318, 322	fluocinonide emulsified base	311	fosinopril sodium-hctz	93, 181
FEMCAP	284	FLUORIDEX	160, 266	FOSRENOL	177, 262
FEMLYV	220, 230, 242				
FEMRING	230, 265				
fenofibrate	107				

FOTIVDA.....	48	gemfibrozil	107	GUARDIAN REAL-TIME	
FRAGMIN.....	84	gemmily	220, 230, 242	CHARGER.....	168
FREESTYLE LIBRE 14 DAY		generlac	175	GUARDIAN REAL-TIME TEST	
READER.....	168	gengraf ... 188, 253, 271, 275, 279		PLUG.....	169
FREESTYLE LIBRE 14 DAY		gentamicin sulfate ..	21, 186, 302	GUARDIAN SENSOR 3.....	169
SENSOR.....	168	gentle laxative	201	GVOKE HYPOPEN 1-PACK	
FREESTYLE LIBRE 2 PLUS		GENVOYA.....	32, 34	.....	15, 235, 262
SENSOR.....	168	GILENYA.....	260, 275	GVOKE HYPOPEN 2-PACK	
FREESTYLE LIBRE 2		GILOTRIF.....	48	.....	15, 235, 262
READER.....	168	glatiramer acetate	252, 275	GVOKE KIT.....	15, 235, 262
FREESTYLE LIBRE 2		glatopa	252, 275	GVOKE PFS.....	15, 236, 262
SENSOR.....	168	GLEOSTINE.....	48	GYNAZOLE-1.....	307
FREESTYLE LIBRE 3 PLUS		glimepiride	250	habitrol	63, 68
SENSOR.....	168	glipizide	251	HAEGARDA.....	268, 269
FREESTYLE LIBRE 3		glipizide er	251	hailey 1.5/30	220, 230, 242
READER.....	168	glipizide-metformin hcl ..	217, 251	hailey 24 fe	220, 230, 242
FREESTYLE LIBRE 3		GLOPERBA.....	263	hailey fe 1.5/30	220, 230, 242
SENSOR.....	168	glucagon emergency kit		hailey fe 1/20	220, 230, 242
frovatriptan succinate	155	.....	15, 235, 262	halcinonide	311
FRUZAQLA.....	48	GLUCAGON EMERGENCY		HALCION.....	134
ft aspirin	87, 88, 128, 154	KIT.....	15, 235, 262	halobetasol propionate	311
ft aspirin low dose		GLUCOTROL XL.....	251	haloperidol	135
.....	87, 88, 128, 154	glutaraldehyde	175	haloperidol lactate	135
ft clearlax	201	glyburide	251	HALUCORT.....	322
ft folic acid	328	glyburide-metformin	217, 251	HAN-EASE.....	169
ft laxative	201	glycerol phenylbutyrate	175	HARLIKU.....	183
ft magnesium citrate	201	glycolax	202	HARVONI.....	30, 31
ft naloxone hcl	15, 148	glycopyrrolate	66, 306	HAVRIX.....	61
ft nicotine	63, 68	glydo	305	heather	220, 242
ft nicotine mini	63, 68	GLYXAMBI.....	225, 249	HEMANGEOL	
furosemide	89, 108, 176	GOLYTELY.....	202	.....	70, 95, 101, 103, 109, 128
fyavolv	230, 242	GOMEKLI.....	48	HEMATINIC/FOLIC ACID..	85, 328
FYCOMPA.....	121	GONAL-F.....	236	HEMLIBRA.....	81
FYREMADEL.....	215	GONAL-F RFF REDIRECT....	236	HEMMOREX-HC....	192, 211, 311
gabapentin	118, 121, 139	goodsense aspirin low dose		HEMOFIL M.....	81
GALAFOLD.....	182, 281	.....	87, 88, 128, 154	heparin na (pork) lock flsh pf ..	84
galantamine hydrobromide	72	goodsense clearlax	202	heparin sod (pork) lock flush ..	84
galantamine hydrobromide		goodsense nicotine	63, 68	heparin sodium (porcine)	84
er	72	goodsense nicotine		heparin sodium (porcine)	
galbriela	220, 230, 242	policrilex	63, 68	+rfid	84
gallifrey	242	GORDOFILM.....	307, 316	heparin sodium (porcine) pf ..	84
GALZIN.....	178	granisetron hcl	199	HEPLISAV-B.....	61
ganirelix acetate	215	GRANISOL.....	199	HEPZATO W/50MM	
GARDASIL 9.....	61	GRASTEK.....	58	CATHETER.....	48
gatifloxacin	186	griseofulvin microsize	23	HEPZATO W/62MM	
GATTEX.....	203, 205	griseofulvin ultramicrosize	23	CATHETER.....	48
gavilax	201	guaifenesin-codeine	288, 292	her style	215, 220, 242
gavilyte-c	201	guanfacine hcl	100, 107, 136	HERNEXEOS.....	48
gavilyte-g	201	guanfacine hcl er	136	HETLIOZ.....	130, 141
gavilyte-n with flavor pack ...	201	GUARDIAN 4 GLUCOSE		HETLIOZ LQ.....	130, 141
GAVRETO.....	48	SENSOR.....	168	HIBERIX.....	61
gefitinib	48	GUARDIAN 4 TRANSMITTER	168	HIPREX.....	44
GELFILM.....	81			HUMALOG.....	248

HUMALOG KWIKPEN.....	248	hydroxyzine pamoate 18, 19, 130	INPEN 100-PINK-LILLY-
HUMALOG MIX 50/50		HYFTOR.....	HUMALOG.....
KWIKPEN.....	248	HYMPAVZI.....	169
HUMALOG MIX 75/25		hyoscyamine sulfate 16, 66, 286	INPEN 100-PINK-NOVOLOG-
KWIKPEN.....	248	hyoscyamine sulfate er	FIASP.....
HUMALOG MIX 75/25 VIAL....	248	.....	169
HUMALOG U-100 JUNIOR		hyoscyamine sulfate sl	INQOVI.....
KWIKPEN.....	248	.....	49
HUMATE-P.....	81	hyosyne	INSPIREASE RESERVOIR
HUMATIN.....	21	16, 66, 286	BAGS.....
HUMULIN 70/30 KWIKPEN		HYPERSAL.....	169
.....	237, 249	HYRNUO.....	INSULIN LISPRO.....
HUMULIN 70/30 VIAL.....	237, 249	ibandronate sodium	248
HUMULIN N KWIKPEN.....	237	IBRANCE.....	INSULIN LISPRO (1 UNIT
HUMULIN N VIAL.....	237	IBTROZI.....	DIAL).....
HUMULIN R U-500 KWIKPEN	249	ibuprofen	248
HUMULIN R VIAL.....	249	icatibant acetate	INSULIN LISPRO JUNIOR
HYCANTIN.....	48, 49	iclevia	KWIKPEN.....
hydralazine hcl	107	ICLUSIG.....	248
HYDRO 40.....	89, 177, 197, 316	ICOTYDE.....	INSULIN LISPRO PROT &
hydrochlorothiazide 90, 113, 181		IDELVION.....	LISPRO.....
hydrocod poli-chlorphe poli		IDHIFA.....	248
er	18, 19, 288	IHEALTH CONTROL	INSULIN PEN NEEDLES
hydrocodone bitartrate er	145	SOLUTION.....	.....
hydrocodone bit-homatrop		IHEALTH LANCING DEVICE. 169	169, 171, 172
mbr	66, 288	imatinib mesylate	INSULIN SYRINGES.....
hydrocodone-		IMBRUVICA.....	169, 170
acetaminophen	118, 143, 145	imipramine hcl	INSUPEN32G EXTR3ME.....
hydrocodone-ibuprofen		imipramine pamoate	170
.....	144, 146, 152	imiquimod	INTELENCE.....
hydrocortisone	192, 211, 312	IMKELDI.....	33
hydrocortisone (perianal)		IMPAVIDO.....	INTRAROSA.....
.....	192, 211, 311	IMVEXXY MAINTENANCE	introvale
hydrocortisone ace-		PACK.....	220, 230, 242
pramoxine	192, 211, 305, 311	IMVEXXY STARTER PACK... 230	INVELTYS.....
hydrocortisone acetate		INBRIJA.....	192
.....	192, 211, 311	incassia	INZIRQO.....
hydrocortisone butyrate		INCRELEX.....	90, 181
.....	192, 211, 311, 312	indapamide	iodine tincture
hydrocortisone valerate		indomethacin	306, 318
.....	192, 211, 312	indomethacin er	IOPIDINE.....
hydrocortisone-acetic acid		INFANRIX.....	184, 195
.....	192, 195, 211, 312	INGREZZA.....	IPOL.....
hydrocortisone-iodoquinol		INLURIYO.....	61
.....	21, 306, 312, 318	INLYTA.....	ipratropium bromide 66, 67, 287
hydrocort-pramoxine		INPEN 100-BLUE-LILLY-	ipratropium bromide hfa 66, 287
(perianal)	192, 211, 305, 312	HUMALOG.....	ipratropium-albuterol 67, 74, 287
hydromorphone hcl	146	INPEN 100-BLUE-NOVOLOG-	IQIRVO.....
hydromorphone hcl er	146	FIASP.....	203, 205
hydroxychloroquine sulfate		INPEN 100-GREY-LILLY-	irbesartan
.....	24, 254, 271, 275	HUMALOG.....	91, 92
hydroxyurea	49	INPEN 100-GREY-	irbesartan-
hydroxyzine hcl	18, 19, 130	NOVOLOG-FIASP.....	hydrochlorothiazide
			92, 181

IWILFIN.....	50	KISQALI (400 MG DOSE).....	50	lansoprazole	207
jaimiess	220, 230, 242	KISQALI (600 MG DOSE).....	50	lanthanum carbonate	177, 262
JAKAFI.....	50, 315	KLARON.....	303	LANTUS SOLOSTAR.....	237
JAKAFI XR.....	50, 315	klayesta	40, 320	LANTUS U-100 VIAL.....	237
JARDIANCE.....	249	KLISYRI (250 MG).....	300, 322	lapatinib ditosylate	50
JASCAYD.....	287, 294, 319	KLISYRI (350 MG).....	300, 323	larin 1.5/30	221, 231, 243
jasmiel	221, 231, 243	klor-con	178, 179	larin 1/20	221, 231, 243
JAVADIN.....	65, 101	klor-con 10	178	larin 24 fe	221, 231, 243
JAYPIRCA.....	50	klor-con m10	178	larin fe 1.5/30	221, 231, 243
jencycla	221, 243	klor-con m15	178	larin fe 1/20	221, 231, 243
JENTADUETO.....	217, 225	klor-con m20	178	LASIX.....	89, 108, 177
JENTADUETO XR.....	217, 226	KLOXXADO.....	16, 148	LASIX ONYU.....	89, 176
jinteli	231, 243	KOATE.....	82	latanoprost	197
JIVI.....	82	KOATE-DVI.....	82	laxative osmotic	202
JOENJA.....	275	KOMZIFTI.....	50	LAZCLUZE.....	51
jolessa	221, 231, 243	KOSELUGO.....	50	lederle leucovorin ...	17, 262, 328
JORNAY PM.....	151	KOURZEQ.....	312	LEDIPASVIR-SOFOSBUVIR	
JOURNAVX.....	118	KOVALTRY.....	82	.....	30, 31
joyeaux	221, 231, 243	K-PHOS.....	179	leflunomide	259, 271, 275, 279
JUBLIA.....	307	K-PHOS NO 2.....	175	lenalidomide	51, 276
juleber	221, 231, 243	K-PHOS-NEUTRAL.....	179	LENVIMA.....	51
JULUCA.....	32, 33	KRAZATI.....	50	LEQEMBI IQLIK.....	259
junel 1.5/30	221, 231, 243	KRINTAFEL.....	24	lessina	221, 231, 243
junel 1/20	221, 231, 243	KRISTALOSE.....	175	letrozole	51, 215
junel fe 1.5/30	221, 231, 243	KT TAPE CGM PATCH.....	170	leucovorin calcium ..	17, 262, 328
junel fe 1/20	221, 231, 243	kurvelo	221, 231, 243	LEUKERAN.....	51
junel fe 24	221, 231, 243	KYGEVVI.....	281	LEUKINE.....	79
JUST RIGHT 5000.....	160, 266	KYZATREX.....	214, 215	leuprolide acetate	51, 236
JUXTAPID.....	94, 109	labetalol hcl		levalbuterol hcl	74, 297
JYLAMVO.....	50, 254, 271, 275, 279	.....	70, 72, 91, 95, 101, 103, 110	LEVALBUTEROL HFA.....	74, 297
kaitlib fe	221, 231, 243	lacosamide	121, 140	LEVBIID.....	16, 67, 287
KALETRA.....	35	lactulose	176	levetiracetam	122
kalliga	221, 231, 243	lactulose encephalopathy	176	levetiracetam er	122
KALYDECO.....	291	LAGEVRIO.....	39	levobunolol hcl	189
KAPSPARGO SPRINKLE		LAMICTAL.....	121, 125	levocarnitine	281
.....	75, 95, 101, 103, 110	LAMICTAL ODT.....	121, 125	levocarnitine sf	281
kariva	221, 231, 243	LAMICTAL STARTER.....	121, 125	levocetirizine	
kelnor 1/35	221, 231, 243	LAMICTAL XR.....	121, 126	dihydrochloride	19
KEPPRA.....	121	lamivudine	34	levofloxacin	26, 41, 186, 303
KEPPRA XR.....	121	lamivudine-zidovudine	34	levonest	221, 231, 243
KERENDIA.....	109	lamotrigine	121, 122, 126	levonorgest-eth estrad 91-	
KESIMPTA.....	259, 275	lamotrigine er	121, 126	day	221, 231, 243
ketoconazole	27, 307	lamotrigine starter kit-blue		levonorgest-eth estradiol-	
ketodan	28, 307	.....	122, 126	iron	221, 231, 243
KETO-DIASTIX.....	175	lamotrigine starter kit-green		levonorgestrel	215, 221, 243
KETONE CARE.....	175	.....	122, 126	levonorgestrel-ethinyl estrad	
ketorolac tromethamine		lamotrigine starter kit-		.....	221, 231, 243
.....	144, 153, 195	orange	122, 126	levonorg-eth estrad triphasic	
KETOSTIX.....	174	LAMPIT.....	25	.....	221, 231, 243
KEVZARA.....	258, 271	LANCETS.....	170	levorphanol tartrate	146
KHINDIVI.....	192, 211, 312	LANCETS 28G THIN.....	170	levo-t	251
KINERET.....	258, 271, 275	LANCETS SUPER THIN.....	170	levothyroxine sodium	251
KISQALI (200 MG DOSE).....	50	LANOXIN.....	94, 100	levoxyl	252

LEVSIN.....	16, 67, 287	loteprednol etabonate ..	192, 193	MAYZENT STARTER PACK	260, 276
LEVSIN/SL.....	16, 67, 287	loteprednol-tobramycin	186, 193	me/naphos/mb/hyo1 ..	44, 67, 281
LEVULAN KERASTICK..	300, 323	lovastatin	108	meclofenamate sodium	144, 153
L-glutamine	281, 323	low-ogestrel	222, 232, 244	MEDROL.....	211
lidocaine	305	loxapine succinate	129, 137	medroxyprogesterone	
lidocaine hcl	196, 305	lo-zumandimine	222, 232, 244	acetate	222, 244
lidocaine hcl		lubiprostone	198, 205	mefenamic acid	144, 153
urethral/mucosal	305	LUCEMYRA.....	65	mefloquine hcl	24
lidocaine viscous hcl	196	LUGOLS STRONG IODINE		megestrol acetate	52, 244
lidocaine-prilocaine	305	.....	306, 318	MEKINIST.....	52
LIFYORLI (125 MG DOSE).....	51	luizza 1.5/30	222, 232, 244	MEKTOVI.....	52
LIFYORLI (150 MG DOSE).....	51	luizza 1/20	222, 232, 244	meleya	222, 244
LIKMEZ.....	21, 25, 38, 201, 303	LUMAKRAS.....	51, 52	MELOXICAM.....	144, 153
linezolid	40	LUMIGAN.....	197	meloxicam	144, 153
LINZESS.....	198, 205	LUMRYZ.....	136, 158, 264	memantine hcl	136
liomny	252	LUMRYZ STARTER PACK		memantine hcl er	136
liothyronine sodium	252	.....	158, 264	MENOPUR.....	236
liraglutide	119, 236	LUPKYNIS.....	260, 279	MENOSTAR.....	232, 265
lisdexamfetamine dimesylate		lurasidone hcl	131	MENQUADFI.....	61
.....	117	LURBIRO.....	144, 153, 196	MENVEO.....	61
lisinopril	93	lyleq	222, 244	meperidine hcl	146
lisinopril-		lyllana	232, 265	meprobamate	130, 142
hydrochlorothiazide	93, 181	LYNKUET.....	136	mercaptopurine	52, 256, 279
LITFULO.....	315, 323	LYNPARZA.....	52	mesalamine	200
lithium	126	LYRICA.....	122, 138, 139	mesalamine-cleanser	200
lithium carbonate	126	LYSODREN.....	52	mesna	284
lithium carbonate er	126	LYTGOBI (12 MG DAILY		MESNEX.....	284
LITHOBID.....	126	DOSE).....	52	MESTINON.....	72
LITHOSTAT.....	176	LYTGOBI (16 MG DAILY		metaxalone	69
LIVDELZI.....	203	DOSE).....	52	metformin hcl	217
LIVMARLI.....	203, 205	LYTGOBI (20 MG DAILY		metformin hcl er	217
LIVTENCITY.....	27	DOSE).....	52	methadone hcl	146
LO LOESTRIN FE...221, 231, 244		LYUMJEV KWIKPEN.....	248	methadone hcl intensol	146
LODOCO.....	76, 281	LYUMJEV VIAL.....	248	METHADOSE.....	146
lofexidine hcl	65	lyza	222, 244	methadose	146
lojaimiess	222, 231, 244	MACROBID.....	44	METHADOSE SUGAR-FREE.146	
LOKELMA.....	177	MACRODANTIN.....	44	methamphetamine hcl	118
LOMOTIL.....	67, 199	magnesium citrate	202	methazolamide	89, 99, 189
lomustine	51	MALARONE.....	24	methenamine hippurate	44
LONSURF.....	51	malathion	320	methenamine mandelate	44
LOPID.....	107	maraviroc	31	METHERGINE.....	285
lopinavir-ritonavir	35	marlissa	222, 232, 244	methimazole	217
LOPRESSOR.....	75, 95, 103	MARPLAN.....	141	METHITEST.....	214
lorazepam	133, 134	MATULANE.....	52	methocarbamol	33, 69
lorazepam intensol	133, 134	matzim la	97, 98, 99, 105, 115	methotrexate sodium	
LORBRENA.....	51	MAVENCLAD...52, 253, 276, 279		.....	52, 255, 271, 276, 279
loryna	222, 232, 244	MAVYRET.....	30, 31	methotrexate sodium (pf)	
losartan potassium	91, 92	MAXIDEX.....	193	.....	52, 255, 271, 276, 279
losartan potassium-hctz ..	92, 181	MAXITROL.....	186, 193	methoxsalen rapid	319
LOTEMAX.....	192	maxi-tuss ac	288, 292	methscopolamine bromide	67
LOTEMAX SM.....	192	MAYZENT.....	260, 276	methsuximide	157
LOTENSIN.....	93, 94			methyl salicylate	307
LOTENSIN HCT.....	93, 181				

methyldopa	65, 101, 107	minocycline hcl er	24, 43, 186, 303, 323	mycophenolate sodium	279
methylergonovine maleate ...	285	minoxidil	107, 308	mycophenolic acid	279
METHYLIN	151	minzoya	222, 232, 244	MYFEMBREE	216, 232, 244
methylphenidate hcl	152	MIPLYFFA	182	MYHIBBIN	279
methylphenidate hcl er	151	mirabegron er	325	MYLERAN	52
methylphenidate hcl er (cd) ..	151	mirtazapine	124, 156	MYSOLINE	132
methylphenidate hcl er (la) ..	151	MIRVASO	185, 301, 323	MYTESI	199
methylphenidate hcl er (osm)	151	misoprostol	207	MYXREDLIN	179, 249
methylphenidate hcl er(diffus)	152	MITIGARE	263	na sulfate-k sulfate-mg sulf ..	202
methylprednisolone	211, 212	MITOSOL	186	nabumetone	144, 153
methyltestosterone	214	mm aspirin	87, 88, 128, 154	nadolol	70, 75, 90, 95, 101, 103, 110
metoclopramide hcl	207	mm clearlax	202	naloxone hcl	16, 17, 148, 262
metolazone	90, 113, 182	M-M-R II	61	naltrexone hcl	15, 17, 63, 148, 262
METOPIRONE	174	M-NATAL PLUS	85, 326, 328	naproxen	128, 144, 153, 263
metoprolol succinate er	75, 95, 101, 103, 110	MNEXSPIKE	61	naproxen dr ... 128, 144, 153, 263	
metoprolol tartrate	75, 95, 101, 103, 110	MOBILE LANCETS 30G	170	naproxen sodium	129, 144, 153, 263
metoprolol- hydrochlorothiazide 95, 101, 181		modafinil	159	naratriptan hcl	155
METROCREAM	21, 38, 303	MODEYSO	52	NARCAN	16, 148
metronidazole	21, 25, 38, 201, 303	moexipril hcl	93, 94	NARDIL	141
metyrosine	174, 281	molindone hcl	129, 137	NASCOBAL	87, 328
mexiletine hcl	102	mometasone furoate	193, 212, 289, 293, 312	NATACYN	187
MIACALCIN	217, 265	mono-lynyah	222, 232, 244	NATAL PNV	85, 326, 328
mibelas 24 fe	222, 232, 244	MONSELS FERRIC SUBSULFATE	82	NATAZIA	222, 232, 245
miconazole 3	307	montelukast sodium	293	nateglinide	238
microgestin 1.5/30	222, 232, 244	morphine sulfate	147	NAYZILAM	133, 134
microgestin 1/20 ... 222, 232, 244		morphine sulfate (concentrate)	146	nebivolol hcl	70, 95, 101, 103
microgestin fe 1.5/30	222, 232, 244	morphine sulfate er	147	NEBUPENT	25
microgestin fe 1/20 222, 232, 244		morphine sulfate er beads ... 146		NEBUSAL	293
MICROLET NEXT LANCETS ..	170	MOTPOLY XR	122, 140	necon 0.5/35 (28) ... 222, 232, 245	
MICROLET NEXT LANCING DEVICE	170	MOUNJARO	236	nefazodone hcl	156
midazolam hcl	134	MOVIPREP	202, 330	NEFFY	65
midodrine hcl	65	moxifloxacin hcl 26, 42, 186, 303		NEMLUVIO	314
MIEBO	188, 195	moxifloxacin hcl (2x day) 42, 186		neomycin sulfate	21, 186, 303
MIFEPREX	285	MOZOBIL	79	neomycin-bacitracin zn- polymyx	186
mifepristone	215, 285	MUCOSITISRX	195	neomycin-polymyxin- dexameth	186, 193
MIGERGOT	71, 128, 152	MULPLETA	79	neomycin-polymyxin- gramicidin	186
miglitol	214	MULTAQ	104	neomycin-polymyxin-hc	186, 187, 193
miglustat	183, 281	multivitamin w/fluoride	159, 160, 266, 326	NEONATAL COMPLETE	85, 326, 328
mili	222, 232, 244	multivitamin/fluoride	159, 160, 266, 326, 328	NEONATAL PLUS	85, 326, 328
milnacipran hcl	138, 154	multi-vitamin/fluoride/iron	85, 266, 326	NEOTUSS PLUS ..	18, 19, 65, 288
milophene	226	mupirocin	303	NERLYNX	53
mimvey	232, 244	mupirocin calcium	303	NESTABS	85, 326, 328
MINIMED INSTINCT GLUC SENSOR	170	my choice	216, 222, 244	NESTABS ONE 85, 281, 326, 328	
minocycline hcl ..	24, 43, 186, 303	my way	216, 222, 244	neuac	37, 303, 318
		MYALEPT	237	NEULASTA	79
		mycophenolate mofetil ..	253, 279		

NEUPRO.....	142	norelgestromin-eth estradiol	223, 232, 245	OBIZUR.....	82
NEURONTIN.....	118, 122, 139	norethin ace-eth estrad-fe	223, 232, 245	octreotide acetate	205, 249, 250
NEVANAC.....	196	norethindrone	223, 245	OCUFLOX.....	42, 187
nevirapine	33	norethindrone acetate	245	ODACTRA.....	58
nevirapine er	33	norethindrone acet-ethinyl		ODEFSEY.....	33, 34, 39
new day	216, 222, 245	est	223, 232, 245	ODOMZO.....	53
NEXLETOL.....	90, 94	norethindrone-eth estradiol	233, 245	ofloxacin	42, 187
NEXLIZET.....	90, 94, 102	norgestimate-eth estradiol	223, 233, 245	OGSIVEO.....	53
NEXTSTELLIS.....	222, 232, 245	norgestimate-ethinyl		OHTUVAYRE.....	286
NGENLA.....	239	estradiol triphasic	223, 233, 245	OJEMDA.....	53
niacin er		NORLIQVA.....	106, 115	OJJAARA.....	53
(antihyperlipidemic)	94, 329	norlyroc	223, 245	olanzapine	126, 131, 199
nicardipine hcl	105, 106, 115	NORPACE.....	102	olanzapine-fluoxetine hcl	
NICORETTE.....	64, 68	NORPACE CR.....	102	.....	126, 131, 156, 199
NICORETTE MINI.....	63, 68	NORPRAMIN.....	157	olmesartan medoxomil	91, 92
nicotine	64, 69	nortrel 0.5/35 (28)	223, 233, 245	olmesartan medoxomil-hctz	
nicotine mini	64, 68	nortrel 1/35 (21)	223, 233, 245	.....	92, 181
nicotine polacrilex	64, 68	nortrel 1/35 (28)	223, 233, 245	olopatadine hcl	19, 185
nicotine polacrilex mini	64, 68	nortrel 7/7/7	223, 233, 245	OLUMIANT.....	258, 271
nicotine step 1	64, 69	nortriptyline hcl	157	omega-3-acid ethyl esters	
nicotine step 2	64, 69	NORVIR.....	35	.....	94, 111
nicotine step 3	64, 69	NOURIANZ.....	117, 136	omeprazole	207
NICOTROL NS.....	64, 69	NOVAREL.....	236	OMNIFLEX DIAPHRAGM.....	284
nifedipine	105, 106, 115	NOVOEIGHT.....	82	OMNIPOD 5 DEXG7G6	
nifedipine er	105, 106, 115	NOVOFINE PEN NEEDLE.....	170	INTRO GEN 5.....	170
nifedipine er osmotic release		NOVOFINE PLUS PEN		OMNIPOD 5 DEXG7G6 PODS	
.....	105, 106, 115	NEEDLE.....	170	GEN 5.....	170
nikki	222, 232, 245	NOVOPEN ECHO.....	170	OMNIPOD 5 LIBRE2 G6	
nilotinib hcl	53	NOVOSEVEN RT.....	82	INTRO GEN5.....	171
nimodipine	105, 106, 115	NOXAFIL.....	28	OMNIPOD 5 LIBRE2 PLUS G6	
NIMODIPINE.....	105, 106, 115	np thyroid	252	PODS.....	171
NINLARO.....	53	NUBEQA.....	53	OMNITROPE.....	239, 250
nintedanib esylate	287	NUCALA.....	288	OMVOH.....	198
nisoldipine er	106	NUCORT.....	193, 212, 312	OMVOH (300 MG DOSE).....	198
nitazoxanide	24, 25	NUCYNTA.....	147	ondansetron hcl	199
nitro-bid	110, 111	NUCYNTA ER.....	147	ondansetron odt	199
NITRO-DUR.....	110, 111	NUEDEXTA.....	136	ONE VITE WOMENS PLUS	
nitrofurantoin	44	NULEV.....	16, 67, 287	.....	85, 326, 329
nitrofurantoin macrocrystal	44	NUPLAZID.....	131	ONENATAL RX.....	85, 179, 326, 329
nitrofurantoin monohydrate		NURTEC.....	135	ONETOUCH DELICA PLUS	
macrocrystals	44	NUWIQ.....	82	LANCING.....	171
nitroglycerin	110, 111, 308, 323	NUZYRA.....	22	ONETOUCH DELICA SAFETY	
NITROSTAT.....	110, 111	nylia 1/35	223, 233, 245	LANCING.....	171
NITRO-TIME.....	110, 111	nylia 7/7/7	223, 233, 245	ONETOUCH ULTRA.....	171
NIVA THYROID.....	252	NYMALIZE.....	106, 115	ONETOUCH VERIO.....	171
NIVESTYM.....	79	nystatin	41, 320	ONFI.....	133, 134
nora-be	222, 245	nystatin-triamcinolone		ONUREG.....	53
NORDIPEN 5 INJECTION		.....	41, 312, 320	ONYDA XR.....	65
DEVICE.....	170	nystop	41, 320	opcicon one-step	216, 223, 245
NORDITROPIN FLEXPRO				OPFOLDA.....	183, 281
.....	239, 250			OPILL.....	223, 245
				opium	147, 199
				OPSUMIT.....	115, 291, 298

option 2	216, 223, 245	oxycodone-acetaminophen	119, 143, 147	pentazocine-naloxone hcl	148, 149
OPTIONS GYNOL II		oxymorphone hcl	147	pentoxifylline er	80
CONTRACEPTIVE.....	284	oxymorphone hcl er	147	perampanel	122
OPVEE.....	148	OZEMPIC.....	236, 237	PERFECT POINT SAFETY	
OPZELURA.....	53, 316, 323	OZOBAX DS.....	70	LANCETS.....	171
ORACIT.....	175	PACERONE.....	104	PERFECT POINT SAFETY	
ORALAIR.....	58	PALFORZIA.....	58	NEEDLE.....	171
ORALAIR ADULT STARTER		PALFORZIA (1 MG DAILY		PERFOROMIST.....	74, 297
PACK.....	58	DOSE).....	58	PERIDEX.....	21, 188, 306, 318
ORALAIR CHILDRENS		PALFORZIA INITIAL DOSE 1-		perindopril erbumine	93, 94
STARTER PACK.....	58	3YRS.....	58	periogard	21, 188, 306, 319
ORALONE.....	312	PALFORZIA INITIAL DOSE 4-		permethrin	320
ORAPRED ODT.....	193, 212	17YRS.....	58	perphenazine	150
ORAVIG.....	307	paliperidone er	131	perphenazine-amitriptyline	150, 158
ORENCIA.....	254, 271, 276	PALYNZIQ.....	183	PERTZYE.....	183, 203
ORENCIA CLICKJECT		PANCREAZE.....	183, 203	phenazopyridine hcl	305
.....	254, 271, 276	PANRETIN.....	300, 323	phenelzine sulfate	142
ORENITRAM.....	115, 295, 298	pantoprazole sodium	208	phenobarbital	132
ORENITRAM MONTH 1		PARI VORTEX ADULT MASK	171	phenoxybenzamine hcl ..	71, 114
.....	115, 295, 298	PARI VORTEX PEDIATRIC		phenylephrine hcl	196, 197
ORENITRAM MONTH 2		MASK.....	171	phenytek	102, 140
.....	115, 295, 298	paricalcitol	331	phenytoin	102, 140
ORENITRAM MONTH 3		PARNATE.....	142	phenytoin infatabs	102, 140
.....	115, 295, 298	paroxetine hcl	156	phenytoin sodium extended	102, 140
ORFADIN.....	183, 281	paroxetine hcl er	156	PHEXX.....	284
ORGOVYX.....	53, 216	PAXLOVID (150/100).....	27, 28	philith	223, 233, 246
ORIAHNN.....	216, 233, 245	PAXLOVID (300/100 &		PHOSPHA 250 NEUTRAL.....	179
ORILISSA.....	216	150/100).....	27, 28	PHOSPHOLINE IODIDE.....	196
ORKAMBI.....	290, 291	PAXLOVID (300/100).....	27, 28	phosphorous	179
ORLYNVAH.....	44, 182, 263	pazopanib hcl	53	phospho-trin 250 neutral	179
orphenadrine citrate er	70, 75, 119	PEDIARIX.....	59, 61	PHOXILLUM B22K4/0.....	179
orquidea	223, 246	PEDVAX HIB.....	62	PHOXILLUM BK4/2.5.....	179
ORSERDU.....	53	peg 3350	202	phytonadione	16, 263, 331
OSCIMIN.....	16, 67, 287	peg 3350-kcl-na bicarb-nacl	202	PIFELTRO.....	33
oseltamivir phosphate	37	peg-3350/electrolytes	202	pilocarpine hcl	72, 196
OSPHENA.....	226	peg- 3350/electrolytes/ascorbat	202, 330	pimecrolimus	279, 314, 323
OTEZLA.....	259, 271, 276, 323	PEGASYS.....	36, 53, 257, 277	pimozide	129, 137
OTEZLA XR.....	259	peg-kcl-nacl-nasulf-na asc-c	202, 330	pimtrea	223, 233, 246
OTEZLA/OTEZLA XR		PEG-PREP.....	202	pindolol	70, 95, 101, 103, 110
INITIATION PK.....	260	PEMAZYRE.....	53	pioglitazone hcl	251
OVIDE.....	320	PEN NEEDLE/5-BEVEL TIP...171		pioglitazone hcl-glimepiride	251
OVIDREL.....	236	PENBRAYA.....	62	pioglitazone hcl-metformin hcl	217, 251
oxaprozin	145, 153	penicillamine	16, 208, 271	PIP GLUCOSE CONTROL	
oxazepam	135	penicillin v potassium	37	SOLUTION.....	171
oxcarbazepine	122, 140	PENMENVY.....	62	PIQRAY.....	54
OXERVATE.....	188, 195	PENTACEL.....	59, 62	pirfenidone	287, 296
oxiconazole nitrate	307	pentamidine isethionate	25	piroxicam	145, 153
oxybutynin chloride	325			PLAN B ONE-STEP.....	216, 223, 246
oxybutynin chloride er	325			PLEGRIDY.....	277
oxycodone hcl	147				

PLEGRIDY STARTER PACK. 277	PRENATE ENHANCE	PROFILNINE..... 82
PLENVU.....202, 330	 86, 179, 282, 327, 329	progesterone 246
plerixafor 79	PRENATE ESSENTIAL	PROGLYCEM.....216
PNEUMOVAX 23.....62	 86, 179, 282, 327, 329	PROGRAF..... 253, 279, 314
pnv 27-ca/fel/fa 85, 326, 329	PRENATE MINI	PROMACTA.....79
PODOCON-25.....317, 323	 86, 180, 282, 327, 329	promethazine hcl
podofilox 317, 323	PRENATE PIXIE	 17, 18, 19, 130, 199, 204, 292
polyethylene glycol 3350 202	 86, 180, 282, 327, 329	promethazine-codeine
polymyxin b-trimethoprim	PRENATE RESTORE	 18, 19, 288
..... 41, 187, 303	 86, 180, 282, 327, 329	promethazine-dm 18, 19, 288
POLY-VI-FLOR/IRON	PREPIDIL.....285	promethazine-phenylephrine
..... 85, 267, 326	PRETOMANID.....26	 18, 19, 65
pomalidomide 54, 277	prevalite 96, 97	PROMETHEGAN
portia-28 223, 233, 246	PREVIDENT..... 159, 161, 267	 18, 19, 130, 200, 204, 292
posaconazole 28	PREVIDENT 5000 BOOSTER	PRONAL..... 307, 317
potassium chloride 179	PLUS.....160, 267	propafenone hcl 102
potassium chloride crys er ..179	PREVIDENT 5000 DRY	propafenone hcl er 102
potassium chloride er 179	MOUTH.....159, 160, 267	proparacaine hcl 196
potassium citrate er 175	PREVIDENT 5000 ENAMEL	propranolol hcl
potassium citrate-citric acid 175	PROTECT.....161, 267	 70, 96, 101, 103, 110, 129
potassium iodide	PREVIDENT 5000 KIDS.161, 267	propranolol hcl er
(expectorant) 292	PREVIDENT 5000 ORTHO	 70, 96, 101, 103, 110, 129
PRADAXA.....78	DEFENSE.....161, 267	propylthiouracil 217
pramipexole dihydrochloride	PREVIDENT 5000 PLUS	PROQUAD.....62
.....143	 159, 161, 267	protriptyline hcl 158
PRAMOSONE.....305, 312	PREVIDENT 5000 SENSITIVE	PROVERA.....246
PRAMOTIC.....188, 196	161, 267	prucalopride succinate 205
prasugrel hcl 87	PREVNAR 20.....62	PRURADIK.....320
pravastatin sodium 108	PREVYMIS.....27	pseudoephedrine-
praziquantel 23	PREZCOBIX.....35, 282	bromphen-dm 18, 19, 65, 288
prazosin hcl 71, 91, 95	PREZISTA.....35	PULMOSAL.....293
PRED MILD.....193, 212	PRIFTIN.....26, 42	PULMOZYME.....184, 293
prednisolone 193, 212	primaquine phosphate 24	PURE COMFORT SAFETY
prednisolone acetate 193, 212	primidone 132	LANCET 30G.....171
prednisolone sodium	PRIORIX.....62	PURE COMFORT SAFETY
phosphate 193, 212	PRISMASOL B22GK 4/0.....180	PEN NEEDLE.....171
prednisone 212	PRISMASOL BGK 0/2.5.....180	PURIXAN.....54, 256, 280
prednisone intensol 212	PRISMASOL BGK 2/0.....180	PYLERA.....23, 25, 43, 199, 201
pregabalin 122, 138, 139	PRISMASOL BGK 2/3.5.....180	pyrazinamide 27
PREGNYL.....236	PRISMASOL BGK 4/0/1.2.....180	PYRIDIUM.....305
PREMARIN.....233, 265, 266	PRISMASOL BGK 4/2.5.....180	pyridostigmine bromide 72
PREMESISRX 179, 282, 326, 329	PRISMASOL BK 0/0/1.2.....180	pyridostigmine bromide er 72
PREMPHASE.....233, 246	probenecid 182, 263	PYRIDOSTIGMINE BROMIDE
PREMPRO.....233, 246	PROCENTRA.....118	ER.....72
prenatal 85, 326, 329	prochlorperazine 150, 200	pyrimethamine 24
prenatal plus vitamin/mineral	prochlorperazine maleate	PYROGALLIC ACID285, 317, 323
.....86, 326, 329	150, 200	PYRUKYND.....77
PRENATE.....180, 327, 329	PROCTOFOAM HC	PYRUKYND TAPER PACK.....77
PRENATE DHA	194, 212, 305, 312	QBRELIS.....94
.....86, 179, 282, 327, 329	procto-med hc 194, 212, 312	QFITLIA.....82
PRENATE ELITE.....86, 327, 329	PROCTOSOL HC...194, 212, 312	QINLOCK.....54
	PROCTOZONE-HC194, 212, 313	QUADRACEL.....59, 62
	PROCYSBI.....282	QUESTRAN.....97

QUESTRAN LIGHT	97	REYVOW	155	salsalate	154
quetiapine fumarate	126, 131	REZDIFFRA	205, 252	SALVAX DUO PLUS	307, 317
quetiapine fumarate er	126, 131	REZENOPY	16, 148	SAMSCA	182
QUICK TOUCH INSULIN PEN		REZLIDHIA	54	SANTYL	184, 308, 323
NEEDLE	171	REZUROCK	282	sapropterin dihydrochloride	
quinapril hcl	93, 94	RHAPSIDO	277, 314	.....	182, 282
quinapril-		RHOFADE	197, 301, 323	SAVAYSA	77
hydrochlorothiazide	94, 181	RHOPRESSA	197	SAVELLA	138, 155
quinidine gluconate er	24, 102	ribavirin	39	SAVELLA TITRATION PACK	
quinidine sulfate	24, 102	RIDAURA	208, 255, 272, 277	.....	138, 155
quinine sulfate	24	rifabutin	27, 42	saxagliptin hcl	226
QULIPTA	135	rifampin	27, 42	saxagliptin-metformin er	
QVAR REDIHALER		rilpivirine hcl	33	.....	217, 226
.....	212, 213, 289, 290, 294	riluzole	116, 136	SCALACORT DK	313, 317
rabeprazole sodium	208	rimantadine hcl	21	SCEMBLIX	54
RADICAVA ORS	116, 136	RINVOQ	258, 272	scopolamine	67, 200, 206
RADICAVA ORS STARTER		RINVOQ LQ	258	SELECT-OB	86, 327, 329
KIT	116, 136	risedronate sodium	266	selegiline hcl	141, 142
RADIOGARDASE	17, 177, 263	risperidone	127, 131, 132	selenium sulfide	306, 319
RAGWITEK	59	ritonavir	35	SELZENTRY	32
RALDESY	156	rivaroxaban	77	SENSILANCE SAFETY	
raloxifene hcl	226, 266	rivastigmine	72	LANCETS 21G	171
ramelteon	130, 141	rivastigmine tartrate	72	SENSILANCE SAFETY	
ramipril	93, 94	rivelsa	223, 233, 246	LANCETS 26G	172
ranolazine er	100	RIVFLOZA	282	SENSILANCE SAFETY	
rasagiline mesylate	141, 142	RIVIVE	16, 149	LANCETS 28G	172
RASUVO	255, 271, 272	RIXUBIS	83	SEPHIENCE	182, 183
RAYA SURE PEN NEEDLE ...	171	rizatriptan benzoate	155	SEREVENT DISKUS	74, 297
reclipsen	223, 233, 246	ROCALTROL	331	SEROSTIM	239, 250
RECOMBIMATE	83	ROCKLATAN	197	sertraline hcl	156
RECOMBIVAX HB	62	roflumilast	294, 316, 319	setlakin	223, 233, 246
RECOTHROM	83	ROMVIMZA	54	sevelamer carbonate	
RECOTHROM SPRAY KIT	83	ropinirole hcl	143	.....	17, 177, 263
RECTIV	110, 308, 323	ropinirole hcl er	143	sevoflurane	140
REGLAN	207	rosuvastatin calcium	108	sf	159, 161, 267
RELENZA DISKHALER	37	rosyrah	223, 233, 246	sf 5000 plus	159, 161, 267
RELION GLUCOSE TEST		ROTARIX	62	sharobel	223, 246
STRIPS	174	ROTATEQ	62	SHARPS COLLECTOR	172
RELISTOR	148, 198, 205	ROWASA	200	SHARPS CONTAINER	172
RELNATE DHA	86, 282, 327, 329	roweepra	122	shewise	216, 224, 246
RENTHYROID	252	ROZLYTREK	54	SHINGRIX	62
repaglinide	238	RUBRACA	54	SIGNIFOR	250
REPATHA	111	RUCONEST	268, 269	sildenafil citrate	
REPATHA SURECLICK	111	rufinamide	122, 140	.....	112, 295, 298, 325
RESTASIS	188, 194, 253	RUKOBIA	31	silodosin	72
RESTORIL	135	RYBELSUS	237	SILVADENE	306, 319
RETACRIT	76, 79	RYDAPT	54	silver nitrate	188
RETEVMO	54	sacubitril-valsartan ...	91, 92, 113	silver sulfadiazine	306, 319
RETROVIR	34	SAFETY PEN NEEDLES	171	simliya	224, 233, 246
REVUFORJ	54	SAFYRAL	223, 233, 246, 329	simpesse	224, 233, 246
REXTOVY	16, 148	SALAGEN	72, 196	SIMPLERA SYNC SENSOR ...	172
REXULTI	131	SALICATE	317	SIMPONI	205, 206, 261, 272, 277
REYATAZ	35	salicylic acid	317	simvastatin	108

SINEMET	138	SPIRIVA HANDIHALER....	67, 287	sulfacetamide-prednisolone	187, 194
SINGULAIR.....	293	SPIRIVA RESPIMAT	67, 287	sulfacetamide-sulfur in urea	304, 317
sirolimus	259, 280, 314, 315	spironolactone	90, 109, 112, 113, 178	sulfadiazine	42
SIRTURO	27	spironolactone-hctz	90, 109, 113, 178, 181	sulfamethoxazole-	
SIVEXTRO.....	40	SPORANOX.....	28	trimethoprim	26, 42, 44
SKYCLARYS.....	282	SPRAVATO (56 MG DOSE)	124, 142	SULFAMYLON.....	304, 319
SKYRIZI.....	206, 315, 324	SPRAVATO (84 MG DOSE)	124, 142	sulfasalazine	42, 200, 255, 272, 277
SKYRIZI PEN.....	315, 323	.....	124, 142	sulfatrim pediatric	26, 42, 44
SKYTROFA.....	239	sprintec 28	224, 233, 246	sulfurated lime	320
SLYND.....	216, 224, 246	SPRIX.....	145, 153, 196	sulindac	145, 153
smooth lax	202	SPS (SODIUM		sumatriptan	155
sod citrate-citric acid	175	POLYSTYRENE SULF)	17, 177, 263	sumatriptan succinate	155
sod fluoride-potassium		ssd	306, 319	SUMAXIN.....	304, 317
nitrate	161, 267	SSKI.....	292	sunitinib malate	55
sodium chloride	293	sss 10-5	303, 317	SUNLENCA.....	26, 31
sodium fluoride		ST JOSEPH LOW DOSE	87, 88, 129, 154	SUNOSI.....	159
.....	159, 160, 161, 267, 268	STARJEMZA.....	258	SUPREP BOWEL PREP KIT..	202
sodium fluoride 5000 enamel	161, 267	STENDRA.....	112	SUTAB.....	202
sodium fluoride 5000 plus	159, 161, 267	STEQEYMA.....	258	syeda	224, 234, 246
sodium fluoride 5000 ppm	159, 161, 267	STIOLTO RESPIMAT	67, 74	SYMBICORT	74, 213
sodium fluoride 5000		STIVARGA.....	55	SYMDEKO.....	290, 291
sensitive	161, 267	STRENSIQ.....	184	SYMFI.....	33, 34
sodium oxybate	136, 159, 264	STRIBILD.....	32, 34, 283	SYMPAZAN.....	133, 135
sodium phenylbutyrate	176	STRIVERDI RESPIMAT...	74, 298	SYMPROIC.....	198, 206
sodium polystyrene		STROMECTOL.....	23	SYNAREL.....	236
sulfonate	17, 177, 263	SUBOXONE.....	149	SYNDROS.....	200, 206
sodium sulfacetamide	303	SUBVENITE.....	122, 127	SYNJARDY.....	217, 249
sodium sulfacetamide wash	303	subvenite	122, 127	SYNJARDY XR.....	218, 249
SOFOSBUVIR-VELPATASVIR	30, 31	subvenite starter kit-blue	123, 127	TABLOID.....	55
.....		subvenite starter kit-green	123, 127	TABRECTA.....	55
SOGROYA.....	239	.....	123, 127	TACLONEX.....	308, 313, 324
SOHONOS.....	282	subvenite starter kit-orange	123, 127	tacrolimus	253, 280, 315, 324
solifenacin succinate	325	.....	123, 127	tadalafil	112, 295
SOLIQUEA.....	237	subvenite starter kit-orange	123, 127	tadalafil (pah)	112, 295, 298
SOLOSEC.....	25	.....	123, 127	TADLIQ.....	112, 295, 298
SOMAVERT.....	250	SUCRAID.....	184	TAFINLAR.....	55
SOOLANTRA.....	320	sucrafate	207	tafluprost (pf)	197
sorafenib tosylate	55	SUFLAVE.....	202	TAGRISSO.....	55
sotalol hcl	70, 96, 101, 103, 104, 110	SULAR.....	106	take action	216, 224, 246
sotalol hcl (af)	70, 96, 101, 103, 104, 110	SULCONAZOLE NITRATE....	307	TAKHZYRO.....	89, 280
SOTYKTU.....	316, 324	sulfacetamide sodium ..	187, 303	TALZENNA.....	55
SOTYLIZE	70, 96, 101, 103, 104, 110	sulfacetamide sodium (acne)	303	tamoxifen citrate	55, 226
SOVALDI.....	30	sulfacetamide sodium	303	tamsulosin hcl	72
SPEVIGO.....	315	(cleans)	303	TANLOR.....	69
SPIKEVAX.....	62	sulfacetamide sodium-sulfur	303, 304, 317	tapentadol hcl	147
SPIKEVAX 6M-11Y.....	62	.....	303, 304, 317	TAPERDEX 12-DAY.....	194, 213
spinosad	320	sulfacetamide sod-sulfur	304, 317	TAPERDEX 6-DAY.....	194, 213
		wash	304, 317	TAPERDEX 7-DAY.....	194, 213
				tarina 24 fe	224, 234, 246
				tarina fe 1/20 eq	224, 234, 246

TARPEYO.....	213	thyroid	252	TRADJENTA.....	226
tasimelteon	130, 141	tiadylt er	97, 98, 99, 105, 115	tramadol hcl	147
tavaborole	319	tiagabine hcl	123, 139	tramadol hcl (er biphasic)	147
TAVALISSE.....	77	TIAZAC.....	97, 98, 99, 105, 116	tramadol hcl er	147
TAVNEOS.....	254, 268, 269	TIBSOVO.....	55	tramadol-acetaminophen	119, 143, 148
taysofy	224, 234, 246	ticagrelor	87	trandolapril	93, 94
TAYTULLA.....	224, 234, 246	TIGLUTIK.....	117, 137	trandolapril-verapamil hcl er	94, 99
tazarotene	317, 324	TIKOSYN.....	104	tranexamic acid	83
TAZORAC.....	317, 324	tilia fe	224, 234, 247	tranylcypropamine sulfate	142
TECHLITE LANCETS 26G.....	172	timolol hemihydrate	70, 96, 103, 189	travoprost (bak free)	197
TECHLITE PLUS PEN NEEDLES.....	172	timolol maleate 70, 71, 96, 101, 104, 110, 129, 189		trazodone hcl	156
TEGLUTIK.....	116, 136	timolol maleate (once-daily)	70, 96, 103, 189	TRELEGY ELLIPTA	67, 74, 194, 213, 290
TEGRETOL.....	123, 127	timolol maleate ocudose	70, 96, 103, 189	TREMFYA.....	255, 315, 324
TEGRETOL-XR.....	123, 127	timolol maleate pf	71, 96, 104, 189	TREMFYA ONE-PRESS	255, 315, 324
TEKTURNA.....	113	TIMOPTIC OCUDOSE	71, 96, 104, 189	TREMFYA PEN.....	255, 315
telmisartan	91, 92	tinidazole	26	TREMFYA-CD/UC INDUCTION.....	255, 315
telmisartan-hctz	92, 181	tiopronin	283	tretinoin	55, 56, 308
temazepam	135	TIROSINT-SOL.....	252	TRETEN.....	83
TEMBEXA.....	39	TISSEEL.....	308, 324	TREXALL..	56, 255, 272, 278, 280
temozolomide	55	TIVICAY.....	32	TREZIX.....	119, 143, 148, 152
TENCON.....	119, 132, 143	TIVICAY PD.....	32	triamcinolone acetanide	213, 313
TENIVAC.....	59	tizanidine hcl	69	triamterene	90, 113, 178
tenofovir disoproxil fumarate 34		TOBI NEBULIZER.....	21, 187	triamterene-hctz	178, 181
TEPMETKO.....	55	TOBI PODHALER.....	22, 187	triazolam	135
terazosin hcl	71, 91, 96	TOBRADEX.....	22, 187, 194	TRICITRASOL.....	76
terbinafine hcl	21	tobramycin	22, 187	tricitrates	175
terbutaline sulfate	74, 298	tobramycin-dexamethasone	22, 187, 194	triderm	213, 313
terconazole	307	TOBREX.....	22, 187	trientine hcl	208
teriflunomide	253, 277	TODAY SPONGE.....	284	tri-estarylla	224, 234, 247
TERIPARATIDE.....	238, 264	tolcapone	135	trifluoperazine hcl	150
terrell	140	tolterodine tartrate	325	trifluridine	188
TESTIM.....	214, 216	tolvaptan	182	trihexyphenidyl hcl	68, 119
testosterone	214, 215, 216	tolvaptan (hyponatremia)	182	TRIJARDY XR.....	218, 226, 249
testosterone cypionate	214, 216	TONMYA.....	69, 138	TRIKAFTA.....	290, 291
testosterone enanthate	214, 216	TOPAMAX.....	123, 129	tri-legest fe	224, 234, 247
tetrabenazine	158	TOPAMAX SPRINKLE....	123, 129	TRILEPTAL.....	123, 140, 141
tetracaine hcl	196, 261	TOPICORT.....	313	tri-linyah	224, 234, 247
tetracycline hcl	24, 43, 201, 304	topiramate	123, 129	tri-lo-estarylla	224, 234, 247
TEXACORT.....	194, 213, 313	toremifene citrate	55, 226	tri-lo-marzia	224, 234, 247
TEZRULY.....	71, 91	torpenz	55, 256	tri-lo-mili	224, 234, 247
TEZSPIRE.....	293, 296	torse mide	89, 108, 177	tri-lo-sprintec	224, 234, 247
THALOMID.....	55, 278	TOUJEO MAX SOLOSTAR....	237	trimethobenzamide hcl	200
THEO-24.....	107, 152, 176, 299, 325	TOUJEO SOLOSTAR.....	237	trimethoprim	44
theophylline	107, 152, 176, 300, 325	TPOXX.....	27	tri-mili	224, 234, 247
theophylline er	107, 152, 176, 299, 300, 325	TRACLEER.....	116, 292, 298	trimipramine maleate	158
thioridazine hcl	150			TRINATE.....	86, 327, 329
thiothixene	157			TRINTELLIX.....	157
THROMBIN-JMI.....	83				
THROMBIN-JMI EPISTAXIS....	83				
THROMBOGEN.....	83				

tri-sprintec	224, 234, 247	UCERIS.....	213	velivet	225, 234, 247
TRISTART DHA		UDENYCA.....	79, 80	VELPHORO.....	177
.....	86, 180, 283, 327, 329	ULTANE.....	140	VELTASSA.....	178
TRIUMEQ.....	32, 35	ULTRA-CARE SAFETY		VENCLEXTA.....	56
TRIUMEQ PD.....	32, 35	LANCETS 30G.....	172	VENCLEXTA STARTING	
TRI-VI-FLORO		UNIFINE OTC PEN NEEDLES		PACK.....	56
160, 161, 268, 327, 329, 330, 331		.....	172	VENELEX.....	324
tri-vite/fluoride		UNIFINE PROTECT PEN		venlafaxine hcl	155
160, 161, 268, 327, 328, 330, 331		NEEDLE.....	172	venlafaxine hcl er	155
tri-vylibra	224, 234, 247	UNISTRIP CONTROL.....	172	VEOZAH.....	137
tri-vylibra lo	224, 234, 247	unithroid	252	verapamil hcl	
tropium chloride	325	UPNEEQ.....	197	.....	97, 98, 99, 105, 116
TRUE COMFORT SAFETY		UPTRAVI.....	299	verapamil hcl er	
PEN NEEDLE.....	172	UPTRAVI TITRATION.....	299	.....	97, 98, 99, 105, 116
TRUE COVER.....	284	urea	89, 90, 177, 197, 317	VEREGEN.....	318, 324
TRUE FOLIC ACID.....	329	URELLE.....	44, 67, 119, 283	VERIFINE INSULIN PEN	
TRUE METRIX LEVEL 1.....	172	uretron d/s	44, 67, 119, 283	NEEDLE.....	172
TRUE METRIX LEVEL 2.....	172	UROCIT-K 10.....	175	VERIFINE INSULIN SYRINGE	
TRUE METRIX LEVEL 3.....	172	UROCIT-K 15.....	175	.....	172
TRULICITY.....	237	UROGESIC-BLUE.....	44, 67, 283	VERIFINE PLUS PEN	
TRUMENBA.....	62	ursodiol	203	NEEDLE.....	173
TRUQAP.....	56	VAFSEO.....	80	VERIFINE SAFE LANCET	
TRUVADA.....	35, 39	valacyclovir hcl	39	MINI 21G.....	173
TRYNGOLZA.....	94, 213, 264	VALCHLOR.....	300, 324	VERIFINE SAFE LANCET	
TRYPTYR.....	195	valganciclovir hcl	39	MINI 23G.....	173
TRYVIO.....	292	valproic acid ..	123, 127, 129, 139	VERIFINE SAFE LANCET	
TUKYSA.....	56	valsartan	91, 92	MINI 28G.....	173
TURALIO.....	56	valsartan-		VERIFINE SAFE LANCET	
turpentine	307	hydrochlorothiazide	92, 181	MINI 30G.....	173
turqoz	224, 234, 247	VALTOCO 10 MG DOSE.....	133	VERIFINE SHARPS	
TUXARIN ER.....	18, 19, 288	VALTOCO 15 MG DOSE.....	133	CONTAINER.....	173
TWIIST REFILL KIT.....	172	VALTOCO 20 MG DOSE.....	133	VERISAFE SAFETY STERILE	
TWIIST REFILL		VALTOCO 5 MG DOSE.....	133	NEEDLE.....	173
KIT/INFUSION SET.....	172	valtya 1/35	224, 234, 247	VERKAZIA.....	188, 194, 254
TWIIST STARTER KIT.....	172	valtya 1/50	224, 234, 247	VERQUVO.....	101, 116
TWINRIX.....	63	VANCOCIN.....	29	VERSAPENN (AG)	
TWIRLA.....	224, 234, 247	vancomycin hcl	29	ANHYDROUS.....	285
TYBLUME.....	224, 234, 247	VANDAZOLE.....	21, 38, 304	VERSAPENN (AL) ANHYD	
tydemy	224, 234, 247, 330	VANFLYTA.....	56	LIPID.....	285
TYMLOS.....	238, 264	VANRAFIA.....	273, 292	VERZENIO.....	56
TYRVAYA.....	64, 195	VAQTA.....	63	vestura	225, 234, 247
TYVASO.....	116, 295, 299	varidenafil hcl	112	VFEND.....	28
TYVASO DPI INSTITUTIONAL		varenicline tartrate	64, 69	VIBERZI.....	199, 206
KIT.....	116, 295, 299	varenicline tartrate (starter)		vienna	225, 234, 247
TYVASO DPI MAINTENANCE		.....	64, 69	vigabatrin	123, 139
KIT.....	116, 295, 299	varenicline tartrate(continue)		VIGADRONE.....	123, 139
TYVASO DPI TITRATION KIT		.....	64, 69	VIGAFYDE.....	139
.....	116, 295, 299	VARIVAX.....	63	VIJOICE.....	283
TYVASO REFILL KIT		VAXELIS.....	59, 63	vilazodone hcl	157
.....	116, 296, 299	VAXNEUVANCE.....	63	VILEVEV MB.....	44, 67, 119, 283
TYVASO STARTER KIT		VCF VAGINAL		VIMPAT.....	123, 141
.....	116, 296, 299	CONTRACEPTIVE.....	284, 285	VIOKACE.....	184, 203
UBRELVY.....	135	VECAMYL.....	114	viorele	225, 234, 247

VIRACEPT	35	wera	225, 235, 247	XPOVIO (60 MG TWICE WEEKLY)	57
VIREAD	35	WESCAP-PN DHA	86, 180, 283, 327, 330	XPOVIO (80 MG ONCE WEEKLY)	57
VISTOGARD	17, 263	WESNATE DHA	86, 283, 327, 330	XPOVIO (80 MG TWICE WEEKLY)	57
VITAFOL FE+	86, 180, 283, 327, 330	WESTGEL DHA	86, 180, 283, 327, 330	XROMI	57
VITAFOL-OB+DHA	86, 180, 283, 327, 330	WEZLANA	258	XTAMPZA ER	148
VITAMIN C BRIGHTENING SERUM	307	wheat germ oil	331	XTANDI	57
vitamin d (ergocalciferol)	331	WIDE-SEAL DIAPHRAGM 60	285	XTORO	187
VITATHELY WITH GINGER	86, 327, 330	WIDE-SEAL DIAPHRAGM 65	285	xulane	225, 235, 247
VITRAKVI	56	WIDE-SEAL DIAPHRAGM 70	285	XYNTHA	83
VIVAGUARD INO CONTROL SOLUTION	173	WIDE-SEAL DIAPHRAGM 75	285	XYNTHA SOLOFUSE	83
VIVAGUARD LANCETS 30G	173	WIDE-SEAL DIAPHRAGM 80	285	xyvona	148
VIVAGUARD LANCING DEVICE	173	WIDE-SEAL DIAPHRAGM 85	285	XYWAV	137
VIVAGUARD SAFETY LANCETS 28G	173	WIDE-SEAL DIAPHRAGM 90	285	YASMIN 28	225, 235, 248
VIVJOA	28	WIDE-SEAL DIAPHRAGM 95	285	YAZ	225, 235, 248
VIZIMPRO	56	WILATE	83	YESINTEK	258
VOCABRIA	32	WINREVAIR	296	YEZTUGO	31
volnea	225, 234, 247	wixela inhub	74, 194, 213, 290	YORVIPATH	238
VONVENDI	83	wymzya fe	225, 235, 247	yulithira	57, 256
VOQUEZNA	207, 208	XACIATO	37, 304	YUPELRI	68, 287
VOQUEZNA DUAL PAK ...	22, 207	xarah fe	225, 235, 247	yuvaferm	235, 266
VOQUEZNA TRIPLE PAK	22, 39, 40, 207	XARELTO	77, 78	ZACARE	307, 319
VORANIGO	56, 57	XARELTO STARTER PACK	78	ZACLIR CLEANSING	319
voriconazole	28	XATMEP ...	57, 255, 272, 278, 280	zafemy	225, 235, 248
VORTEX VALVE CHAMBER-PEDI MASK	173	XCOPRI	123, 124, 141	zafirlukast	293
VORTEX VALVED HOLDING CHAMBER	173	XDEMVY	188	zaleplon	130, 142
VOSEVI	30, 31	XELJANZ	259, 272	ZANAFLEX	69
VOWST	206, 283	XELJANZ XR	259, 273	ZARONTIN	157
VOXZOGO	283	XELPROS	197	ZARXIO	80
VOYDEYA	268	xelria fe	225, 235, 247	ZAVZPRET	135
VOYXACT	253	XELSTRYM	118	ZELAPAR	141, 142
VRAYLAR	132	XEPI	304	ZELBORAF	57
VTAMA	304, 308, 324	XERMELO	199	ZELSUVMI	306, 324
vyfemla	225, 234, 247	XIFAXAN	42	zelvysia	183, 283
VYLEESI	137, 208	XIIDRA	188, 194	ZEMPLAR	331
vylibra	225, 235, 247	XIRUN	307, 318	zenatane	318, 324
VYNDAMAX	100, 137, 283	XOFLUZA (40 MG DOSE) ..	27, 28	ZENPEP	184, 204
VYSCOXA	137	XOFLUZA (80 MG DOSE) ..	27, 28	ZEPATIER	30, 31
VYVGART HYTRULO	259	XOLAIR	257, 296	ZEPOSIA	278
WAINUA	264	XOLREMDI	80	ZEPOSIA 7-DAY STARTER PACK	278
WAKIX	159	XOPENEX HFA	74, 298	ZEPOSIA STARTER KIT	278
warfarin sodium	77	XOSPATA	57	ZIAGEN	35
WAYRILZ	77	XPHOZAH	177, 178, 206	zidovudine	35
WELIREG	57	XPOVIO (100 MG ONCE WEEKLY)	57	ZILBRYSQ	254, 268
		XPOVIO (40 MG ONCE WEEKLY)	57	zileuton er	293
		XPOVIO (40 MG TWICE WEEKLY)	57	ZILXI	24, 43, 187, 304
		XPOVIO (60 MG ONCE WEEKLY)	57	ZIOPTAN	197
				ziprasidone hcl	127, 132
				ZIRGAN	39, 188
				ZITHROMAX	39, 40

ZITHROMAX TRI-PAK	40
ZITHROMAX Z-PAK	40
ZOKINVY	183, 283, 284
ZOLINZA	57
zolmitriptan	155
zolpidem tartrate	130, 142
zolpidem tartrate er	130, 142
ZOMIG	155
ZONEGRAN	124, 141
ZONISADE	124, 141
zonisamide	124, 141
ZONTIVITY	87
ZORYVE	294, 316, 319, 324
zovia 1/35 (28)	225, 235, 248
ZTALMY	124, 139
ZTLIDO	261, 305
ZUBSOLV	149
zumandimine	225, 235, 248
ZURNAL	149
ZURZUVAE	124
ZYCUBO	180
ZYDELIG	57
ZYLET	187, 194
ZYVOX	40