



2025 California Advantage Large Group 3-Tier HMO and PPO Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of Oct. 1, 2025 and is subject to change after this date. All previous versions of this PDL are no longer in effect. Your estimated coverage and copay/coinsurance may vary based on the benefit plan you choose and the effective date of the plan.

The current PDL can also be accessed online at uhc.com/CA-LargeGroup-3TADV-DMHC-Current. An example of a plan coverage document may be accessed online at uhc.com/content/dam/uhcdotcom/en/statepdl/lg/2024-CA-LrgGrp-SBC.pdf.

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

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

- Navigate
- Navigate Plus
- Choice
- Choice Plus
- Select
- Select Plus
- Core
- Core Essential
- Options PPO
- Non-Differential PPO
- SignatureValue
- SignatureValue Advantage
- SignatureValue Alliance
- SignatureValue Focus
- SignatureValue Harmony
- Doctors Plan
- Surest

Please refer to your member ID card for plan type (HMO or PPO).

Updated 8/1/2025

Contents

Understand your medication options 3

How do I use my PDL? 5

What are tiers? 6

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

Utilization Management programs.....7

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

Requesting a prior authorization or step therapy exception 9

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

Prescription delivery options.....9

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

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

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

Nondiscrimination notice and access to communication services ..12

Prescription drug list.....16

Understand your medication options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do I use my PDL?

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

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

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

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

Example:

Prescription drug name	Drug tier	Coverage requirements & limits
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG <i>(irbesartan)</i>	3	
<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.

Drug Tier 1	Your lowest cost medications	M	May be covered under the medical benefit with prior authorization for HMO plans
Drug Tier 2	Your mid-range cost medications	SMCS	Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit)
Drug Tier 3	Your highest cost medications	E	Excluded from coverage unless covered as part of health care reform preventive
PA	Prior authorization required	SM	\$0 cost-share by state mandate when condition appropriate
QL	Quantity limit	IF	Two one-month fills are required before a three-month fill is available if allowed
ST	Step therapy		
H	Part of health care reform preventive when age and/or condition appropriate		
SP	Specialty medication		
CM	Orally administered anti-cancer medication		

What are tiers?

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

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

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. A mix of brand-name and generic drugs.	Use tier 2 drugs instead of Tier 3 to help reduce your out-of-pocket costs.
\$\$\$	Tier 3 Your highest cost	Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Many tier 3 drugs have lower-cost options in tier 1 or 2. Ask your doctor if they could work for you.

Please note: If you have a high deductible plan, the tier cost levels may apply once you reach your deductible. Refer to your enrollment and plan materials on myuhc.com, or call the toll-free number on your member ID card for more information about your benefit plan. For HMO plans, please reference your Schedule of Benefits for costs associated with medications covered under the medical benefit. 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 become subject to new or revised utilization management procedures, such as prior authorization, step therapy or quantity limits, at any time but most often upon FDA approval of the medication or its generic, Jan. 1, May 1, or Sept. 1.

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

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

Utilization Management programs

Prior authorization required – Your doctor is required to provide additional information to us to determine coverage.

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

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

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

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

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

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

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

- Abortion*
- COVID-19

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

Specialty Medication Cost Share (SMCS) – Specialty medication cost share may apply. Please refer to the Pharmacy Schedule of Benefits for specific cost share. For HMO plans, does not apply to injectable medications covered under the medical benefit.

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

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

Your right to request access to a non-formulary drug

This plan must cover all medically necessary Prescription Drug Products.

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

Urgent requests

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

External review

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

Expedited external review

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

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

Requesting a prior authorization or step therapy exception

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

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

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

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

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

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

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

Prescription delivery options

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

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

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

E-prescribe

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

Ordering prescriptions for home delivery

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

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

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

You have two options:

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

Designated pharmacies

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

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

How do I get updated information about my pharmacy benefit?

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

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

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

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

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

Learn more

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

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

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆኑ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

[illegible]

দেখুন: আপফ্র যফ্র **বাংলায়** (Bengali-Bangala) কথা বঁ : , তাহঁ ঙ্গ মূঁ' ভাষা সহায়তা পঙ্কষবা এবং বড় মুদ্রঁ ফ্রমতো অ: '।: ' ফফ্রম্ টে যোগাযোগগুঁফ্র আপ: ফ্রজ: ঙ্গ মূঁ' উর্প ঙ্গ। আপ: ফ্রস: সঁে ফ্রপঙ্কচয়র্পে ফ্রকাডেঁফ্র'। -ঙ্গ: স্বফ্রের্ক কর:

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Cambodian-Mon-Khmer)
សេវាជំនួយភាសាភាគីភាគីក្នុង និងការទំនាក់ទំនងភាគីភាគីក្នុងប្រព័ន្ធផ្សេងទៀត
ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ចូរសម្របកាលបរិច្ឆេទភាគីភាគីក្នុងនោះលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

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

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

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

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

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય 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: ກິດຈະກຳພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ໂທຫາເບີໂທຟຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

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

بوحه: لکړه يې دېان وایسې (Persian-Farsi) صحېدې می کسېدې حېماپ ېلکېان کمکې دېلې و لېبداطاب
ېلکېان دې والېه ای ېکړې مېلېدې حېاپ ېرر کې دې سېر سېس مېا هېسېدې. ېلېس مېاړه ېلکېان مېدرج روي کارب
سېلرېلې عصفو ېلېس مېاس ېکېود.

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 ਿ ਤੁਸ਼ 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.

โปรดทราบหากคุณพูดภาษาไทย (Thai) ได้

คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่นๆ ฟรีเช่น

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 لہےصفتو ردا ے کی معاو ے خدمات اوربذکر وایمیسےس
مواطن اب، حسے درفرب، اب کلے معب سہابمسلسے مدرسہلحی کارب ریسے کفول وری
سمبر کال کس۔

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 California

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION.....	1
ANTIDOTE THERAPEUTICS.....	16
ANTIHISTAMINE DRUGS - Drugs for Allergy.....	19
ANTI-INFECTIVE AGENTS - Drugs for Infections.....	21
ANTINEOPLASTIC AGENTS - Drugs for Cancer.....	47
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM.....	60
AUTONOMIC DRUGS.....	65
AUTONOMIC DRUGS - Drugs for the Nervous System.....	66
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood.....	78
CARDIOVASCULAR DRUGS.....	92
CARDIOVASCULAR DRUGS - Drugs for the Heart.....	93
CENTRAL NERVOUS SYSTEM AGENTS.....	121
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System.....	121
DENTAL AGENTS.....	168
DENTAL AGENTS - Oral Care.....	169
DEVICES - Medical Supplies and Durable Medical Equipment.....	171
DIAGNOSTIC AGENTS.....	182
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants.....	185
ELECTROLYTIC, CALORIC, AND WATER BALANCE.....	185
ENZYMES.....	194
EYE, EAR, NOSE AND THROAT (EENT) PREPS.....	196
GASTROINTESTINAL DRUGS.....	210
GASTROINTESTINAL DRUGS - Drugs for the Stomach.....	211
GOLD COMPOUNDS.....	222
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron.....	223
HORMONES AND SYNTHETIC SUBSTITUTES.....	223
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones.....	223
IMMUNOMODULATORY AGENTS (90:00).....	269
LOCAL ANESTHETICS - Drugs for Numbing.....	278
MISCELLANEOUS THERAPEUTIC AGENTS.....	278
NONHORMONAL CONTRACEPTIVES - Drugs for Women.....	304
OXYTOCICS - Drugs for Women.....	305
PHARMACEUTICAL AIDS.....	305
RESPIRATORY TRACT AGENTS.....	306
RESPIRATORY TRACT AGENTS - Drugs for the Lungs.....	306
SKIN AND MUCOUS MEMBRANE AGENTS.....	321
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin.....	321
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles.....	349
VITAMINS.....	350

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	SMCS; SP
<i>ft naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	QL (2 auto-injectors per prescription.)
<i>glucagon emergency kit injection kit 1 mg</i>	2	QL (2 boxes per prescription.)
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	QL (2 boxes per prescription.)
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	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
iodine strong oral solution 5 %	1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (naloxone hcl)	1	QL (2 devices per prescription.)
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (hyoscyamine sulfate)	3	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	3	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (hyoscyamine sulfate)	3	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	
naloxone hcl nasal liquid 4 mg/0.1ml	1	QL (2 auto-injectors per prescription.)
NARCAN NASAL LIQUID 4 MG/0.1ML (naloxone hcl)	1	QL (2 auto-injectors per prescription.)
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (hyoscyamine sulfate)	3	
OSCIMIN ORAL TABLET 0.125 MG	3	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3	
penicillamine oral tablet 250 mg	2	SMCS; SP
phytonadione oral tablet 5 mg	3	QL (5 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	QL (one package (2 devices) per prescription.)
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	2	QL (1 package (2 devices) per prescription.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	2	QL (1 ml per prescription.)
ANTIDOTES (91:04)		
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	
<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>	2	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	2	
<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	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	2	QL (1 ml per prescription.)
CHEMOTHERAPY ANTIDOTES/PROTECTANTS		
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUOROPYRIMIDINE ANTIDOTE		
VISTOGARD ORAL PACKET 10 GM (<i>uridine triacetate</i>)	2	QL (20 packets per prescription.)
XURIDEN ORAL PACKET 2 GM (<i>uridine triacetate</i>)	2	PA; QL (30 packets per month.); SMCS; SP
ANTIHISTAMINE DRUGS - Drugs for Allergy		
ANTIHISTAMINE 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	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA
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>bromphen-pseudoeph-dm oral syrup 2-30-10 mg/5ml</i>	1	
<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	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	3	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 syrup 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-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	
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>	3	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>promethazine-codeine oral solution 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>bromphen-pseudoeph-dm oral syrup 2-30-10 mg/5ml</i>	1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	3	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	
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
<i>epinastine hcl ophthalmic solution 0.05 %</i>	3	QL (5 ml per prescription)
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	3	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	3	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	3	
<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	
<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	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (<i>metronidazole benzoate</i>)	3	PA
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	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	3	
METROLOTION EXTERNAL LOTION 0.75 % (<i>metronidazole</i>)	3	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	2	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (chlorhexidine gluconate)	3	
periogard mouth/throat solution 0.12 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	3	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (amikacin sulfate liposome)	3	PA; QL (8.4 ml per day.); SMCS; SP
gentamicin sulfate external cream 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate external ointment 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate ophthalmic solution 0.3 %	1	QL (15 ml per prescription.)
HUMATIN ORAL CAPSULE 250 MG (paromomycin sulfate)	2	
neomycin sulfate oral tablet 500 mg	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (tobramycin)	3	PA; QL (280 ml (1 carton) per 56 days.); SMCS; SP
TOBI PODHALER INHALATION CAPSULE 28 MG (tobramycin)	3	PA; QL (224 capsules per 56 days.); SMCS; SP
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	
tobramycin inhalation nebulization solution 300 mg/4ml	2	PA; QL (224 ml per 56 days.); SMCS; SP
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
TOBREX OPHTHALMIC OINTMENT 0.3 % (tobramycin)	3	QL (3.5 grams per prescription.)
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (omadacycline tosylate)	3	QL (30 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
OMECLAMOX-PAK ORAL 500-500-20 MG (<i>amoxicillin-clarithro-omeprazole</i>)	3	QL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	3	ST; QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicillin-clarithro-vonoprazan</i>)	3	ST; QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
<i>albendazole oral tablet 200 mg</i>	3	PA; QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (<i>praziquantel</i>)	3	
EGATEN ORAL TABLET 250 MG (<i>triclabendazole</i>)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (<i>mebendazole</i>)	3	PA; 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>	2	
STROMECTOL ORAL TABLET 3 MG (<i>ivermectin</i>)	3	PA; QL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
BREXAFEMME ORAL TABLET 150 MG (<i>ibrexafungerp citrate</i>)	3	PA; QL (4 tablets per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	
<i>iodine strong oral solution 5 %</i>	1	
ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
<i>dapsone external gel 5 %, 7.5 %</i>	3	QL (60 grams per prescription.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3	QL (30 grams per prescription.)
ARAKODA ORAL TABLET 100 MG (<i>tafenoquine succinate</i>)	3	QL (16 tablets per month.)
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	2	
AVIDOXY ORAL TABLET 100 MG	3	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	1	
COARTEM ORAL TABLET 20-120 MG (<i>artemether-lumefantrine</i>)	2	
DARAPRIM ORAL TABLET 25 MG (<i>pyrimethamine</i>)	3	PA; SMCS; SP
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg</i>	2	
<i>doxycycline hyclate oral tablet 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>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	
<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>	2	
<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>	2	PA; SMCS; SP
<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>	3	
ZILXI EXTERNAL FOAM 1.5 % (<i>minocycline hcl micronized</i>)	3	PA; ST; QL (30 grams per prescription.)
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
<i>nitazoxanide oral tablet 500 mg</i>	2	QL (6 tablets per prescription.)
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
<i>atovaquone oral suspension 750 mg/5ml</i>	2	
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 100 MG	2	QL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	3	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	3	QL (120 capsules per 180 days.)
dapsone external gel 5 %, 7.5 %	3	QL (60 grams per prescription.)
dapsone oral tablet 100 mg, 25 mg	2	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
IMPAVIDO ORAL CAPSULE 50 MG (miltefosine)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (nifurtimox)	3	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (nifurtimox)	3	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	3	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (pentamidine isethionate)	3	
nitazoxanide oral tablet 500 mg	2	QL (6 tablets per prescription.)
pentamidine isethionate inhalation solution reconstituted 300 mg	2	
PYLERA ORAL CAPSULE 140-125-125 MG (bis subcit-metronid-tetracyc)	3	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (secnidazole)	3	ST; QL (1 packet per prescription.)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>tinidazole oral tablet 250 mg, 500 mg</i>	3	
ANTIPROTOZOALS, NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat		
<i>tinidazole oral tablet 250 mg, 500 mg</i>	3	
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (<i>lenacapavir sodium</i>)	3	QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	3	QL (5 tablets per 365 days.)
ANTITUBERCULOSIS AGENTS - Antibiotics		
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	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	2	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
<i>cycloserine oral capsule 250 mg</i>	1	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	1	
<i>isoniazid oral syrup 50 mg/5ml</i>	1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	3	
PRETOMANID ORAL TABLET 200 MG	3	
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	2	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (<i>rifampin</i>)	3	PA
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	PA; QL (4 tablets per day.); SMCS; SP
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	2	SM
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	2	
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	2	SM
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	
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>	2	QL (1800 ml per 365 days)
<i>ketoconazole external cream 2 %</i>	1	QL (30 grams per prescription.)
<i>ketoconazole external foam 2 %</i>	3	ST
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ketodan external foam 2 %	3	ST
NOXAFIL ORAL PACKET 300 MG (posaconazole)	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML (posaconazole)	3	QL (20 ml per day.)
posaconazole oral suspension 40 mg/ml	2	QL (20 ml per day.)
posaconazole oral tablet delayed release 100 mg	2	
SPORANOX ORAL CAPSULE 100 MG (itraconazole)	3	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (voriconazole)	3	QL (300 mL per prescription.)
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (oteseconazole)	3	PA; QL (18 capsules per 84 days.)
voriconazole oral suspension reconstituted 40 mg/ml	1	QL (300 mL per prescription.)
voriconazole oral tablet 200 mg	1	QL (62 tablets per prescription.)
voriconazole oral tablet 50 mg	1	QL (124 tablets per prescription)
XOLEGEL COREPAK EXTERNAL KIT 2 & 1 % (ketoconazole-hydrocortisone)	3	
XOLEGEL DUO/HEAD & SHOULDERS EXTERNAL KIT 2 & 1 % (ketoconazole & pyrithione zinc)	3	
XOLEGEL DUO/XOLEX EXTERNAL KIT 2 & 1 % (ketoconazole & pyrithione zinc)	3	
BACITRACIN ANTIBIOTICS - Antibiotics		
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (bacitracin-polymyx-neo-hc)	3	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM (bacitracin-polymyxin b)	3	
CORONAVIRUS (COVID-19) - Drugs for Viral Infections		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (nirmatrelvir-ritonavir)	2	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	2	
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	2	SM
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	
<i>ery external pad 2 %</i>	1	
ERYGEL EXTERNAL GEL 2 % (<i>erythromycin</i>)	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (<i>erythromycin ethylsuccinate</i>)	3	
<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>	3	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml</i>	3	
<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>	3	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (<i>vancomycin hcl</i>)	3	
VANCOGIN ORAL CAPSULE 125 MG, 250 MG (<i>vancomycin hcl</i>)	3	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	1	
VANCOMYCIN+SYRSPEND SF ORAL SUSPENSION 50 MG/ML (vancomycin hcl)	3	PA
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (sofosbuvir-velpatasvir)	2	PA; QL (2 packets per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (sofosbuvir-velpatasvir)	2	PA; QL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (sofosbuvir-velpatasvir)	2	PA; QL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (sofosbuvir-velpatasvir)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (ledipasvir-sofosbuvir)	2	PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.); SMCS
HARVONI ORAL TABLET 45-200 MG (ledipasvir-sofosbuvir)	2	PA; ST; QL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (ledipasvir-sofosbuvir)	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; QL (84 tablets per 720 days.); SMCS; SP
SOVALDI ORAL PACKET 150 MG, 200 MG (sofosbuvir)	3	PA; ST; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.); SMCS; SP
SOVALDI ORAL TABLET 200 MG (sofosbuvir)	3	PA; ST; QL (84 tablets per 720 days.); SMCS
SOVALDI ORAL TABLET 400 MG (sofosbuvir)	3	PA; ST; QL (84 tablets per 720 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
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.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (168 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	2	PA; QL (84 tablets per 720 days (12 weeks).); SMCS; SP
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.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.); SMCS
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; ST; QL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (5 packets per day and 280 packets per 720 days.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	2	PA; QL (168 tablets per 720 days.); SMCS; SP
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; QL (84 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	2	PA; QL (84 tablets per 720 days (12 weeks).); SMCS; SP
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	3	QL (24 tablets per year.); H
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (<i>lenacapavir sodium</i>)	3	QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	3	QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	3	H
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (<i>enfuvirtide</i>)	3	SMCS
<i>maraviroc oral tablet 150 mg, 300 mg</i>	2	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	3	
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	2	
SELZENTRY ORAL TABLET 150 MG, 300 MG (<i>maraviroc</i>)	3	
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofof</i>)	2	QL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	2	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	2	
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	2	
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	2	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	2	
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>)	2	QL (1 tablet per day.)
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	3	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	3	
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	
HIV NONNUCLEOSIDE REV.TRANScrip. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofov</i>)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofov</i>)	2	QL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofov df</i>)	2	QL (1 tablet per day.)
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	2	
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (<i>rilpivirine hcl</i>)	2	
<i>efavirenz oral tablet 600 mg</i>	2	
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	2	QL (1 tablet per day.)
<i>efavirenz-lamivudine-tenofov</i> oral tablet 400-300-300 mg, 600-300-300 mg	2	QL (1 tablet per day.)
<i>emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg</i>	3	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
etravirine oral tablet 100 mg, 200 mg	2	
INTELENCE ORAL TABLET 100 MG, 200 MG (etravirine)	3	
INTELENCE ORAL TABLET 25 MG (etravirine)	2	
JULUCA ORAL TABLET 50-25 MG (dolutegravir-rilpivirine)	2	QL (1 tablet per day.)
methocarbamol oral tablet 500 mg	1	
nevirapine er oral tablet extended release 24 hour 400 mg	3	
nevirapine oral suspension 50 mg/5ml	1	
nevirapine oral tablet 200 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitab-rilpivir-tenofof af)	2	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (doravirine)	3	
SYMFI ORAL TABLET 600-300-300 MG (efavirenz-lamivudine-tenofovir)	2	QL (1 tablet per day.)
HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections		
abacavir sulfate oral solution 20 mg/ml	1	
abacavir sulfate oral tablet 300 mg	1	
abacavir sulfate-lamivudine oral tablet 600-300 mg	2	QL (1 tablet per day.)
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (bictegravir-emtricitab-tenofof)	2	QL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (lamivudine-tenofovir)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (emtricitab-rilpivir-tenofovir)	2	QL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG (doravirin-lamivudin-tenofof df)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (emtricitabine-tenofovir af)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG (emtricitabine-tenofovir af)	2	QL (1 tablet per day.); H
DOVATO ORAL TABLET 50-300 MG (dolutegravir-lamivudine)	2	QL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	2	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	2	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>emtricitabine oral capsule 200 mg</i>	2	
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1	QL (1 tablet per day.)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	QL (1 tablet per day.); H
<i>emtricitab-rilpivir-tenofovir df oral tablet 200-25-300 mg</i>	3	QL (1 tablet per day.)
EMTRIVA ORAL CAPSULE 200 MG (<i>emtricitabine</i>)	3	
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	2	
EPIVIR ORAL SOLUTION 10 MG/ML (<i>lamivudine</i>)	3	
EPIVIR ORAL TABLET 150 MG, 300 MG (<i>lamivudine</i>)	3	
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	2	QL (1 tablet per day.)
<i>lamivudine oral solution 10 mg/ml</i>	1	
<i>lamivudine oral tablet 100 mg, 150 mg, 300 mg</i>	1	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	1	
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofovir af</i>)	2	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (<i>zidovudine</i>)	3	
RETROVIR ORAL SYRUP 50 MG/5ML (<i>zidovudine</i>)	3	
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	2	QL (1 tablet per day.)
SYMFI ORAL TABLET 600-300-300 MG (<i>efavirenz-lamivudine-tenofovir</i>)	2	QL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	2	QL (1 tablet per day.)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	1	H
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.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (<i>emtricitabine-tenofovir df</i>)	3	QL (1 tablet per day.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZIAGEN ORAL SOLUTION 20 MG/ML (<i>abacavir sulfate</i>)	3	
<i>zidovudine oral capsule 100 mg</i>	1	
<i>zidovudine oral syrup 50 mg/5ml</i>	1	
<i>zidovudine oral tablet 300 mg</i>	1	
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>	2	
<i>darunavir oral tablet 600 mg, 800 mg</i>	1	
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	2	
<i>fosamprenavir calcium oral tablet 700 mg</i>	2	
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	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	2	
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	2	
PREZCOBIX ORAL TABLET 800-150 MG (<i>darunavir-cobicistat</i>)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	2	
PREZISTA ORAL TABLET 150 MG, 75 MG (<i>darunavir</i>)	2	
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	2	
<i>ritonavir oral tablet 100 mg</i>	2	
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	2	QL (1 tablet per day.)
VIRACEPT ORAL TABLET 250 MG, 625 MG (<i>nelfinavir mesylate</i>)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3	PA; QL (0.08 ml per day.); SMCS; SP; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	SMCS; SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LINCOMYCIN ANTIBIOTICS - Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (<i>clindamycin hcl</i>)	3	
CLEOCIN ORAL CAPSULE 75 MG (<i>clindamycin hcl</i>)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (<i>clindamycin palmitate hcl</i>)	3	
CLEOCIN VAGINAL CREAM 2 % (<i>clindamycin phosphate</i>)	3	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (<i>clindamycin phosphate</i>)	3	
<i>clindacin etz external swab 1 %</i>	1	
<i>clindacin external foam 1 %</i>	3	
<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>	2	
<i>clindamycin phos (once-daily) external gel 1 %</i>	2	QL (75 grams per prescription.)
<i>clindamycin phos (twice-daily) external gel 1 %</i>	2	QL (75 grams per prescription.)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	3	QL (1 bottle (45 grams) per month.)
<i>clindamycin phosphate external foam 1 %</i>	3	
<i>clindamycin phosphate external lotion 1 %</i>	3	
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>clindamycin phosphate vaginal cream 2 %</i>	2	
CLINDESSE VAGINAL CREAM 2 % (<i>clindamycin phosphate (1 dose)</i>)	2	
<i>neuac external gel 1.2-5 %</i>	3	QL (1 bottle (45 grams) per month.)
XACIATO VAGINAL GEL 2 % (<i>clindamycin phosphate</i>)	2	QL (1 gel tube (8 grams) per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (<i>aztreonam lysine</i>)	3	PA; ST; QL (84 vials per 56 days.); SMCS; SP
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>	2	
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	2	
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.)
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	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	3	
METROLOTION EXTERNAL LOTION 0.75 % (<i>metronidazole</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	2	
VANDAZOLE VAGINAL GEL 0.75 % (<i>metronidazole</i>)	3	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
<i>acyclovir external ointment 5 %</i>	3	QL (15 grams per prescription.)
<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>	2	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (<i>entecavir</i>)	2	
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitabine-rilpivir-tenofovir</i>)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	2	QL (1 tablet per day.); H
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1	QL (1 tablet per day.)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	QL (1 tablet per day.); H
<i>emtricitabine-rilpivir-tenofovir df oral tablet 200-25-300 mg</i>	3	QL (1 tablet per day.)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	1	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	2	
LAGEVRIO ORAL CAPSULE 200 MG (<i>molnupiravir</i>)	2	SM
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitabine-rilpivir-tenofovir af</i>)	2	QL (1 tablet per day.)
<i>ribavirin inhalation solution reconstituted 6 gm</i>	3	
<i>ribavirin oral capsule 200 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ribavirin oral tablet 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (brincidofovir)	3	
TEMBEXA ORAL TABLET 100 MG (brincidofovir)	3	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (emtricitabine-tenofovir df)	3	QL (1 tablet per day.)
valacyclovir hcl oral tablet 1 gm	1	QL (31 tablets per prescription)
valacyclovir hcl oral tablet 500 mg	1	QL (62 tablets per prescription.)
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (ganciclovir)	3	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (fidaxomicin)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	3	QL (20 tablets per 7 days)
OMECLAMOX-PAK ORAL 500-500-20 MG (amoxicill-clarithro-omeprazole)	3	QL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (amoxicill-clarithro-vonoprazan)	3	ST; QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (azithromycin)	3	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (azithromycin)	3	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (azithromycin)	3	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (azithromycin)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>	2	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<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>	3	QL (20 tablets per 7 days)
OMECLAMOX-PAK ORAL 500-500-20 MG (<i>amoxicill-clarithro-omeprazole</i>)	3	QL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	3	ST; QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (<i>azithromycin</i>)	3	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	3	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	3	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	3	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	2	
<i>linezolid oral tablet 600 mg</i>	2	
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	
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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>nyamyc 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 oral tablet 500000 unit</i>	1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	2	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	2	
<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	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG, 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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	3	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	3	
<i>moxifloxacin hcl oral tablet 400 mg</i>	3	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (<i>ofloxacin</i>)	3	
<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>	2	
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	
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (<i>rifampin</i>)	3	PA
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.)
SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3	
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3	QL (30 grams per prescription.)
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	3	
AVIDOXY ORAL TABLET 100 MG	3	
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	3	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>	2	
<i>doxycycline hyclate oral tablet 100 mg</i>	2	
<i>doxycycline hyclate oral tablet 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>	3	
<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>	2	
<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	QL (120 capsules per 180 days.)
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	3	
ZILXI EXTERNAL FOAM 1.5 % (<i>minocycline hcl micronized</i>)	3	PA; ST; QL (30 grams per prescription.)
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	3	
<i>fosfomycin tromethamine oral packet 3 gm</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HIPREX ORAL TABLET 1 GM (<i>methenamine hippurate</i>)	3	
MACROBID ORAL CAPSULE 100 MG (<i>nitrofurantoin monohyd macro</i>)	3	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>nitrofurantoin macrocrystal</i>)	3	
<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>	3	
<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>	2	QL (4 tablets per day.); SMCS; SP; CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (<i>niraparib-abiraterone acetate</i>)	3	PA; ST; QL (2 tablets per day.); SMCS; SP; CM
ALECENSA ORAL CAPSULE 150 MG (<i>alectinib hcl</i>)	2	PA; QL (8 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALUNBRIG ORAL TABLET 180 MG (<i>brigatinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
ALUNBRIG ORAL TABLET 30 MG (<i>brigatinib</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
<i>anastrozole oral tablet 1 mg</i>	1	H
AUGTYRO ORAL CAPSULE 160 MG (<i>repotrectinib</i>)	2	PA; QL (60 capsules per month.); SMCS; SP; CM
AUGTYRO ORAL CAPSULE 40 MG (<i>repotrectinib</i>)	2	PA; QL (8 capsules per day.); SMCS; SP; CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (<i>avutometinib-defactinib</i>)	3	PA; QL (66 capsules/tablets per month.); SMCS; SP; CM
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (<i>avapritinib</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
BALVERSA ORAL TABLET 3 MG (<i>erdafitinib</i>)	3	PA; QL (3 tablets per day.); SMCS; SP; CM
BALVERSA ORAL TABLET 4 MG (<i>erdafitinib</i>)	3	PA; QL (2 tablets per day.); SMCS; SP; CM
BALVERSA ORAL TABLET 5 MG (<i>erdafitinib</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3	PA; QL (0.08 ml per day.); SMCS; SP; CM
<i>bexarotene external gel 1 %</i>	3	QL (60 grams per prescription.); SMCS; SP
<i>bexarotene oral capsule 75 mg</i>	2	SMCS; CM
<i>bicalutamide oral tablet 50 mg</i>	1	CM
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	2	PA; ST; QL (3 Capsules per day.); SMCS; SP; CM
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	2	PA; ST; QL (1 Capsule per day.); SMCS; SP; CM
BOSULIF ORAL TABLET 100 MG (<i>bosutinib</i>)	2	PA; ST; QL (4 tablets per day.); SMCS; SP; CM
BOSULIF ORAL TABLET 400 MG, 500 MG (<i>bosutinib</i>)	2	PA; ST; QL (1 tablet per day.); SMCS; SP; CM
BRAFTOVI ORAL CAPSULE 75 MG (<i>encorafenib</i>)	3	PA; ST; QL (6 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BRUKINSA ORAL CAPSULE 80 MG (<i>zanubrutinib</i>)	3	PA; ST; SMCS; SP; CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
CALQUENCE ORAL TABLET 100 MG (<i>acalabrutinib maleate</i>)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>capecitabine oral tablet 150 mg, 500 mg</i>	1	SMCS; SP; CM
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
COMETRIQ ORAL KIT 20 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (93 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (124 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 80 & 20 MG (<i>cabozantinib s-malate</i>)	2	PA; QL (62 capsules per month.); SMCS; SP; CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (<i>duvelisib</i>)	3	PA; QL (2 capsules per day.); SMCS; SP; CM
COTELLIC ORAL TABLET 20 MG (<i>cobimetinib fumarate</i>)	2	PA; QL (63 tablets per 21 days); SMCS; SP; CM
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>dasatinib oral tablet 20 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
DAURISMO ORAL TABLET 100 MG, 25 MG (<i>glasdegib maleate</i>)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	1	CM
ERIVEDGE ORAL CAPSULE 150 MG (<i>vismodegib</i>)	2	PA; QL (1 capsule per day.); SMCS; SP; CM
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	2	PA; QL (1 tablet per day.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>erlotinib hcl oral tablet 25 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>etoposide oral capsule 50 mg</i>	1	SMCS; SP; CM
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	3	
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>everolimus oral tablet 2.5 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>exemestane oral tablet 25 mg</i>	2	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (<i>degarelix acetate</i>)	3	SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	3	SMCS; SP
<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	PA; QL (0.75 capsules per day.); SMCS; SP; CM
FRUZAQLA ORAL CAPSULE 1 MG (<i>fruquintinib</i>)	3	PA; ST; QL (84 capsules per 21 days.); SMCS; SP; CM
FRUZAQLA ORAL CAPSULE 5 MG (<i>fruquintinib</i>)	3	PA; ST; QL (21 capsules per 21 days.); SMCS; SP; CM
GAVRETO ORAL CAPSULE 100 MG (<i>pralsetinib</i>)	3	PA; QL (4 capsules per day.); SMCS; SP; CM
<i>gefitinib oral tablet 250 mg</i>	3	PA; QL (2 tablets per day.); SMCS; SP; CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (<i>afatinib dimaleate</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (<i>lomustine</i>)	2	SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GOMEKLI ORAL CAPSULE 1 MG (<i>mirdametinib</i>)	3	PA; QL (42 capsules per 4 weeks.); SMCS; SP
GOMEKLI ORAL CAPSULE 2 MG (<i>mirdametinib</i>)	3	PA; QL (84 capsules per 4 weeks.); SMCS; SP
GOMEKLI ORAL TABLET SOLUBLE 1 MG (<i>mirdametinib</i>)	3	PA; QL (168 tablets per 4 weeks.); SMCS
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (<i>melfalan hcl</i>)	3	
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (<i>melfalan hcl</i>)	3	
HYCANTIN ORAL CAPSULE 0.25 MG (<i>topotecan hcl</i>)	2	PA; QL (20 capsules per three weeks.); SMCS; SP; CM
HYCANTIN ORAL CAPSULE 1 MG (<i>topotecan hcl</i>)	2	PA; QL (305 capsules per 15 days.); SMCS; SP; CM
HYDREA ORAL CAPSULE 500 MG (<i>hydroxyurea</i>)	3	CM
<i>hydroxyurea oral capsule 500 mg</i>	1	CM
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	2	PA; ST; QL (21 capsules per month.); SMCS; SP; CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	2	PA; ST; QL (0.75 tablets per day.); SMCS; SP; CM
ICLUSIG ORAL TABLET 15 MG, 45 MG (<i>ponatinib hcl</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
IDHIFA ORAL TABLET 100 MG, 50 MG (<i>enasidenib mesylate</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>imatinib mesylate oral tablet 100 mg</i>	1	QL (6 tablets per day.); SMCS; SP; CM
<i>imatinib mesylate oral tablet 400 mg</i>	1	QL (1 tablet per day.); SMCS; SP; CM
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	2	PA; QL (1 capsule per day.); SMCS; SP; CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (<i>ibrutinib</i>)	2	PA; QL (7.2 ml per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMBRUVICA ORAL TABLET 420 MG (<i>ibrutinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
IMKELDI ORAL SOLUTION 80 MG/ML	3	PA; QL (280 ml (2 bottles) per month.); SMCS; SP; CM
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	3	PA; QL (6 tablets per day.); SMCS; SP; CM
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	3	PA; QL (124 tablets per 30 days.); SMCS; SP; CM
INQOVI ORAL TABLET 35-100 MG (<i>decitabine-cedazuridine</i>)	3	PA; QL (5 tablets per month.); SMCS; SP; CM
INREBIC ORAL CAPSULE 100 MG (<i>fedratinib hcl</i>)	3	PA; ST; QL (4 capsules per day.); SMCS; SP; CM
IRESSA ORAL TABLET 250 MG (<i>gefitinib</i>)	3	PA; QL (2 tablets per day.); SMCS; SP; CM
ITOVEBI ORAL TABLET 3 MG (<i>inavolisib</i>)	2	PA; QL (56 tablets per month.); SMCS; SP; CM
ITOVEBI ORAL TABLET 9 MG (<i>inavolisib</i>)	2	PA; QL (28 tablets per month.); SMCS; SP; CM
IWILFIN ORAL TABLET 192 MG (<i>eflornithine hcl</i>)	2	PA; QL (8 tablets per day.); SMCS; SP; 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.); SMCS; SP; CM
JAYPIRCA ORAL TABLET 100 MG (<i>pirtobrutinib</i>)	3	PA; QL (3 tablets per day.); SMCS; SP; CM
JAYPIRCA ORAL TABLET 50 MG (<i>pirtobrutinib</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (21 tablets per month.); SMCS; SP; CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (42 tablets per 21 days.); SMCS; SP; CM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	2	PA; QL (63 tablets per 21 days.); SMCS; SP; CM
KOSELUGO ORAL CAPSULE 10 MG (<i>selumetinib sulfate</i>)	3	PA; QL (8 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KOSELUGO ORAL CAPSULE 25 MG (<i>selumetinib sulfate</i>)	3	PA; QL (4 capsules per day.); SMCS; SP; CM
KRAZATI ORAL TABLET 200 MG (<i>adagrasib</i>)	3	PA; QL (6 tablets per day.); SMCS; SP; CM
<i>lapatinib ditosylate oral tablet 250 mg</i>	2	PA; QL (186 tablets per prescription); SMCS; SP; CM
LAZCLUZE ORAL TABLET 240 MG (<i>lazertinib mesylate</i>)	3	PA; QL (30 tablets per month.); SMCS; SP; CM
LAZCLUZE ORAL TABLET 80 MG (<i>lazertinib mesylate</i>)	3	PA; QL (60 tablets per month.); SMCS; SP; CM
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg</i>	2	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
<i>lenalidomide oral capsule 20 mg, 25 mg</i>	2	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (<i>lenvatinib mesylate</i>)	3	PA; QL (2 capsules per day.); SMCS; SP; CM
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>)	3	PA; QL (3 capsules per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (<i>lenvatinib mesylate</i>)	3	PA; QL (1 capsule per day.); SMCS; SP; CM
<i>letrozole oral tablet 2.5 mg</i>	1	H
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	2	CM
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SMCS
LONSURF ORAL TABLET 15-6.14 MG (<i>trifluridine-tipiracil</i>)	3	PA; QL (100 tablets per month.); SMCS; SP; CM
LONSURF ORAL TABLET 20-8.19 MG (<i>trifluridine-tipiracil</i>)	3	PA; QL (80 tablets per 21 days.); SMCS; SP; CM
LORBRENA ORAL TABLET 100 MG (<i>lorlatinib</i>)	3	PA; ST; QL (30 tablets per month.); SMCS; SP; CM
LORBRENA ORAL TABLET 25 MG (<i>lorlatinib</i>)	3	PA; ST; QL (90 tablets per month.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 120 MG (<i>sotorasib</i>)	3	PA; QL (240 tablets per month.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 240 MG (<i>sotorasib</i>)	3	PA; QL (120 tablets per month.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	PA; QL (3 tablets per day.); SMCS; SP; CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (<i>olaparib</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
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	PA; QL (84 tablets per month.); SMCS; SP; CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	3	PA; QL (112 tablets per month.); SMCS; SP; CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	3	PA; QL (140 tablets per month.); SMCS; SP; CM
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	2	SMCS; SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
<i>megestrol acetate oral suspension 40 mg/ml</i>	1	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	3	
<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	ST; QL (17.4 ml per day.); SMCS; SP; CM
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	3	PA; ST; QL (2 tablets per day.); SMCS; SP; CM
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	3	PA; ST; QL (1 tablet per day.); SMCS; SP; CM
MEKTOVI ORAL TABLET 15 MG (<i>binimetinib</i>)	3	PA; ST; QL (6 tablets per day.); SMCS; SP; CM
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	1	SMCS; SP; 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
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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP; CM
<i>nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg</i>	2	PA; ST; QL (4 capsules per day.); SMCS; SP; CM
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (<i>ixazomib citrate</i>)	2	PA; QL (3 capsules per prescription.); SMCS; SP; CM
NUBEQA ORAL TABLET 300 MG (<i>darolutamide</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
ODOMZO ORAL CAPSULE 200 MG (<i>sonidegib phosphate</i>)	2	PA; QL (1 capsule per day.); SMCS; SP; CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (<i>nirogacestat hydrobromide</i>)	2	PA; SMCS; SP; CM
OGSIVEO ORAL TABLET 50 MG (<i>nirogacestat hydrobromide</i>)	2	PA; QL (6 tablets per day.); SMCS; SP; CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (<i>tovorafenib</i>)	3	PA; QL (96 ml per month.); SMCS; SP; CM
OJEMDA ORAL TABLET 100 MG (<i>tovorafenib</i>)	3	PA; QL (24 tablets per month.); SMCS; SP; CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (<i>momelotinib dihydrochloride</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
ONUREG ORAL TABLET 200 MG, 300 MG (<i>azacitidine</i>)	2	PA; QL (14 tablets per 24 days.); SMCS; SP; CM
OPZELURA EXTERNAL CREAM 1.5 % (<i>ruxolitinib phosphate</i>)	3	PA; QL (240 grams per prescription and 1200 grams per 365 days.); SMCS; SP
ORGOVYX ORAL TABLET 120 MG (<i>relugolix</i>)	3	PA; QL (1 tablet per day); SMCS; SP; CM
ORSERDU ORAL TABLET 345 MG (<i>elacestrant hydrochloride</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
ORSERDU ORAL TABLET 86 MG (<i>elacestrant hydrochloride</i>)	2	PA; QL (3 tablets per day.); SMCS; SP; CM
<i>pazopanib hcl oral tablet 200 mg</i>	3	PA; QL (4 tablets per day.); SMCS; SP; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PREFILLED SYRINGE 180 MCG/0.5ML (peginterferon alfa-2a)	2	SMCS; SP
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (pemigatinib)	3	PA; QL (31 tablets per month.); SMCS; SP; CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (alpelisib)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (alpelisib)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	3	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (mercaptopurine)	3	SMCS; SP; CM
QINLOCK ORAL TABLET 50 MG (ripretinib)	3	PA; QL (3 tablets per day.); SMCS; SP; CM
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (selpercatinib)	3	PA; QL (60 tablets per month.); SMCS; SP; CM
RETEVMO ORAL TABLET 40 MG (selpercatinib)	3	PA; QL (90 tablets per month.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (lenalidomide)	2	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 20 MG, 25 MG (lenalidomide)	2	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
REVUFORJ ORAL TABLET 110 MG (revumenib citrate)	3	PA; QL (120 tablets per month.); SMCS; SP; CM
REVUFORJ ORAL TABLET 160 MG (revumenib citrate)	3	PA; QL (60 tablets per month.); SMCS; SP; CM
REVUFORJ ORAL TABLET 25 MG (revumenib citrate)	3	PA; QL (240 tablets per month.); SMCS; SP; CM
REZLIDHIA ORAL CAPSULE 150 MG (olutasidenib)	2	PA; QL (2 capsules per day.); SMCS; SP; CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (vimseltinib)	2	PA; QL (8 capsules per 4 weeks.); SMCS; SP; CM
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (entrectinib)	2	PA; QL (3 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ROZLYTREK ORAL PACKET 50 MG (<i>entrectinib</i>)	2	PA; QL (84 packets (2 boxes) per month.); SMCS; SP; CM
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (<i>rucaparib camsylate</i>)	3	PA; ST; QL (4 tablets per day.); SMCS; SP; CM
RYDAPT ORAL CAPSULE 25 MG (<i>midostaurin</i>)	2	PA; QL (8 capsules per day.); SMCS; SP; CM
SCEMBLIX ORAL TABLET 100 MG (<i>asciminib hcl</i>)	3	PA; QL (120 tablets per month.); SMCS; SP; CM
SCEMBLIX ORAL TABLET 20 MG, 40 MG (<i>asciminib hcl</i>)	3	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>sorafenib tosylate oral tablet 200 mg</i>	2	PA; QL (4 tablets per day.); SMCS; SP; CM
STIVARGA ORAL TABLET 40 MG (<i>regorafenib</i>)	2	PA; QL (84 tablets per 21 days.); SMCS; SP; CM
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	2	PA; QL (1 capsule per day.); SMCS; SP; CM
TABLOID ORAL TABLET 40 MG (<i>thioguanine</i>)	2	SMCS; SP; CM
TABRECTA ORAL TABLET 150 MG, 200 MG (<i>capmatinib hcl</i>)	3	PA; QL (4 tablets per day.); SMCS; SP; CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (<i>dabrafenib mesylate</i>)	3	PA; ST; QL (4 capsules per day.); SMCS; SP; CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (<i>dabrafenib mesylate</i>)	3	ST; QL (420 tablets per month.); SMCS; SP; CM
TAGRISSE ORAL TABLET 40 MG, 80 MG (<i>osimertinib mesylate</i>)	3	PA; QL (1 tablet per day.); SMCS; SP; 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	PA; ST; QL (1 capsule per day.); SMCS; SP; CM
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H
TAZVERIK ORAL TABLET 200 MG (<i>tazemetostat hbr</i>)	3	PA; QL (8 tablets per day.); SMCS; SP; CM
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	1	SMCS; SP; CM
TEPMETKO ORAL TABLET 225 MG (<i>tepotinib hcl</i>)	3	PA; QL (2 tablets per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP; CM
TIBSOVO ORAL TABLET 250 MG (<i>ivosidenib</i>)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>toremifene citrate oral tablet 60 mg</i>	2	CM
<i>torpenz oral tablet 10 mg, 7.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>torpenz oral tablet 2.5 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	3	QL (20 grams per prescription.)
<i>tretinoin oral capsule 10 mg</i>	2	QL (279 capsules per prescription.); SMCS; SP; CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	2	CM
TRUQAP ORAL TABLET 200 MG (<i>capivasertib</i>)	2	PA; QL (64 tablets per month.); SP
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (<i>capivasertib</i>)	2	PA; QL (64 tablets every month.); SMCS; SP; CM
TUKYSA ORAL TABLET 150 MG (<i>tucatinib</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
TUKYSA ORAL TABLET 50 MG (<i>tucatinib</i>)	2	PA; QL (10 tablets per day.); SMCS; SP; CM
TURALIO ORAL CAPSULE 125 MG (<i>pexidartinib hcl</i>)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (<i>quizartinib dihydrochloride</i>)	3	PA; QL (2 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 10 MG (<i>venetoclax</i>)	2	PA; QL (14 tablets per month.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 100 MG (<i>venetoclax</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 50 MG (<i>venetoclax</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (venetoclax)	2	PA; QL (42 tablets per year.); SMCS; SP; CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (abemaciclib)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 100 MG (larotrectinib sulfate)	2	PA; QL (2 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 25 MG (larotrectinib sulfate)	2	PA; QL (6 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL SOLUTION 20 MG/ML (larotrectinib sulfate)	2	PA; QL (10 mL per day.); SMCS; SP; CM
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (dacomitinib)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
VONJO ORAL CAPSULE 100 MG (pacritinib citrate)	3	PA; QL (4 capsules per day.); SMCS; SP; CM
VORANIGO ORAL TABLET 10 MG (vorasidenib)	2	PA; QL (62 tablets per month.); SMCS; SP; CM
VORANIGO ORAL TABLET 40 MG (vorasidenib)	2	PA; QL (31 tablets per month.); SMCS; SP; CM
WELIREG ORAL TABLET 40 MG (belzutifan)	3	PA; QL (3 tablets day.); SMCS; SP; CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	3	PA; QL (4 ml per day.); CM
XOSPATA ORAL TABLET 40 MG (gilteritinib fumarate)	3	PA; QL (3 tablets per day.); SMCS; SP; CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (selinexor)	3	PA; QL (0.26 tablet per day.); SMCS; SP; CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (selinexor)	3	PA; QL (16 tablets per month.); SMCS; SP; CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (selinexor)	3	PA; QL (1 therapy pack per month.); SMCS; SP; CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (selinexor)	3	PA; QL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (selinexor)	3	PA; QL (1 therapy pack per month.); SMCS; SP; CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (selinexor)	3	PA; QL (0.86 tablets per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (<i>selinexor</i>)	3	PA; QL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (<i>selinexor</i>)	3	PA; QL (1.15 tablets per day.); SMCS; SP; CM
XROMI ORAL SOLUTION 100 MG/ML (<i>hydroxyurea</i>)	3	PA
XTANDI ORAL CAPSULE 40 MG (<i>enzalutamide</i>)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
XTANDI ORAL TABLET 40 MG (<i>enzalutamide</i>)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
XTANDI ORAL TABLET 80 MG (<i>enzalutamide</i>)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (<i>niraparib tosylate</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
ZELBORAF ORAL TABLET 240 MG (<i>vemurafenib</i>)	2	PA; QL (8 tablets per day.); SMCS; SP; CM
ZOLINZA ORAL CAPSULE 100 MG (<i>vorinostat</i>)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (<i>idelalisib</i>)	3	PA; QL (60 tablets per month.); SMCS; SP; CM
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (<i>timothy grass pollen allergen</i>)	3	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (<i>dust mite mixed allergen ext</i>)	3	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	3	PA; QL (1 tablet per day.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (<i>grass mix pollens allergen ext</i>)	3	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	3	PA; QL (1 tablet per day.)
PALFORZIA (1 MG DAILY DOSE) ORAL 1 X 1 MG (<i>peanut powder-dnfp</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PALFORZIA 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 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.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (<i>short ragweed pollen ext</i>)	3	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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 INJECTABLE 5-2 LFU (<i>tetanus-diphtheria toxoids td</i>)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recmb</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
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	3	H
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	3	H
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (<i>rsvpref3 vac recomb adjuvanted</i>)	3	H
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b recomb omv adj</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
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 21-valent conjuga</i>)	3	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (<i>diphth-acell pertussis-tetanus</i>)	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DENGVAIXA SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>dengue virus vaccine live tetr</i>)	3	H
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	2	H
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	2	H
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac a&b surf ant adj</i>)	3	H
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	3	H
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac tiss-cult subunt</i>)	3	H
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>hvp 9-valent recomb vaccine</i>)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>hvp 9-valent recomb vaccine</i>)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML (<i>hepatitis a vaccine</i>)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IPOL INJECTION INJECTABLE (<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 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
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3	H
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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</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
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
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (<i>varicella virus vaccine live</i>)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recmb</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
<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>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	3	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	2	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 INHALATION INHALER 10 MG (<i>nicotine</i>)	3	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	3	H
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	3	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>	3	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	3	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	3	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.)
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.)
<i>bromphen-pseudoeph-dm oral syrup 2-30-10 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>droxidopa oral capsule 100 mg</i>	3	PA; QL (90 tablets per month.); SMCS; SP
<i>droxidopa oral capsule 200 mg, 300 mg</i>	3	PA; QL (180 tablets per month.); SMCS; SP
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml</i>	1	QL (2 injections per prescription.)
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.)
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (<i>epinephrine</i>)	3	QL (2 injections per prescription.)
LETS KIT	3	PA
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (<i>epinephrine</i>)	3	QL (2 nasal sprays (1 box) per copay.)
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
ALPHA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	2	
<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>	3	
<i>lofexidine hcl oral tablet 0.18 mg</i>	3	PA; QL (192 tablets per year.)
LUCEMYRA ORAL TABLET 0.18 MG (<i>lofexidine hcl</i>)	3	PA; QL (192 tablets per year.)
<i>methyldopa oral tablet 250 mg, 500 mg</i>	3	PA; ST
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	3	QL (2 blisters per day.)
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	3	QL (0.87 grams per day.)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	2	QL (0.36 grams per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	3	QL (0.36 grams per day.)
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	3	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	3	QL (0.28 grams per day.)
CUVPOSA ORAL SOLUTION 1 MG/5ML (<i>glycopyrrolate</i>)	3	
<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>dicyclomine hcl oral tablet 40 mg</i>	3	
<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	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (<i>aclidinium br-formoterol fum</i>)	3	QL (0.04 mcg per day.)
<i>glycopyrrolate oral solution 1 mg/5ml</i>	3	
<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>hydromet oral solution 5-1.5 mg/5ml</i>	1	PA; QL (120 mL per prescription and 360 ml per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (hyoscyamine sulfate)	3	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	3	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (hyoscyamine sulfate)	3	
LOMOTIL ORAL TABLET 2.5-0.025 MG (diphenoxylate-atropine)	3	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (hyoscyamine sulfate)	3	
OSCIMIN ORAL TABLET 0.125 MG	3	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3	
scopolamine transdermal patch 72 hour 1 mg/3days	3	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (tiotropium bromide monohydrate)	2	QL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (tiotropium bromide monohydrate)	2	QL (0.15 grams per day.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (tiotropium bromide-olodaterol)	2	QL (0.15 grams per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.)
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	
YUPELRI INHALATION SOLUTION 175 MCG/3ML (<i>revefenacin</i>)	3	PA; QL (3 ml per day.)
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<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		
<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>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	2	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 INHALATION INHALER 10 MG (<i>nicotine</i>)	3	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	3	H
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	3	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	3	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	3	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - 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	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
ENOVARX-CYCLOBENZAPRINE HCL TRANSDERMAL CREAM 20 MG/GM	3	PA
<i>metaxalone oral tablet 400 mg, 800 mg</i>	3	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	1	
TABRADOL FUSEPAQ ORAL SUSPENSION 1 MG/ML (<i>cyclobenzaprine hcl-msm</i>)	3	PA
TANLOR ORAL TABLET 1000 MG (<i>methocarbamol</i>)	3	
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	3	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	
VP FC KIT EXTERNAL CREAM	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZANAFLEX ORAL TABLET 4 MG (<i>tizanidine hcl</i>)	3	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (<i>dantrolene sodium</i>)	3	
<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>	3	PA
<i>baclofen oral solution 5 mg/5ml</i>	3	
<i>baclofen oral suspension 25 mg/5ml</i>	3	PA
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	1	
ENOVARX-BACLOFEN EXTERNAL CREAM 1 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (<i>baclofen</i>)	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (<i>ketoprofen-baclofen-gabap-lido</i>)	3	PA
OZOBAX DS ORAL SOLUTION 10 MG/5ML (<i>baclofen</i>)	3	PA
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	2	
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	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3	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	
<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>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	2	
<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	PA
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	2	QL (5 ml per prescription.)
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	3	
<i>timolol maleate ocudose ophthalmic solution 0.5 %</i>	2	
<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>	2	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3	
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	
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	
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	3	PA; QL (8 mL per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (<i>ergotamine tartrate</i>)	3	PA; QL (5 tablets per prescription.)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	3	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	2	
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, 5 mg</i>	1	
<i>donepezil hcl oral tablet 23 mg</i>	2	
<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.); SMCS; SP
<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	
<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>	3	
<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>	3	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (<i>pilocarpine hcl</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>	3	
<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.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per copay.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (18 grams per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (6.7 grams per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (8.5 grams per prescription.)
<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	
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	3	PA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	3	QL (2 blisters per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	3	QL (2 nebulizers per day)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (glycopyrrolate-formoterol)	2	QL (0.36 grams per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	QL (0.36 grams per day.)
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (arformoterol tartrate)	3	QL (2 nebulizers per day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (ipratropium-albuterol)	3	QL (0.28 grams per day.)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (aclidinium bromoterol fumarate)	3	QL (0.04 mcg per day.)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	QL (2 blisters per day.)
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.)
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	3	QL (2 vials per day.)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	3	QL (90 ml per prescription.)
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	3	QL (30 vials per prescription)
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.)
PERFORMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (formoterol fumarate)	3	QL (2 vials per day.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (salmeterol xinafoate)	2	QL (1 diskus (60 blisters) per month.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (tiotropium bromide-olodaterol)	2	QL (0.15 grams per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	QL (0.15 grams per day.)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (<i>budesonide-formoterol fumarate</i>)	3	QL (0.35 grams per day.)
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</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.)
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (<i>levalbuterol tartrate</i>)	3	QL (15 grams per prescription.)
SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>atenolol</i>)	3	PA
<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	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 25 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	2	
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); SMCS; SP
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); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	2	QL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	2	QL (1 prefill syringe per month); SMCS; SP
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); SMCS; SP
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); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	2	QL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month); SMCS; SP
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (8 ml per 21 days); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (12 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	SMCS
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (4 ml per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	2	QL (24 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	2	QL (15 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	2	QL (12 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	2	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.); SMCS; SP
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	3	QL (1 tablet per day.)
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (<i>mitapivat sulfat</i>)	3	PA; QL (56 tablets per 28 days.); SMCS; SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (<i>mitapivat sulfat</i>)	3	PA; QL (7 tablets per 365 days.); SMCS; SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (<i>mitapivat sulfat</i>)	3	PA; QL (14 tablets per 365 days.); SMCS; SP; CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (<i>fostamatinib disodium</i>)	3	PA; QL (2 tablets per day.); SMCS; SP
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
<i>jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	2	QL (2.5 tablets per day.)
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.)
rivaroxaban oral suspension reconstituted 1 mg/ml	2	QL (20 ml per day.)
rivaroxaban oral tablet 2.5 mg	2	QL (2 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (<i>edoxaban tosylate</i>)	3	ST; QL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	2	QL (20 ml per day.)
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		
dabigatran etexilate mesylate oral capsule 110 mg	2	QL (2 tablets per day.)
dabigatran etexilate mesylate oral capsule 150 mg, 75 mg	2	QL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (<i>dabigatran etexilate mesylate</i>)	3	PA; QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (<i>dabigatran etexilate mesylate</i>)	3	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	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 100 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month); SMCS; SP
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); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	2	QL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	2	QL (1 prefill syringe per month); SMCS; SP
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); SMCS; SP
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); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	2	QL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	2	QL (2 syringes per month); SMCS; SP
DOPTelet ORAL TABLET 20 MG (<i>avatrombopag maleate</i>)	3	PA; QL (60 tablets per month.); SMCS; SP
<i>eltrombopag olamine oral packet 12.5 mg</i>	1	PA; QL (6 packets per day.); SMCS; SP
<i>eltrombopag olamine oral packet 25 mg</i>	1	PA; QL (6 packets per day.); SMCS
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (<i>sargramostim</i>)	2	SMCS
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (<i>plerixafor</i>)	3	SMCS; SP
MULPLETA ORAL TABLET 3 MG (<i>lusutrombopag</i>)	3	PA; QL (7 tablets per prescription.); SMCS; SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim</i>)	2	SMCS
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	2	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	2	SMCS; SP
<i>plerixafor subcutaneous solution 24 mg/1.2ml</i>	2	SMCS; SP
PROMACTA ORAL PACKET 12.5 MG (<i>eltrombopag olamine</i>)	3	PA; QL (6 packets per day.); SMCS; SP
PROMACTA ORAL PACKET 25 MG (<i>eltrombopag olamine</i>)	3	PA; QL (6 packets per day.); SMCS
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (8 ml per 21 days); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (12 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	SMCS
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	2	QL (4 ml per 21 days.); SMCS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	2	SMCS
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	2	SMCS; SP
VAFSEO ORAL TABLET 150 MG, 300 MG (<i>vadadustat</i>)	3	PA; QL (31 tablets per month.)
XOLREMDI ORAL CAPSULE 100 MG (<i>mavorixafor</i>)	2	PA; QL (120 capsules per month.); SMCS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	2	SMCS; SP
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	SMCS; SP
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	3	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact single chain</i>)	3	PA; SMCS; SP
ALHEMO SUBCUTANEOUS SOLUTION PEN-INJECTOR 150 MG/1.5ML (<i>concizumab-mtci</i>)	3	PA; QL (4.5 mL (3 Pen-injectors) per month.); SMCS; SP
ALHEMO SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/3ML (<i>concizumab-mtci</i>)	3	PA; QL (9 mL (3 Pen-injectors) per month.); SMCS; SP
ALHEMO SUBCUTANEOUS SOLUTION PEN-INJECTOR 60 MG/1.5ML (<i>concizumab-mtci</i>)	3	PA; QL (10.5 mL (7 Pen-injectors) per month.); SMCS; SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor-vwf</i>)	2	SMCS; SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (<i>coagulation factor ix</i>)	2	SMCS
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 500 UNIT (<i>coagulation factor ix</i>)	2	SMCS; SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>coagulation factor ix (rfixfc)</i>)	3	SMCS; SP
ALTUVIIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact fc-vwf-xten-eh1</i>)	3	PA; SMCS; SP
<i>aminocaproic acid oral solution 0.25 gm/ml</i>	3	
<i>aminocaproic acid oral tablet 1000 mg, 500 mg</i>	3	
ASTRINGYN EXTERNAL SOLUTION 259 MG/GM (<i>ferric subsulfate</i>)	3	
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>coagulation factor ix (recomb)</i>)	2	SMCS; SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (<i>coagulation factor x (human)</i>)	2	SMCS; SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (<i>factor xiii concentrate human</i>)	2	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (<i>crinecerfont</i>)	3	PA; QL (62 capsules per month.); SMCS; SP
CRENESSITY ORAL SOLUTION 50 MG/ML (<i>crinecerfont</i>)	3	PA; QL (120 mL (4 bottles) per month.); SMCS; SP
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<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	
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (<i>antihem fact (bdd-rfviiiifc)</i>)	3	PA; SMCS; SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (<i>antiinhibitor coagulant cmplx</i>)	2	SMCS; SP
GELFILM OPHTHALMIC FILM (<i>gelatin adsorbable</i>)	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 (<i>emicizumab-kxwh</i>)	2	PA; SMCS; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	2	SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT (<i>antihemophilic factor</i>)	2	SMCS; SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (<i>antihemophilic factor-vwf</i>)	2	SMCS; SP
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>marstacimab-hncq</i>)	2	PA; QL (4 mL (4 Auto-injectors) per month.); SMCS; SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (<i>coagulation factor ix (rix-fp)</i>)	3	SMCS; SP
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>ahf (bdd-rfviii peg-aucl)</i>)	3	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	2	SMCS
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (<i>antihemophilic factor</i>)	2	SMCS
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihem factor recomb (rfviii)</i>)	2	SMCS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	2	SMCS; SP
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact bd truncated</i>)	2	SMCS
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT (<i>antihemophil fact bd truncated</i>)	2	SMCS; SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (<i>coagulation factor viia recomb</i>)	2	SMCS; SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	2	SMCS; SP
NUWIQ INTRAVENOUS KIT 1500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	2	SMCS
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	2	SMCS; SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	2	SMCS
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	3	SMCS; SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>factor ix complex</i>)	2	SMCS; SP
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (<i>fitusiran sodium</i>)	3	PA; QL (0.2 mL (1 vial) per month.); SMCS; SP
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>fitusiran sodium</i>)	3	PA; QL (0.5 mL (1 pen) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	SMCS; SP
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	SMCS
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>	2	QL (Benefit maximum quantity 1 per day.)
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (<i>coagulation factor xiii a-sub</i>)	3	SMCS; SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (<i>von willebrand factor (recomb)</i>)	2	SMCS; SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (<i>antihemophilic factor-vwf</i>)	2	SMCS; SP
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,mor)</i>)	3	PA; ST; SMCS
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,mor)</i>)	3	PA; ST; SMCS
XYNTHA SOLOFUSE INTRAVENOUS KIT 3000 UNIT (<i>antihem fact (bdd-rfviii,mor)</i>)	3	PA; ST; SMCS; SP
HEPARINS - Drugs to Prevent Blood Clots		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	2	QL (42 ml (14 vials) per prescription)
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml</i>	2	QL (30 syringes per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	QL (24 ml (30 syringes) per prescription)
<i>enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml</i>	2	QL (9 ml (30 syringes) per prescription)
<i>enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml</i>	2	QL (12 ml (30 syringes) per prescription)
<i>enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml</i>	2	QL (18 ml (30 syringes) per prescription)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	3	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML (<i>dalteparin sodium</i>)	3	QL (10 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12500 UNIT/0.5ML (<i>dalteparin sodium</i>)	3	QL (5 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 15000 UNIT/0.6ML (<i>dalteparin sodium</i>)	3	QL (6 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 18000 UNT/0.72ML (<i>dalteparin sodium</i>)	3	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	QL (2 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 7500 UNIT/0.3ML (<i>dalteparin sodium</i>)	3	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) 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	QL (24 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	2	QL (15 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	2	QL (12 ml (30 syringes) per prescription)
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	2	QL (18 ml (30 syringes) per prescription)
IRON PREPARATIONS - Vitamins and Minerals		
ATABEX OB ORAL TABLET 29-1 MG (<i>prenatal vit w/ fe bisg-fa</i>)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (<i>prenat-fecb-fefum-fa-dha w/o a</i>)	3	
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	
FOLATEXCEL ORAL TABLET 1 MG	3	
<i>hematinic/folic acid oral tablet 324-1 mg</i>	1	
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	
NEO-VITAL RX ORAL TABLET 1 MG	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	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
<i>prenatal oral tablet 27-1 mg</i>	1	
<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-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	
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	
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	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals		
<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>	3	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (<i>cyanocobalamin</i>)	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>	3	
<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>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ST JOSEPH LOW DOSE ORAL TABLET 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>	3	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (<i>vorapaxar sulfate</i>)	3	QL (1 tablet per day.)
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.); SMCS; SP
CARDIOVASCULAR DRUGS		
BRADYKININ RECEPTORS ANTAGONISTS		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	2	PA; QL (0.6 ml per day.); SMCS; SP
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>	2	PA; QL (4 tablets per day.); SMCS; SP
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.0375 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
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	
<i>ethacrynic acid oral tablet 25 mg</i>	3	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (<i>furosemide</i>)	3	PA; QL (4 cartridges per prescription.)
<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	
<i>torseamide oral tablet 10 mg, 100 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DIURETICS (24:36)		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %, 45 %</i>	1	
<i>urea external lotion 40 %</i>	1	
<i>urea nail external gel 45 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
POTASSIUM-SPARING DIURETIC		
<i>amiloride hcl oral tablet 5 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	3	
THIAZIDE DIURETICS (24:36)		
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	2	
<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	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; ST; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; ST; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for Varicose Veins		
CARDURA ORAL TABLET 1 MG, 2 MG, 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>nadolol oral tablet 20 mg, 40 mg, 80 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	
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	
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	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	3	PA; QL (240 sprinkle capsules (pellets) per month)
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	3	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>	3	
<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>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	2	
<i>valsartan solution 4 mg/ml oral</i>	1	PA
VALSARTAN SOLUTION 4 MG/ML ORAL	3	PA
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>	2	
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	3	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	3	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (<i>sacubitril-valsartan</i>)	3	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	3	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>	2	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	2	
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	3	PA; QL (2 tablets per day.)
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	2	
<i>valsartan solution 4 mg/ml oral</i>	1	PA
VALSARTAN SOLUTION 4 MG/ML ORAL	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
ANGIOTENSIN-CONVERT. ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
enalapril maleate oral solution 1 mg/ml	3	PA
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
EPANED ORAL SOLUTION 1 MG/ML (enalapril maleate)	3	PA
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (benazepril hcl)	3	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG (quinapril-hydrochlorothiazide)	3	
amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
enalapril maleate oral solution 1 mg/ml	3	PA
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
EPANED ORAL SOLUTION 1 MG/ML (enalapril maleate)	3	PA
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (benazepril-hydrochlorothiazide)	3	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (benazepril hcl)	3	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
QBRELIS ORAL SOLUTION 1 MG/ML (lisinopril)	3	PA
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	3	
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (digoxin)	3	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (lomitapide mesylate)	3	PA; ST; QL (1 capsule per day.); SMCS; SP
JUXTAPID ORAL CAPSULE 30 MG (lomitapide mesylate)	3	PA; ST; QL (62 capsules per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	2	PA; ST; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; ST; QL (1 tablet per day.)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	2	
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	2	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	3	PA; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
BETA-ADRENERGIC BLOCKING AGENTS - Drugs for High Blood Pressure		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>atenolol</i>)	3	PA
<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	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3	QL (5 ml per prescription.)
<i>bisoprolol fumarate oral tablet 10 mg, 2.5 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	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3	
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	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 25 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>	3	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<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	PA
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	2	QL (5 ml per prescription.)
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	3	
<i>timolol maleate ocudose ophthalmic solution 0.5 %</i>	2	
<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>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3	
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	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (<i>clindamycin-tretinoin-cholesty</i>)	3	PA
<i>colesevelam hcl oral packet 3.75 gm</i>	2	
<i>colesevelam hcl oral tablet 625 mg</i>	2	
COLESTID ORAL GRANULES 5 GM (<i>colestipol hcl</i>)	3	
COLESTID ORAL TABLET 1 GM (<i>colestipol hcl</i>)	3	
<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	
<i>prevalite oral powder 4 gm/dose</i>	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (<i>cholestyramine light</i>)	3	
QUESTRAN ORAL PACKET 4 GM (<i>cholestyramine</i>)	3	
QUESTRAN ORAL POWDER 4 GM/DOSE (<i>cholestyramine</i>)	3	
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>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	
<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>	2	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
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	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 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 - Drugs for High Blood Pressure & Angina		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<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>	2	
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
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	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 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>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<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>	2	
<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>	2	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 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		
ASPRUZYO SPRINKLE ORAL PACKET 1000 MG (<i>ranolazine</i>)	3	PA
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>mavacamten</i>)	3	PA; QL (1 capsule per day.); SMCS; SP
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>	3	PA; QL (2 tablets per day.)
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	2	
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.); SMCS; SP
VYNDAQEL ORAL CAPSULE 20 MG (<i>tafamidis meglumine (cardiac)</i>)	2	PA; QL (4 capsules per day.); SMCS; SP
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	3	PA; QL (2 tablets per day.)
LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG (<i>digoxin</i>)	3	
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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>atenolol</i>)	3	PA
<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	
<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>	3	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	3	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	3	PA; ST
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>metoprolol succinate er oral tablet extended release 24 hour 25 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>	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>	2	
<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	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	PA; QL (1 tablet per day.)
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
<i>ezetimibe oral tablet 10 mg</i>	2	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	3	
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; ST; 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	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	3	
<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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>atenolol</i>)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3	QL (5 ml per prescription.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (propranolol hcl)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (timolol maleate)	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	3	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	3	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 25 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	3	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	2	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol hcl)	3	PA
timolol hemihydrate ophthalmic solution 0.5 %	2	QL (5 ml per prescription.)
timolol maleate (once-daily) ophthalmic solution 0.5 %	3	
timolol maleate ocudose ophthalmic solution 0.5 %	2	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3	
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	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	2	
MULTAQ ORAL TABLET 400 MG (<i>dronedarone hcl</i>)	3	PA
PACERONE ORAL TABLET 100 MG, 200 MG (<i>amiodarone hcl</i>)	3	
<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	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (<i>dofetilide</i>)	3	
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<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>	2	
<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>	2	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 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		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>amlodipine besylate</i>)	3	PA
<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>	2	
<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, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	3	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	3	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>amlodipine besylate</i>)	3	PA
<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, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	3	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	
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.)
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	2	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	3	
EDEX 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>	2	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	3	PA; ST
<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 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>	2	
<i>fenofibrate oral capsule 134 mg, 200 mg, 67 mg</i>	2	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	2	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	2	
<i>gemfibrozil oral tablet 600 mg</i>	1	
LOPID ORAL TABLET 600 MG (<i>gemfibrozil</i>)	3	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (<i>atorvastatin calcium</i>)	3	PA
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1	H
<i>atorvastatin calcium oral tablet 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	3	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3	PA
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	3	ST
<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>	2	
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	H
<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>	3	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (<i>furosemide</i>)	3	PA; QL (4 cartridges per prescription.)
<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	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNISTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
KERENDIA ORAL TABLET 10 MG, 20 MG (<i>finerenone</i>)	3	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (<i>finerenone</i>)	3	PA
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG (<i>lomitapide mesylate</i>)	3	PA; ST; QL (1 capsule per day.); SMCS; SP
JUXTAPID ORAL CAPSULE 30 MG (<i>lomitapide mesylate</i>)	3	PA; ST; QL (62 capsules per month.); SMCS; SP
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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>atenolol</i>)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	3	
<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>	2	
<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	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 25 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	
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	3	
<i>nitroglycerin rectal ointment 0.4 %</i>	3	QL (30 grams per month.)
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</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	
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>	2	
<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	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	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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	
<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	
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	3	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</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	
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>	2	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (<i>evolocumab</i>)	2	QL (3.5 ml (1 cartridge) per month.)
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 ml per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
<i>alyq oral tablet 20 mg</i>	2	PA; QL (2 tablets per day); SMCS; SP
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	3	
<i>avanafil oral tablet 100 mg, 200 mg, 50 mg</i>	3	PA; QL (3 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>cilostazol oral tablet 100 mg, 50 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	3	PA; QL (186 ml per month.); SMCS; SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (0.5 tablet per day.)
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.); SMCS
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	3	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day); SMCS; SP
<i>tadalafil oral tablet 10 mg, 20 mg</i>	2	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	2	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.); SMCS; SP
<i>varafenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	3	QL (3 tablets per month.)
<i>varafenafil hcl oral tablet dispersible 10 mg</i>	3	QL (3 tablets per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
<i>alyq oral tablet 20 mg</i>	2	PA; QL (2 tablets per day); SMCS; SP
<i>avanafil oral tablet 100 mg, 200 mg, 50 mg</i>	3	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>	3	PA; QL (186 ml per month.); SMCS; SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (0.5 tablet per day.)
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.); SMCS
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	3	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day); SMCS; SP
<i>tadalafil oral tablet 10 mg, 20 mg</i>	2	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	2	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	3	QL (3 tablets per month.)
<i>vardenafil hcl oral tablet dispersible 10 mg</i>	3	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	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	3	
RENIN INHIBITORS - Drugs for the Heart		
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	3	
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	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	3	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3	PA; QL (1 tablet per day.); SMCS; SP
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	3	PA; QL (2 tablets per day.)
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	3	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	2	
<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	
VASODILATING AGENTS, MISCELLANEOUS - Drugs for High Blood Pressure & Angina		
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	2	
VECAMYL ORAL TABLET 2.5 MG (<i>mecamylamine hcl</i>)	3	PA
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>amlodipine besylate</i>)	3	PA
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SMCS; SP
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<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>	2	
<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>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	3	PA; QL (2 tablets per day.)
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<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	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	3	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3	PA; QL (168 tablets per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3	PA; QL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	3	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	3	PA; QL (6 tablets per day.); SMCS; SP
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
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	
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	2	PA; QL (4 tablets per day.); SMCS; SP
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (<i>iloprost</i>)	2	PA; SMCS; SP
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	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.); SMCS; SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (1 starter kit per year.); SMCS; SP
<i>riluzole oral tablet 50 mg</i>	1	SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA; SMCS; SP
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA; SMCS; SP
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.)
AMPHETAMINE DERIVATIVES - Drugs for the Nervous System		
ADIPEX-P ORAL TABLET 37.5 MG (<i>phentermine hcl</i>)	3	PA
<i>diethylpropion hcl er oral tablet extended release 24 hour 75 mg</i>	1	PA
<i>diethylpropion hcl oral tablet 25 mg</i>	1	PA
LOMAIRA ORAL TABLET 8 MG (<i>phentermine hcl</i>)	3	PA
<i>phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg</i>	1	PA
<i>phendimetrazine tartrate oral tablet 35 mg</i>	1	PA
<i>phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg</i>	1	PA
<i>phentermine hcl oral tablet 37.5 mg</i>	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AMPHETAMINES - Drugs for the Nervous System		
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	2	
<i>amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	2	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>	3	QL (1 capsule per day.)
<i>benzphetamine hcl oral tablet 50 mg</i>	1	PA
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	3	QL (5 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	3	QL (4 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	2	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>	2	
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	3	QL (2 capsules per day.)
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	3	QL (1 capsule per day)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	3	QL (2 tablets per day.)
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	3	QL (1 tablet per day.)
<i>methamphetamine hcl oral tablet 5 mg</i>	1	
PROCENTRA ORAL SOLUTION 5 MG/5ML (<i>dextroamphetamine sulfate</i>)	3	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (<i>dextroamphetamine</i>)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	3	QL (40 capsules per prescription.); NTT
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	NTT
<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 (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	3	QL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
<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
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (<i>gabapentin</i>)	3	PA
FIORICET ORAL CAPSULE 50-300-40 MG (<i>butalbital-apap-caffeine</i>)	3	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</i>	1	NTT
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15ml</i>	2	
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	2	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 (<i>suzetrigine</i>)	3	QL (30 tablets per 90 Days.)
NEURAPTINE EXTERNAL CREAM 10 % (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (<i>gabapentin</i>)	3	PA
NEURORUB EXTERNAL CREAM 10 % (<i>gabapentin</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	QL (40 tablets per prescription.); NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (apap-caff-dihydrocodeine)	3	QL (40 capsules per prescription.); NTT
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	3	
uretron d/s oral tablet 81.6 mg	1	
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	3	
ANOREXIGENIC AGENTS - Drugs for the Nervous System		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (naltrexone-bupropion hcl)	3	PA; QL (4 tablets per day.)
phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg	3	PA; QL (1 capsule per day.)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (phentermine-topiramate)	3	PA; QL (1 capsule per day.)
ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System		
phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg	3	PA; QL (1 capsule per day.)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (phentermine-topiramate)	3	PA; QL (1 capsule per day.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (diazoxide choline)	3	PA; QL (90 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (diazoxide choline)	3	PA; QL (120 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (diazoxide choline)	3	PA; QL (210 tablets per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (<i>naltrexone-bupropion hcl</i>)	3	PA; QL (4 tablets per day.)
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (<i>setmelanotide acetate</i>)	3	PA; QL (9 mls per month.); SMCS; SP
<i>liraglutide solution pen-injector 18 mg/3ml subcutaneous</i>	2	PA; QL (If member has previous history of Victoza, then member may be eligible to receive 9ml (3 pens) per month (only applies to 3 pack NDC-00169406013). This medication is over-rideable.)
<i>liraglutide solution pen-injector 18 mg/3ml subcutaneous</i>	3	PA; QL (If member has previous history of Victoza, then member may be eligible to receive 9ml (3 pens) per month (only applies to 3 pack NDC-00169406013). This medication is over-rideable.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide -weight management</i>)	3	PA; QL (0.6 ml per day.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (<i>semaglutide-weight management</i>)	3	PA; QL (0.08 ml per day and 4 ml per 365 days.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (<i>semaglutide-weight management</i>)	3	PA; QL (0.11 ml per day.)
ZEPBOUND SUBCUTANEOUS SOLUTION 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-weight management</i>)	3	PA
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide-weight management</i>)	3	PA; QL (4 pens per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (<i>tirzepatide-weight management</i>)	3	PA; QL (4 pens per month and 8 pens per year.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
<i>benztropine mesylate oral tablet 0.5 mg, 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	2	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	
ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
APTOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (<i>eslicarbazepine acetate</i>)	3	PA
BANZEL ORAL SUSPENSION 40 MG/ML (<i>rufinamide</i>)	3	PA
BANZEL ORAL TABLET 200 MG, 400 MG (<i>rufinamide</i>)	3	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (<i>brivaracetam</i>)	3	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (<i>brivaracetam</i>)	3	PA
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	2	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	
<i>carbamazepine oral tablet 200 mg</i>	1	
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine</i>)	3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (<i>stiripentol</i>)	3	PA; SMCS; SP
DIACOMIT ORAL PACKET 250 MG, 500 MG (<i>stiripentol</i>)	3	PA; SMCS; SP
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	2	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (<i>cannabidiol</i>)	3	PA; SMCS; SP
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine (antipsychotic)</i>)	3	
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	3	PA
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (<i>gabapentin</i>)	3	PA
<i>felbamate oral suspension 600 mg/5ml</i>	1	
<i>felbamate oral tablet 400 mg, 600 mg</i>	1	
FELBATOL ORAL TABLET 400 MG, 600 MG (<i>felbamate</i>)	3	PA
FINTEPLA ORAL SOLUTION 2.2 MG/ML (<i>fenfluramine hcl</i>)	3	PA; SMCS
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (<i>perampanel</i>)	3	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	PA
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (<i>levetiracetam</i>)	3	PA
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (<i>levetiracetam</i>)	3	PA
<i>lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml</i>	2	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
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	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (<i>lamotrigine</i>)	3	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	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>	3	
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	3	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>	3	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>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	2	
<i>levetiracetam oral solution 100 mg/ml, 500 mg/5ml</i>	1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 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	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	3	PA
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (<i>lacosamide</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (<i>gabapentin</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>perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	2	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	2	
<i>pregabalin oral solution 20 mg/ml</i>	3	
<i>roweepra oral tablet 500 mg</i>	1	
<i>rufinamide oral suspension 40 mg/ml</i>	3	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	3	PA
<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	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	3	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	3	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (<i>topiramate</i>)	3	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (<i>topiramate</i>)	3	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	
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (<i>oxcarbazepine</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	PA
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<i>vigabatrin oral packet 500 mg</i>	2	PA; QL (6 packets per day.); SMCS
<i>vigabatrin oral tablet 500 mg</i>	2	PA; QL (6 tablets per day.); SMCS; SP
VIGADRONE ORAL PACKET 500 MG (<i>vigabatrin</i>)	2	PA; QL (6 packets per day.); SMCS
VIGADRONE ORAL TABLET 500 MG (<i>vigabatrin</i>)	2	PA; QL (6 tablets per day.); SMCS; SP
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	3	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>lacosamide</i>)	3	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 X 200 MG, 14 X 50 MG & 14 X 100 MG, 150 & 200 MG (<i>cenobamate</i>)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (<i>zonisamide</i>)	3	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	3	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	3	PA; SMCS; SP
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (<i>dextromethorphan-bupropion</i>)	3	ST; 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	PA; QL (8 devices (4 kits) per month.); SMCS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3	PA; QL (12 devices (4 kits) per month.); SMCS
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	2	PA; QL (28 capsules per year.); SMCS; SP
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	2	PA; QL (14 capsules per year.); SMCS; SP
ANTIMANIC AGENTS - Drugs for Personality Disorder		
<i>aripiprazole oral solution 1 mg/ml</i>	2	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	2	QL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	3	QL (2 tablets per day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	3	QL (2 tablets per day.)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	2	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	
<i>carbamazepine oral tablet 200 mg</i>	1	
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine</i>)	3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	3	PA
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 oral capsule delayed release sprinkle 125 mg</i>	2	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine (antipsychotic)</i>)	3	
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	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (<i>lamotrigine</i>)	3	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (<i>lamotrigine</i>)	3	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	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>	3	
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	3	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>	3	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	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>	2	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg</i>	2	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>	2	
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	1	
<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	
<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	
SYMBYAX ORAL CAPSULE 3-25 MG (<i>olanzapine-fluoxetine hcl</i>)	3	QL (1 capsule per day)
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	3	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	3	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	3	
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	2	
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
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	2	QL (7.5 ml (3 bottles) per prescription.)
<i>caffeine citrate oral solution 20 mg/ml, 60 mg/3ml</i>	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	3	PA
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	3	PA; QL (8 mL per prescription.)
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	2	
<i>divalproex sodium oral tablet delayed release 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG (<i>naproxen</i>)	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (<i>ergotamine tartrate</i>)	3	PA; QL (5 tablets per prescription.)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	
<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
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	3	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	3	
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
<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>	2	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<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	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (<i>topiramate</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (<i>loxapine</i>)	3	
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (<i>xanomeline-trospium chloride</i>)	3	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (<i>xanomeline-trospium chloride</i>)	3	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>	3	
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
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	ST; QL (1 tablet per day.)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	3	ST; QL (1 tablet per day.)
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	2	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	3	PA; QL (5.1 mL per day.); SMCS; SP
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	3	PA; QL (1 capsule per day.); SMCS; SP
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>promethazine hcl oral syrup 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>	3	ST; QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	3	PA; QL (1 capsule per day.); SMCS; SP
<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>	2	
<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>	2	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	2	QL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	3	QL (2 tablets per day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	3	QL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (<i>lumateperone tosylate</i>)	3	PA; ST; 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	
FANAPT ORAL TABLET 1 MG (<i>iloperidone</i>)	3	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (<i>iloperidone</i>)	3	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (<i>iloperidone</i>)	3	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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (<i>iloperidone</i>)	3	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg</i>	2	QL (1 tablet per day.)
<i>lurasidone hcl oral tablet 40 mg</i>	2	QL (1 tablet per day)
<i>lurasidone hcl oral tablet 80 mg</i>	2	QL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (<i>pimavanserin tartrate</i>)	3	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (<i>pimavanserin tartrate</i>)	3	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>	2	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	2	QL (1 capsule per day)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	3	QL (1 tablet per day)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	3	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>	2	
<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	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	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (<i>olanzapine-fluoxetine hcl</i>)	3	QL (1 capsule per day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	3	QL (1 capsule per day.)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 (6 capsules per day.)
<i>butalbital-apap-cafeine oral capsule 50-300-40 mg</i>	3	QL (6 capsules per day.)
<i>butalbital-apap-cafeine oral capsule 50-325-40 mg</i>	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
<i>butalbital-apap-cafeine 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-cafeine oral capsule 50-325-40 mg</i>	1	
FIORICET ORAL CAPSULE 50-300-40 MG (<i>butalbital-apap-cafeine</i>)	3	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	
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
<i>clobazam oral suspension 2.5 mg/ml</i>	3	PA
<i>clobazam oral tablet 10 mg, 20 mg</i>	2	PA
<i>clonazepam oral tablet 0.5 mg, 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	3	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	3	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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	3	
clobazam oral suspension 2.5 mg/ml	3	PA
clobazam oral tablet 10 mg, 20 mg	2	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	QL (1 box (2 doses/box) per prescription)
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
HALCION ORAL TABLET 0.25 MG (<i>triazolam</i>)	3	
lorazepam intensol oral concentrate 2 mg/ml	1	
lorazepam oral concentrate 2 mg/ml	1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
midazolam hcl oral syrup 2 mg/ml	1	
MIDAZOLAM+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (<i>midazolam</i>)	3	PA
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	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	3	PA
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (<i>temazepam</i>)	3	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	3	PA
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	1	
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	1	
BUTYROPHENONES - Drugs for Depression & Psychosis		
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	1	
CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (<i>erenumab-aooe</i>)	2	PA; QL (1 pen per month.)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (<i>galcanezumab-gnlm</i>)	2	PA; QL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>galcanezumab-gnlm</i>)	2	PA; QL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>galcanezumab-gnlm</i>)	2	PA; QL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (<i>rimegepant sulfate</i>)	2	PA; QL (0.27 tablets per day.)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (<i>atogepant</i>)	2	PA; QL (1 tablet per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG (<i>ubrogepant</i>)	2	PA; ST; QL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (<i>zavegepant hcl</i>)	3	PA; ST; QL (6 mg per prescription.)
CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson		
<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	
<i>entacapone oral tablet 200 mg</i>	1	
<i>tolcapone oral tablet 100 mg</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	PA; QL (1 tablet per day.)
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	3	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	3	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	3	QL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	3	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (<i>trofinetide</i>)	2	PA; QL (120 ml per day.); SMCS; SP
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	2	
<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	PA; QL (1 packet per day.); SMCS; SP
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	3	
<i>memantine hcl oral solution 2 mg/ml</i>	3	
<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.); SMCS; SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	3	PA; QL (1 starter kit per year.); SMCS; SP
<i>riluzole oral tablet 50 mg</i>	1	SMCS
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3	PA; QL (18 ml per day.); SMCS; SP
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA; SMCS; SP
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	3	PA; SMCS; SP
VEOZAH ORAL TABLET 45 MG (<i>fezolinetant</i>)	3	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (<i>bremelanotide acetate</i>)	3	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.); SMCS; SP
XYWAV ORAL SOLUTION 500 MG/ML (<i>ca, mg, k, and na oxybates</i>)	3	PA; QL (18 mL per day.); SMCS; SP
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	2	
DIBENZOXAPINES - Drugs for Depression & Psychosis		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (<i>loxapine</i>)	3	
<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>	3	
DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis		
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
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	ST
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (<i>carbidopa-levodopa</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (<i>carbidopa-levodopa</i>)	3	
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>	2	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	2	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (<i>pregabalin</i>)	3	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	3	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	2	
<i>pregabalin oral solution 20 mg/ml</i>	3	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	3	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	3	QL (1 pack per 365 days.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	3	PA
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (<i>stiripentol</i>)	3	PA; SMCS; SP
DIACOMIT ORAL PACKET 250 MG, 500 MG (<i>stiripentol</i>)	3	PA; SMCS; SP
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	3	PA
NEURAPTINE EXTERNAL CREAM 10 % (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (<i>gabapentin</i>)	3	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (<i>gabapentin</i>)	3	PA
NEURORUB EXTERNAL CREAM 10 % (<i>gabapentin</i>)	3	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	2	
<i>pregabalin oral solution 20 mg/ml</i>	3	
<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>	2	PA; QL (6 packets per day.); SMCS
<i>vigabatrin oral tablet 500 mg</i>	2	PA; QL (6 tablets per day.); SMCS; SP
VIGADRONE ORAL PACKET 500 MG (<i>vigabatrin</i>)	2	PA; QL (6 packets per day.); SMCS
VIGADRONE ORAL TABLET 500 MG (<i>vigabatrin</i>)	2	PA; QL (6 tablets per day.); SMCS; SP
VIGAFYDE ORAL SOLUTION 100 MG/ML (<i>vigabatrin</i>)	2	PA; QL (900 mL per month.); SMCS; SP
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	3	PA; SMCS; SP
HYDANTOINS - Drugs for Seizures		
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>phenytek oral capsule 200 mg, 300 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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		
APTOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (<i>eslicarbazepine acetate</i>)	3	PA
BANZEL ORAL SUSPENSION 40 MG/ML (<i>rufinamide</i>)	3	PA
BANZEL ORAL TABLET 200 MG, 400 MG (<i>rufinamide</i>)	3	PA
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	3	PA
<i>lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml</i>	2	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
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>	3	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	3	PA
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (<i>oxcarbazepine</i>)	3	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (<i>oxcarbazepine</i>)	3	PA
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	3	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>lacosamide</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (<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	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	3	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	PA; QL (5.1 mL per day.); SMCS; SP
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	3	PA; QL (1 capsule per day.); SMCS; SP
<i>ramelteon oral tablet 8 mg</i>	3	ST; QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	3	PA; QL (1 capsule per day.); SMCS; SP
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>	3	
<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	
PARNATE ORAL TABLET 10 MG (<i>tranylcypromine sulfate</i>)	3	
<i>phenelzine sulfate oral tablet 15 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	3	
<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	PA; QL (8 devices (4 kits) per month.); SMCS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	3	PA; QL (12 devices (4 kits) per month.); SMCS
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>	2	
<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>	2	
<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	PA; QL (3 ml per day.); SMCS; SP
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	3	PA; QL (3 ml per day.); SMCS; SP
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	
<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 oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	3	QL (40 capsules per prescription.); NTT
<i>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	NTT
<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 (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	3	QL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
<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	QL (6 capsules per day.)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15ml</i>	1	NTT
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15ml</i>	2	
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	2	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	QL (40 tablets per prescription.); NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (<i>apap-caff-dihydrocodeine</i>)	3	QL (40 capsules per prescription.); NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	3	
<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>	3	
<i>diflunisal oral tablet 500 mg</i>	3	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG (<i>naproxen</i>)	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	3	
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	
<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	
INDOCIN ORAL SUSPENSION 25 MG/5ML (<i>indomethacin</i>)	3	PA
INDOCIN RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	3	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	3	PA
<i>indomethacin rectal suppository 50 mg</i>	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (<i>ketoprofen-baclofen-gabap-lido</i>)	3	PA
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	3	
<i>mefenamic acid oral capsule 250 mg</i>	3	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	2	
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3	ST; 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>	3	QL (40 capsules per prescription.); NTT
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	NTT
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	QL (6 capsules 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>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>	2	PA; QL (0.34 patches per day.)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	2	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>	3	PA; QL (2 capsules per day.)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg</i>	3	PA; QL (0 tablets per 100 days, diagnosis review required.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	3	PA; QL (1 tablet per day.)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15ml</i>	1	NTT
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15ml</i>	2	
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	2	NTT
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	NTT
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	NTT
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg</i>	3	PA; QL (2 tablets per day.)
<i>hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg</i>	3	PA; QL (1 tablet per day.)
<i>hydromorphone hcl er oral tablet extended release 24 hour 32 mg</i>	3	PA; QL (0 tablet per 100 days, diagnosis review required.)
<i>hydromorphone hcl oral liquid 1 mg/ml</i>	1	NTT
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	1	NTT
<i>hydromorphone hcl rectal suppository 3 mg</i>	1	NTT
<i>levorphanol tartrate oral tablet 2 mg, 3 mg</i>	3	ST; QL (4 tablets per day.); NTT
<i>meperidine hcl oral solution 50 mg/5ml</i>	1	NTT
<i>meperidine hcl oral tablet 50 mg</i>	1	NTT
<i>methadone hcl intensol oral concentrate 10 mg/ml</i>	1	QL (6 ml per day.)
<i>methadone hcl oral concentrate 10 mg/ml</i>	1	QL (6 ml per day.)
<i>methadone hcl oral solution 10 mg/5ml</i>	1	PA; QL (11.3 ml per day.)
<i>methadone hcl oral solution 5 mg/5ml</i>	1	PA; QL (22.6 ml per day.)
<i>methadone hcl oral tablet 10 mg</i>	1	PA; QL (2 tablets per day.)
<i>methadone hcl oral tablet 5 mg</i>	1	PA; QL (4 tablets per day.)
<i>methadone hcl oral tablet soluble 40 mg</i>	1	QL (1.5 tablets per day.)
METHADOSE ORAL CONCENTRATE 10 MG/ML (<i>methadone hcl</i>)	3	QL (6 ml per day.)
<i>methadose oral tablet soluble 40 mg</i>	1	QL (1.5 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (<i>methadone hcl</i>)	3	QL (6 ml per day.)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	1	NTT
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg</i>	3	PA; QL (0 capsule per 100 days, diagnosis review required.)
<i>morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	3	PA; QL (1 capsule per day.)
<i>morphine sulfate er oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg</i>	3	PA; QL (62 capsules per 31 days.)
<i>morphine sulfate er oral capsule extended release 24 hour 100 mg</i>	3	PA; QL (0 capsule per 100 days, diagnosis review required.)
<i>morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg, 80 mg</i>	3	PA; QL (1 capsule per day.)
<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	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	NTT
<i>oxycodone hcl oral tablet 5 mg</i>	1	QL (12 tablets per day.); 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>	3	PA; QL (2 tablets per day.)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg</i>	3	PA; QL (0 tablet per 100 days.)
<i>oxymorphone hcl oral tablet 10 mg, 5 mg</i>	2	QL (6 tablets per day.); NTT
SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML (<i>tramadol hcl</i>)	3	PA; NTT
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	2	QL (1 tablet per day)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	2	QL (1 tablet per day)
<i>tramadol hcl oral tablet 50 mg</i>	1	NTT
<i>tramadol hcl oral tablet 75 mg</i>	3	NTT
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	QL (40 tablets per prescription.); NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (<i>apap-caff-dihydrocodeine</i>)	3	QL (40 capsules per prescription.); NTT
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (<i>oxycodone</i>)	3	PA; QL (2 tablets per day.)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (<i>oxycodone</i>)	3	PA; QL (0 capsules per 100 days, diagnosis review required.)
OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1	QL (2 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg</i>	1	QL (1 film per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1	QL (3 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>ft naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	QL (2 auto-injectors per prescription.)
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	1	QL (2 devices per prescription.)
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	QL (2 auto-injectors per prescription.)
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	1	QL (2 auto-injectors per prescription.)
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (<i>nalmefene hcl</i>)	1	QL (2 spray bottles per prescription.)
<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	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	3	PA; QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	QL (one package (2 devices) per prescription.)
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	2	QL (1 package (2 devices) per prescription.)
SUBOXONE SUBLINGUAL FILM 12-3 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (3 films per day.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	2	QL (1 ml per prescription.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (<i>buprenorphine hcl-naloxone hcl</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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	QL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	QL (2 tablets per day.)
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</i>	1	QL (3 sublingual tablets per day.)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1	QL (3 tablets per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1	QL (2 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg</i>	1	QL (1 film per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1	QL (3 films per day.)
<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>	3	PA; QL (4 patches per 28 days.)
<i>buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr</i>	3	PA; QL (4 patches per month.)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	2	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 (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	PA; ST; QL (3 films per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	QL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	QL (3 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	QL (2 tablets per day.)
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	3	ST; QL (1 tablet per day.)
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	3	ST; QL (1 tablet per day.)
PHENOTHIAZINES - Drugs for Depression & Psychosis		
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	3	PA
<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>	3	QL (40 capsules per prescription.); NTT
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	3	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	3	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	3	QL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	3	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	ST; QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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 (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	3	QL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
<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	
<i>caffeine citrate oral solution 20 mg/ml, 60 mg/3ml</i>	1	
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg</i>	2	QL (2 capsules per day.)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg</i>	2	QL (31 capsules per 31 days.)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	
FIORICET ORAL CAPSULE 50-300-40 MG (<i>butalbital-apap-caffeine</i>)	3	QL (6 capsules per day.)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>dexmethylphenidate hcl</i>)	3	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (<i>methylphenidate hcl</i>)	3	ST; QL (1 capsule per day.)
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (<i>methylphenidate hcl</i>)	3	
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	2	QL (2 tablets per day.)
<i>methylphenidate hcl er (cd) oral capsule extended release 60 mg</i>	2	QL (31 capsules per 31 days.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg</i>	2	QL (5 capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg</i>	2	QL (5capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (la) oral capsule extended release 24 hour 30 mg</i>	2	QL (3 capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg</i>	2	QL (2 capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg</i>	2	
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg</i>	2	QL (2 tablets per day.)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	2	QL (10 tablets per day.)
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	2	QL (5 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>	3	
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 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	QL (40 capsules per prescription.); NTT
REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	3	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	3	
<i>diclofenac sodium external gel 3 %</i>	2	PA; QL (100 grams per prescription.)
<i>diflunisal oral tablet 500 mg</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG (<i>naproxen</i>)	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	3	
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	
<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
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
INDOCIN ORAL SUSPENSION 25 MG/5ML (<i>indomethacin</i>)	3	PA
INDOCIN RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	3	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	3	PA
<i>indomethacin rectal suppository 50 mg</i>	3	PA
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	3	
<i>mefenamic acid oral capsule 250 mg</i>	3	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3	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>	2	
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3	ST; 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
<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>	3	
<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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 50 mg</i>	3	QL (1 tablet per day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg</i>	3	QL (1 tablet per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (<i>duloxetine hcl</i>)	3	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (<i>duloxetine hcl</i>)	3	QL (1 capsule per day.)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	2	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (<i>levomilnacipran hcl</i>)	3	ST; QL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (<i>levomilnacipran hcl</i>)	3	ST; QL (28 capsules per year.)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	3	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	3	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>	3	QL (4 tablets per prescription)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	2	QL (4 tablets per prescription)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	3	QL (4 tablets per prescription)
<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	PA; ST; QL (0.27 tablets per day. 8 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
REYVOW ORAL TABLET 50 MG (<i>lasmiditan succinate</i>)	3	PA; ST; QL (0.14 tablets per day. Benefit maximum quantity 4 tablets per prescription.)
<i>rizatriptan benzoate oral tablet 10 mg</i>	1	QL (10 tablets per prescription.)
<i>rizatriptan benzoate oral tablet 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>	2	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 refill subcutaneous solution cartridge subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</i>	1	QL (2 kits 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 4 mg/0.5ml, 6 mg/0.5ml</i>	1	QL (2 kits per prescription)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	2	QL (4 tablets per prescription)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	3	QL (4 tablets per prescription)
ZOMIG NASAL SOLUTION 2.5 MG (<i>zolmitriptan</i>)	3	QL (6 units per prescription.)
ZOMIG NASAL SOLUTION 5 MG (<i>zolmitriptan</i>)	2	QL (1 box per prescription)
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>	2	
<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>	3	QL (4 capsules per 28 days.)
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>fluoxetine hcl oral tablet 10 mg</i>	3	QL (1 tablet per day.)
<i>fluoxetine hcl oral tablet 20 mg, 60 mg</i>	3	
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	3	QL (2 capsules per day)
<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>	2	QL (1 capsule per day)
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg</i>	3	QL (1 tablet per day)
<i>paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg</i>	3	QL (2 tablets per day)
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	3	
<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	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (<i>olanzapine-fluoxetine hcl</i>)	3	QL (1 capsule per day)
SEROTONIN MODULATORS - Drugs for Depression & Psychosis		
<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	PA
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	1	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (<i>vortioxetine hbr</i>)	3	ST; QL (1 tablet per day.)
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	3	QL (1 tablet per day)
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (<i>methsuximide</i>)	3	
<i>ethosuximide oral capsule 250 mg</i>	1	
<i>ethosuximide oral solution 250 mg/5ml</i>	1	
<i>methsuximide oral capsule 300 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZARONTIN ORAL CAPSULE 250 MG (<i>ethosuximide</i>)	3	
ZARONTIN ORAL SOLUTION 250 MG/5ML (<i>ethosuximide</i>)	3	
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>chlorthalidone-amlodipine oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	3	
<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>	3	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	
ENOVARX-AMITRIPTYLINE EXTERNAL KIT 2 %	3	PA
<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	
<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	
<i>perphenazine-amlodipine 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>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (<i>deutetrabenazine</i>)	2	PA; QL (4 tablets per day.); SMCS; SP
AUSTEDO ORAL TABLET 6 MG (<i>deutetrabenazine</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
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.); SMCS; SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (<i>deutetrabenazine</i>)	2	PA; QL (30 Tablets per month.); SMCS; SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (<i>deutetrabenazine</i>)	2	PA; SMCS; SP
INGREZZA ORAL CAPSULE 40 MG, 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (1 capsule per day.); SMCS; SP
INGREZZA ORAL CAPSULE 60 MG (<i>valbenazine tosylate</i>)	2	PA; QL (1 capsule per day.); SMCS
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	2	PA; QL (30 tablets per month.); SMCS; SP
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (30 capsules per month.); SMCS; SP
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (<i>valbenazine tosylate</i>)	2	PA; QL (1 kit (28 tablets) per year.); SMCS; SP
<i>tetrabenazine oral tablet 12.5 mg</i>	2	PA; SMCS
<i>tetrabenazine oral tablet 25 mg</i>	2	PA; SMCS; SP
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
<i>armodafinil oral tablet 150 mg, 250 mg</i>	2	QL (1 tablet per day)
<i>armodafinil oral tablet 200 mg</i>	2	QL (1 tablet per day.)
<i>armodafinil oral tablet 50 mg</i>	2	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	PA; QL (1 packet per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	3	PA; QL (1 box (28 packets) per year.); SMCS; SP
<i>modafinil oral tablet 100 mg, 200 mg</i>	2	QL (3 tablets per day.)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3	PA; QL (18 ml per day.); SMCS; SP
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	PA; QL (2 tablets per day.); SMCS; SP
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3	
DENTAGEL DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3	
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	
FRAICHE 5000 DENTAL DENTAL GEL 1.1 %	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</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	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (<i>sodium fluoride</i>)	3	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (<i>pediatric multivitamins-fl</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</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 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	
<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	
<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	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	3	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
FRAICHE 5000 DENTAL DENTAL GEL 1.1 %	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	3	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (pediatric multivitamins-fl)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>sodium fluoride 5000 ppm 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	
<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	
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	
ADVOCATE SAFETY LANCETS 21G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 23G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 28G (<i>lancets</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AEROCHAMBER HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (<i>spacer/aero-holding chambers</i>)	3	
AEROCHAMBER2GO ANTI-STATIC DEVICE (<i>spacer/aero-holding chambers</i>)	3	
ALCOHOL PREP PADS SHEET 70 %	3	
AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	QL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (<i>insulin pen needle</i>)	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 (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
AUTOLET LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
AUTOLET LITE LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (<i>needle (disp)</i>)	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (<i>needle (disp)</i>)	2	
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
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	3	
BREATHE COMFORT CHAMBER/CHILD DEVICE	3	
CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 25G X 5/8"	2	
CAREPOINT POLY HUB NEEDLE 21G X 1-1/2"	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CAREPOINT POLY HUB NEEDLE 22G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 27G X 1/2"	2	
CAREPOINT SAFETY 1ST NEEDLE 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8"	2	
CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION (blood glucose calibration)	2	
CARESENS LANCETS 30G (lancets)	3	
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	ST
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 DEVICE (blood glucose monitoring suppl)	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 GEN MONITOR KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR NEXT MONITOR KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR NEXT ONE DEVICE (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR NEXT ONE KIT (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR PLUS BLUE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.)
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (3 sensors per month.)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.)
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.)
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (3 sensors per month.)
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 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" (<i>needle (disp)</i>)	2	
EASIVENT (<i>spacer/aero-holding chambers</i>)	3	
EASY COMFORT SHARPS CONTAINER	3	
EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (blood glucose calibration)	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL (blood glucose calibration)	3	
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (blood glucose calibration)	3	
EMBECTA AUTOSHIELD DUO 30G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML, 28G X 1/2" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (insulin syringe/needle u-500)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
ENLITE GLUCOSE SENSOR (continuous glucose sensor)	3	PA
FLEXICHAMBER ADULT MASK/SMALL (spacer/aero-hold chamber mask)	2	
FLEXICHAMBER CHILD MASK/LARGE (spacer/aero-hold chamber mask)	2	
FLEXICHAMBER CHILD MASK/SMALL (spacer/aero-hold chamber mask)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DEVICE (<i>spacer/aero-holding chambers</i>)	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.)
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.)
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 receiver per 999 days.)
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.)
GUARDIAN 4 GLUCOSE SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per month.)
GUARDIAN 4 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 transmitter kit per year.)
GUARDIAN LINK 3 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 transmitter kit per 365 days.)
GUARDIAN REAL-TIME CHARGER (<i>continuous glucose monitor sup</i>)	3	PA
GUARDIAN REAL-TIME REPLACE PED DEVICE (<i>continuous glucose receiver</i>)	3	PA
GUARDIAN REAL-TIME TEST PLUG (<i>continuous glucose monitor sup</i>)	3	PA
GUARDIAN SENSOR 3	3	PA; QL (5 sensors per 24 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 31G X 8 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 , 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.)
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 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 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 (<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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, 32G 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.)
LANCETS (<i>lancets</i>)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (<i>lancets</i>)	3	
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
MOBILE LANCETS 30G	3	
MODD1 SUPPLY KIT KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per copay.)
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
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (10 pods per prescription.)
OMNIPOD 5 LIBRE2 G6 INTRO G5 KIT (<i>insulin disposable pump</i>)	2	PA
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	2	PA
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	1	QL (1 device per prescription.)
ONETOUCH DELICA SAFETY LANCING (<i>lancets</i>)	1	
ONETOUCH ULTRA 2 KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
ONETOUCH ULTRA IN VITRO LIQUID (<i>blood glucose calibration</i>)	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE (blood glucose monitoring suppl)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (blood glucose calibration)	1	
ONETOUCH VERIO REFLECT KIT W/DEVICE (blood glucose monitoring suppl)	1	
PARI VORTEX ADULT MASK (spacer/aero-hold chamber mask)	2	
PARI VORTEX PEDIATRIC MASK (spacer/aero-hold chamber mask)	2	
PEN NEEDLE/5-BEVEL TIP 32G X 4 MM	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (RX)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (RX)	2	QL (10 pen needles per day.)
PERFECT POINT SAFETY LANCETS (lancets)	3	
PERFECT POINT SAFETY NEEDLE 25G X 1" (needle (disp))	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (blood glucose calibration)	3	
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 33G X 8 MM (insulin pen needle)	2	QL (10 pen needles per day.)
RAYA SURE PEN NEEDLE 29G X 12MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM	2	QL (10 pen needles per day.)
SAFETY PEN NEEDLES 30G X 5 MM , 30G X 8 MM	2	QL (10 pen needles per day.)
SHARPS COLLECTOR	3	
SHARPS CONTAINER	3	
SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)	2	QL (10 pen needles per day.)
TECHLITE LANCETS 26G (lancets)	3	
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>)	3	
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	3	
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (<i>corticotropin</i>)	3	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (21 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (20 ml per 24 days.); SMCS; SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; SMCS; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (20 ml per 24 days.); SMCS; SP
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (<i>cosyntropin</i>)	3	
<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>	3	
<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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	
ONETOUCH ULTRA BLUE TEST IN VITRO STRIP (<i>glucose blood</i>)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
ONETOUCH ULTRA IN VITRO STRIP (<i>glucose blood</i>)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
ONETOUCH ULTRA TEST IN VITRO STRIP (<i>glucose blood</i>)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
ONETOUCH VERIO IN VITRO STRIP (<i>glucose blood</i>)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
DIAGNOSTIC AGENTS		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
CARESTART COVID-19 HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
CLEARDETECT COVID-19 AG HOME IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
CLINITEST RAPID COVID-19 TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
COVID-19 AT HOME ANTIGEN TEST IN VITRO KIT	3	SM
COVID-19 AT-HOME TEST IN VITRO KIT	3	SM
DIATRUST COVID-19 HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
ELLUME COVID-19 HOME TEST IN VITRO KIT	3	SM
FASTEP COVID-19 ANTIGEN TEST IN VITRO KIT	3	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
IHEALTH COVID-19 RAPID TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
INDICAID COVID-19 RAPID TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
ON/GO COVID-19 ANTIGEN TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
ON/GO ONE COVID-19 HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
PILOT COVID-19 AT-HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
SPEEDY SWAB COVID-19 ANTIGEN IN VITRO KIT (<i>covid-19 at home test</i>)	3	SM
KETONES		
CHEMSTRIP K IN VITRO STRIP (<i>acetone (urine) test</i>)	2	
KETOSTIX IN VITRO STRIP (<i>acetone (urine) test</i>)	2	
PHEOCHROMOCYTOMA		
DEMSEER ORAL CAPSULE 250 MG (<i>metirosine</i>)	3	PA
<i>metirosine oral capsule 250 mg</i>	3	PA
PITUITARY FUNCTION		
METOPIRONE ORAL CAPSULE 250 MG (<i>metirapone</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	
KETO-DIASTIX 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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 10 %, 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	
ORAL CITRATE ORAL SOLUTION 490-640 MG/5ML	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	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (<i>potassium citrate</i>)	3	
AMMONIA DETOXICANTS		
<i>carglumic acid oral tablet soluble 200 mg</i>	2	PA; SMCS; SP
<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	
KRISTALOSE ORAL PACKET 10 GM, 20 GM (<i>lactulose</i>)	3	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 oral packet 20 gm</i>	3	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	1	
LITHOSTAT ORAL TABLET 250 MG (<i>acetohydroxamic acid</i>)	3	
RAVICTI ORAL LIQUID 1.1 GM/ML (<i>glycerol phenylbutyrate</i>)	3	PA; ST; QL (17.5 ml per day.); SMCS; SP
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	1	PA; SMCS
<i>sodium phenylbutyrate oral tablet 500 mg</i>	3	PA; SMCS
CALORIC AGENTS - Drugs for Nutrition		
CAMINO PRO COMPLETE/GLYTACTIN ORAL BAR (<i>nutritional supplements</i>)	3	
COMPLEX ESSENTIAL MSD ORAL POWDER (<i>nutritional supplements</i>)	3	
DOJOLVI ORAL LIQUID 100 % (<i>triheptanoin</i>)	3	PA; SMCS; SP
EAA SUPPLEMENT ORAL PACKET (<i>nutritional supplements</i>)	3	
ENCALA ORAL POWDER (<i>nutritional supplements</i>)	3	
ENSURE ORIGINAL ORAL LIQUID (<i>nutritional supplements</i>)	3	
ENSURE PLUS ORAL LIQUID (<i>nutritional supplements</i>)	3	
GLYTACTIN BETTERMILK 15 ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN BETTERMILK DE-LITE ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN BUILD 10PE ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN BUILD 20/20 ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN BUILD 20/20 PKU ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN BURST ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN COMPLETE 10PE ORAL BAR (<i>nutritional supplements</i>)	3	
GLYTACTIN RESTORE 10 ORAL LIQUID (<i>nutritional supplements</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GLYTACTIN RESTORE 5 ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN RESTORE LITE 10 ORAL LIQUID (<i>nutritional supplements</i>)	3	
GLYTACTIN RESTORE LITE 10PE ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN RTD 10 ORAL LIQUID (<i>nutritional supplements</i>)	3	
GLYTACTIN RTD 15 ORAL LIQUID (<i>nutritional supplements</i>)	3	
GLYTACTIN RTD LITE 15 ORAL LIQUID (<i>nutritional supplements</i>)	3	
GLYTACTIN SWIRL 15 ORAL PACKET (<i>nutritional supplements</i>)	3	
GLYTACTIN SWIRL 15PE ORAL PACKET (<i>nutritional supplements</i>)	3	
L-ISOLEUCINE POWDER	3	PA
MALTOCARB ORAL POWDER (<i>nutritional supplements</i>)	3	
NEOCATE SYNEO JUNIOR ORAL POWDER (<i>nutritional supplements</i>)	3	
PEPTICATE ORAL POWDER (<i>infant foods</i>)	3	
PHENYLADE ESSENTIAL DRINK MIX ORAL POWDER (<i>nutritional supplements</i>)	3	
PHENYLADE GMP MIX DHA/FIBER ORAL POWDER (<i>nutritional supplements</i>)	3	
PHENYLADE GMP MIX-IN ORAL POWDER (<i>nutritional supplements</i>)	3	
PHENYLADE GMP ULTRA ORAL PACKET (<i>nutritional supplements</i>)	3	
PHENYLADE60 DRINK MIX ORAL POWDER (<i>nutritional supplements</i>)	3	
PKU EASY MICROTABS ORAL TABLET DELAYED RELEASE (<i>nutritional supplements</i>)	3	
PKU EASY MICROTABS PLUS ORAL TABLET DELAYED RELEASE (<i>nutritional supplements</i>)	3	
PKU EASY SHAKE & GO ORAL POWDER (<i>nutritional supplements</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PKU GOLIKE PLUS 16+ ORAL PACKET	3	
PKU GOLIKE PLUS 4-16 ORAL PACKET	3	
PKU START ORAL POWDER (<i>nutritional supplements</i>)	3	
PREKUNIL ORAL TABLET (<i>nutritional supplements</i>)	3	
PRO-STAT/FIBER ORAL LIQUID (<i>amino acids-protein hydrolys</i>)	3	
REAL FOOD BLENDS ENTERAL LIQUID (<i>nutritional supplements</i>)	3	
REFRESH AA 15 PKU ORAL LIQUID (<i>amino acids</i>)	3	
CARBONIC ANHYDRASE INHIBITORS - 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 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	
<i>ethacrynic acid oral tablet 25 mg</i>	3	
FUROSIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML (<i>furosemide</i>)	3	PA; QL (4 cartridges per prescription.)
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
OSMOTIC DIURETICS - Drugs for Water Balance		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %, 45 %</i>	1	
<i>urea external lotion 40 %</i>	1	
<i>urea nail external gel 45 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
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	ST
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	3	ST
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	2	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	2	
VELPHORO ORAL TABLET CHEWABLE 500 MG (<i>sucroferric oxyhydroxide</i>)	3	ST
XPHOZAH ORAL TABLET 20 MG, 30 MG (<i>tenapanor hcl (ckd)</i>)	3	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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS - 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	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	3	
<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	
FOLATEXCEL ORAL TABLET 1 MG	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 packet 20 meq</i>	1	
<i>klor-con oral tablet extended release 8 meq</i>	1	
<i>klor-con/ef oral tablet effervescent 25 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	
K-PRIME ORAL TABLET EFFERVESCENT 25 MEQ (<i>potassium bicarbonate</i>)	3	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (<i>insulin regular(human) in nacl</i>)	3	
NEO-VITAL RX ORAL TABLET 1 MG	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	
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	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
wes-phos 250 neutral oral tablet 155-852-130 mg	1	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DIURETICS - Drugs for Water Balance		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG (<i>quinapril-hydrochlorothiazide</i>)	3	
<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	
<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>	3	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	2	
<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 (<i>hydrochlorothiazide</i>)	3	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 (<i>benazepril-hydrochlorothiazide</i>)	3	
<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>	2	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	2	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	
<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	
THIAZIDE-LIKE DIURETICS - 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	
<i>probenecid oral tablet 500 mg</i>	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (<i>tolvaptan</i>)	3	PA; QL (90 tablets per 365 days.); SMCS; SP
SAMSCA ORAL TABLET 30 MG (<i>tolvaptan</i>)	3	PA; QL (60 tablets per 365 days.); SMCS; SP
<i>tolvaptan oral tablet 15 mg</i>	2	PA; SMCS; SP
<i>tolvaptan oral tablet therapy pack 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP
<i>tolvaptan oral tablet therapy pack 30 & 15 mg</i>	2	PA; QL (2 tablets per day.); SMCS
<i>tolvaptan tablet 30 mg oral</i>	2	PA; SMCS; SP
<i>tolvaptan tablet 30 mg oral</i>	2	PA; QL (2 tablets per day.); SMCS; SP
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	3	PA; QL (14 capsules per 21 days.); SMCS; SP
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (<i>arimoclomol citrate</i>)	3	PA; QL (90 capsules per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>sapropterin dihydrochloride oral packet 100 mg</i>	2	PA; QL (16 packets per day.); SMCS; SP
<i>sapropterin dihydrochloride oral packet 500 mg</i>	2	PA; QL (4 packets per day.); SMCS; SP
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	2	PA; QL (16 tablets per day); SMCS; SP
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	2	PA; SMCS; SP
<i>miglustat oral capsule 100 mg</i>	2	SMCS
OPFOLDA ORAL CAPSULE 65 MG (<i>miglustat (gaa deficiency)</i>)	2	PA; QL (8 capsules per 21 days.); SMCS; SP
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	2	PA; SMCS; SP
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	2	PA; SMCS; SP
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	2	PA; QL (5 capsules per day.); SMCS; SP
ZOKINVY ORAL CAPSULE 75 MG (<i>lonafarnib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
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; ST; QL (7 mL per year.); SMCS; SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (<i>pegvaliase-pqpz</i>)	3	PA; ST; QL (6 syringes per 365 days.); SMCS; SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (<i>pegvaliase-pqpz</i>)	3	PA; ST; QL (1 ml per day.); SMCS; SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST
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	ST

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP
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.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (<i>asfotase alfa</i>)	2	PA; QL (8.4 ml per month.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (<i>asfotase alfa</i>)	2	PA; QL (12 ml tablets per month.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (<i>asfotase alfa</i>)	2	PA; QL (9.6 ml (12 vials) per month.); SMCS; SP
SUCRAID ORAL SOLUTION 8500 UNIT/ML (<i>sacrosidase</i>)	2	PA; SMCS; SP
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	2	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
ALPHA-ADRENERGIC AGONISTS (EENT) - Drugs for the Eye		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (<i>brimonidine tartrate</i>)	2	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	3	QL (10 ml per prescription)
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	1	
<i>brimonidine tartrate external gel 0.33 %</i>	3	PA; QL (30 grams per prescription.)
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	2	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>)	2	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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	2	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	
<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>	3	QL (5 ml per prescription)
<i>olopatadine hcl nasal solution 0.6 %</i>	3	
ANTIBACTERIALS (52:04) - Drugs for Infections		
AMZEEQ EXTERNAL FOAM 4 % (<i>minocycline hcl micronized</i>)	3	QL (30 grams per prescription.)
AZASITE OPHTHALMIC SOLUTION 1 % (<i>azithromycin</i>)	3	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	
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	
<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>	3	
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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
<i>ery external pad 2 %</i>	1	
ERYGEL EXTERNAL GEL 2 % (<i>erythromycin</i>)	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
<i>gatifloxacin ophthalmic solution 0.5 %</i>	3	
<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	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (<i>neomycin-polymyxin-dexameth</i>)	3	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (<i>neomycin-polymyxin-dexameth</i>)	3	
<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>	2	
<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>	3	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	3	
<i>neomycin sulfate oral tablet 500 mg</i>	1	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (bacitracin-polymyx-neo-hc)	3	
NEO-POLYCIN OPHTHALMIC OINTMENT 3.5-400-10000 (neomycin-bacitracin zn-polymyx)	3	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (ofloxacin)	3	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin otic solution 0.3 %	2	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM (bacitracin-polymyxin b)	3	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sulfacetamide sodium ophthalmic ointment 10 %	1	
sulfacetamide sodium ophthalmic solution 10 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (tobramycin)	3	PA; QL (280 ml (1 carton) per 56 days.); SMCS; SP
TOBI PODHALER INHALATION CAPSULE 28 MG (tobramycin)	3	PA; QL (224 capsules per 56 days.); SMCS; SP
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	
tobramycin inhalation nebulization solution 300 mg/4ml	2	PA; QL (224 ml per 56 days.); SMCS; SP
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
TOBREX OPHTHALMIC OINTMENT 0.3 % (tobramycin)	3	QL (3.5 grams per prescription.)
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZILXI EXTERNAL FOAM 1.5 % (<i>minocycline hcl micronized</i>)	3	PA; ST; QL (30 grams per prescription.)
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (<i>loteprednol-tobramycin</i>)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (<i>natamycin</i>)	3	
ANTI-INFECTIVES, MISCELLANEOUS (52:04) - Drugs for Infections		
ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % (<i>silver nitrate-pot nitrate</i>)	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (<i>povidone-iodine</i>)	3	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	3	
<i>periogard mouth/throat solution 0.12 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (<i>pramoxine-chloroxylenol</i>)	3	
<i>silver nitrate external solution 0.5 %</i>	1	
XDEMVY OPHTHALMIC SOLUTION 0.25 % (<i>lotilaner</i>)	3	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	
<i>gengraf oral solution 100 mg/ml</i>	1	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	3	PA; QL (3 ml per 23 days.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (<i>cenegermin-bkbj</i>)	3	PA; QL (1 ml per day and 56 ml per 365 days.); SMCS; SP
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	3	PA; QL (60 vials per prescription.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	3	PA; QL (4 vials per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	3	PA; QL (60 vials per prescription.)
ANTIVIRALS (EENT) - Drugs for Infections		
<i>trifluridine ophthalmic solution 1 %</i>	1	
ZIRGAN OPHTHALMIC 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	
<i>periogard mouth/throat solution 0.12 %</i>	1	
BETA-ADRENERGIC BLOCKING AGENTS (EENT) - Drugs for the Eye		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	3	QL (5 ml per prescription.)
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>)	2	QL (5 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	3	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	3	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	2	QL (5 ml per prescription.)
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	3	
<i>timolol maleate ocudose ophthalmic solution 0.5 %</i>	2	
<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>	2	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CARBONIC ANHYDRASE INHIBITORS (EENT) - 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>	2	QL (10 ml per prescription)
COSOPT OPTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	3	
DORZOLAMIDE HCL SOLUTION 2 % OPTHALMIC	3	
<i>dorzolamide hcl solution 2 % ophthalmic</i>	1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
<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.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.)
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	3	
ALREX OPTHALMIC SUSPENSION 0.2 % (<i>loteprednol etabonate</i>)	3	QL (5 ml per prescription)
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 packet per day.)
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.)
CIPRO HC OTIC SUSPENSION 0.2-1 % (ciprofloxacin-hydrocortisone)	3	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	3	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (hydrocortisone)	3	
CORTENEMA RECTAL ENEMA 100 MG/60ML (hydrocortisone)	3	
CORTIFOAM EXTERNAL FOAM 10 % (hydrocortisone acetate)	2	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin-colist-hc-thonzonium)	3	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (fluocinolone acetonide)	3	QL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (fluocinolone acetonide)	3	
DERMOTIC OTIC OIL 0.01 % (fluocinolone acetonide)	3	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	3	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	3	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (loteprednol etabonate)	3	QL (8.3 mL per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLAREX OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone acetate</i>)	2	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	3	
<i>fluocinolone acetonide body external oil 0.01 %</i>	3	QL (118.28 ml per prescription.)
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	3	QL (15 grams per prescription.)
<i>fluocinolone acetonide external ointment 0.025 %</i>	2	QL (15 grams per prescription.)
<i>fluocinolone acetonide external solution 0.01 %</i>	1	QL (60 ml per prescription.)
<i>fluocinolone acetonide otic oil 0.01 %</i>	1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	3	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	2	QL (16 grams (1 bottle) per prescription)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
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.)
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (<i>fluorometholone</i>)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone</i>)	3	
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>	2	
<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 %</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	2	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	3	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (loteprednol etabonate)	3	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (loteprednol etabonate)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (loteprednol etabonate)	3	QL (5 grams per prescription.)
loteprednol etabonate ophthalmic suspension 0.2 %	3	QL (5 ml per prescription)
loteprednol etabonate ophthalmic suspension 0.5 %	3	QL (5 ml per prescription.)
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (dexamethasone)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (neomycin-polymyxin-dexameth)	3	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (neomycin-polymyxin-dexameth)	3	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	3	QL (17 grams (1 bottle) per prescription)
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (bacitracin-polymyx-neo-hc)	3	
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (prednisolone sodium phosphate)	3	
PEDIAPRED ORAL SOLUTION 5 MG/5ML (prednisolone sodium phosphate)	2	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (prednisolone acetate)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	3	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (dexamethasone)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21) (dexamethasone)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (dexamethasone)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	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.)
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
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>)	3	PA; QL (60 vials per prescription.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	3	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	3	PA; QL (60 vials per prescription.)
EENT DRUGS, MISCELLANEOUS		
<i>acetic acid otic solution 2 %</i>	1	
<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	
<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	PA; QL (20 mL per 21 days); SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	2	PA; QL (60 ml (4 bottles) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	PA; QL (3 ml per 23 days.)
MUCOSITISRX MOUTH/THROAT PACKET (<i>artificial saliva</i>)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (<i>cenegermin-bkbj</i>)	3	PA; QL (1 ml per day and 56 ml per 365 days.); SMCS; SP
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	3	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	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	3	
<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	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (<i>nepafenac</i>)	3	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (<i>ketorolac tromethamine</i>)	3	ST; QL (5 bottles per prescription.)
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA
<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	PA; QL (20 mL per 21 days); SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	2	PA; QL (60 ml (4 bottles) per month.); SMCS; SP
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	
MYDRIATICS - Drugs for the Eye		
<i>altafrin ophthalmic solution 10 %, 2.5 %</i>	1	
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (<i>cyclopentolate hcl</i>)	3	
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	
OSMOTIC AGENTS - Drugs for the Eye		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %, 45 %</i>	1	
<i>urea external lotion 40 %</i>	1	
<i>urea nail external gel 45 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
<i>bimatoprost ophthalmic solution 0.03 %</i>	2	QL (2.5 ml per prescription.)
LATANOPROST OIL	3	PA
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
LUMIGAN OPTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	2	
ROCKLATAN OPTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per prescription.)
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	3	ST; QL (30 unit of use droppers per prescription.)
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	3	QL (2.5 ml per prescription)
XELPROS OPTHALMIC EMULSION 0.005 % (<i>latanoprost</i>)	3	QL (2.5 ml per prescription.)
ZIOPTAN OPTHALMIC SOLUTION 0.0015 % (<i>tafluprost</i>)	3	ST; QL (30 unit of use droppers per prescription.)
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPTHALMIC SOLUTION 0.02 % (<i>netarsudil dimesylate</i>)	3	QL (2.5 ml per prescription.)
ROCKLATAN OPTHALMIC 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	
<i>altafrin ophthalmic solution 10 %, 2.5 %</i>	1	
CYCLOMYDRIL OPTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	3	
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	3	PA; QL (30 grams per prescription.)
UPNEEQ OPTHALMIC SOLUTION 0.1 % (<i>oxymetazoline hcl</i>)	3	PA; QL (30 single-use vials per prescription.)
GASTROINTESTINAL DRUGS		
ANTACIDS AND ADSORBENTS		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CHLORIDE CHANNEL ACTIVATORS		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	2	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.); SMCS; SP
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.); SMCS; SP
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.); SMCS; SP
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mirikizumab-mrkz</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mirikizumab-mrkz</i>)	2	PA; QL (2 prefilled syringe per month.); SMCS; SP
OPIOID ANTAGONISTS (56:18)		
<i>alvimopan oral capsule 12 mg</i>	3	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	3	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	3	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	QL (1 capsule per prescription.)
ANZEMET ORAL TABLET 50 MG (<i>dolasetron mesylate</i>)	3	QL (6 tablets per prescription.)
<i>granisetron hcl oral tablet 1 mg</i>	2	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	1	
<i>ondansetron hcl oral tablet 24 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>ondansetron odt oral tablet dispersible 4 mg, 8 mg</i>	1	
ANTIDIARRHEA AGENTS - Drugs for Diarrhea		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
<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	
LOMOTIL ORAL TABLET 2.5-0.025 MG (<i>diphenoxylate-atropine</i>)	3	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (<i>crofelemer</i>)	3	PA; QL (2 tablets per day.)
<i>opium oral tincture 10 mg/ml (1%)</i>	1	
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3	QL (120 capsules per 180 days.)
VIBERZI ORAL TABLET 100 MG, 75 MG (<i>eluxadoline</i>)	3	PA; QL (2 tablets per day.)
XERMELO ORAL TABLET 250 MG (<i>telotristat etiprate</i>)	3	PA; QL (3 tablets per day.); SMCS; SP
ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	1	
<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>	2	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	2	QL (1 capsule per day)
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 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>scopolamine transdermal patch 72 hour 1 mg/3days</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (<i>olanzapine-fluoxetine hcl</i>)	3	QL (1 capsule per day)
SYNDROS ORAL SOLUTION 5 MG/ML (<i>dronabinol</i>)	3	PA; QL (4 ml per day.)
ANTIFLATULENTS - Drugs for Gas		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA
ANTIHISTAMINES (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>	2	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	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3	
<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>	2	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	2	
<i>mesalamine rectal enema 4 gm</i>	1	
<i>mesalamine rectal suppository 1000 mg</i>	2	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	QL (4 kits per month.)
SFROWASA RECTAL ENEMA 4 GM/60ML (<i>mesalamine</i>)	3	
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	3	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	3	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>	2	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (<i>metronidazole benzoate</i>)	3	PA
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	3	
<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>	3	
CATHARTICS AND LAXATIVES - Drugs for Constipation		
<i>bisacodyl ec oral tablet delayed release 5 mg</i>	E	H
<i>citroma oral solution 1.745 gm/30ml</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 acd</i>)	3	QL (350 ml per prescription.)
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (<i>dph-lido-alhydr-mghydr-simeth</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	H
true laxative oral powder 17 gm/scoop	E	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (odevixibat)	3	PA; QL (2 capsules per day.); SMCS; SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (odevixibat)	3	PA; QL (1 capsule per day.); SMCS; SP
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (odevixibat)	3	PA; QL (2 capsules per day.); SMCS; SP
CHENODAL ORAL TABLET 250 MG (chenodiol)	3	ST; QL (93 tablets per month.); SMCS; SP
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (cholic acid)	2	PA; QL (4 capsules per day.); SMCS; SP
CTEXLI ORAL TABLET 250 MG (chenodiol)	3	PA; ST; QL (93 tablets per month.); SMCS; SP
IQIRVO ORAL TABLET 80 MG (elafibranor)	3	PA; ST; QL (31 tablets per month.); SMCS; SP
LIVDELZI ORAL CAPSULE 10 MG (seladelpar lysine)	3	PA; ST; QL (30 capsules per month.); SMCS; SP
LIVMARLI ORAL SOLUTION 19 MG/ML (maralixibat chloride)	3	PA; QL (60 mL (1140 mg) per month.); SMCS; SP
LIVMARLI ORAL SOLUTION 9.5 MG/ML (maralixibat chloride)	3	PA; QL (4 mL per day.); SMCS; SP
LIVMARLI ORAL TABLET 10 MG, 15 MG, 30 MG (maralixibat chloride)	3	PA; QL (30 tablets per month.); SMCS; SP
LIVMARLI ORAL TABLET 20 MG (maralixibat chloride)	3	PA; QL (60 tablets per month.); SMCS; SP
OICALIVA ORAL TABLET 10 MG, 5 MG (obeticholic acid)	3	PA; ST; QL (1 tablet per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>ursodiol oral capsule 300 mg</i>	1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	1	
URSODIOL+SYRSPEND SF ORAL SUSPENSION 30 MG/ML (<i>ursodiol</i>)	3	PA
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.); SMCS; SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST
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	ST
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<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.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.); SMCS; SP
alvimopan oral capsule 12 mg	3	
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (adalimumab-atto)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (adalimumab-atto)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (adalimumab-atto)	2	PA; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (adalimumab-atto)	2	PA; SMCS; SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (odevixibat)	3	PA; QL (2 capsules per day.); SMCS; SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (odevixibat)	3	PA; QL (1 capsule per day.); SMCS; SP
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (odevixibat)	3	PA; QL (2 capsules per day.); SMCS; SP
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (cholic acid)	2	PA; QL (4 capsules per day.); SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (certolizumab pegol)	2	PA; QL (1 kit per 21 days.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (certolizumab pegol)	2	PA; QL (1 kit per 21 days.); SMCS; SP
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (vedolizumab)	2	PA; QL (0.05 ml per day.); SMCS; SP
GATTEX SUBCUTANEOUS KIT 5 MG (teduglutide (rdna))	2	PA; QL (1 vial per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA-PSORIASIS/UEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	2	PA; QL (3 pens per year.); SMCS; SP
IQIRVO ORAL TABLET 80 MG (<i>elafibranor</i>)	3	PA; ST; QL (31 tablets per month.); SMCS; SP
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	PA; QL (4 mL per day.); SMCS; SP
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	2	PA; QL (2 capsules per day.)
OCALIVA ORAL TABLET 10 MG, 5 MG (<i>obeticholic acid</i>)	3	PA; ST; QL (1 tablet per day.); SMCS; SP
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA; SMCS
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA; SMCS
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mirikizumab-mrkz</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORLISTAT ORAL CAPSULE 120 MG	3	PA
prucalopride succinate oral tablet 1 mg, 2 mg	3	PA; QL (1 tablet per day.)
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (methylnaltrexone bromide)	3	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (methylnaltrexone bromide)	3	PA; QL (0.4 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (golimumab)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (golimumab)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (golimumab)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (golimumab)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (risankizumab-rzaa)	2	PA; QL (1.2 ml per 42 days.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (risankizumab-rzaa)	2	PA; QL (2.4 mL per 42 days.); SMCS; SP
SYMPROIC ORAL TABLET 0.2 MG (naldemedine tosylate)	2	PA; QL (1 tablet per day.)
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	3	PA; QL (4 ml per day.)
VIBERZI ORAL TABLET 100 MG, 75 MG (eluxadoline)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (fecal microb spores, live-brpk)	3	PA; QL (12 capsules per 365 days.); SMCS; SP
XENICAL ORAL CAPSULE 120 MG (orlistat)	3	PA
XPHOZAH ORAL TABLET 30 MG (tenapanor hcl (ckd))	3	PA; QL (2 tablets per day.)
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
scopolamine transdermal patch 72 hour 1 mg/3days	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	3	QL (1 capsule per prescription.)
<i>aprepitant oral 80 & 125 mg</i>	2	QL (3 capsules per prescription)
<i>aprepitant oral capsule 125 mg, 40 mg</i>	2	QL (1 capsule per prescription)
<i>aprepitant oral capsule 80 & 125 mg</i>	2	QL (3 capsules per prescription)
<i>aprepitant oral capsule 80 mg</i>	2	QL (2 capsules per prescription)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (<i>aprepitant</i>)	2	QL (3 pouches per prescription.)
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	3	ST; QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (<i>vonoprazan fumarate</i>)	3	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	3	PA; QL (1 tablet per day and 62 tablets per 365 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicillin-clarithro-vonoprazan</i>)	3	ST; 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	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (<i>misoprostol</i>)	3	SM
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	3	
<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>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	3	PA; ST; QL (1 packet per day.)
<i>esomeprazole magnesium oral packet 40 mg</i>	3	PA; ST; QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (<i>lansoprazole</i>)	3	PA
FIRST-OMEPRAZOLE ORAL SUSPENSION 2 MG/ML (<i>omeprazole</i>)	3	PA
FIRST-PANTOPRAZOLE ORAL SUSPENSION 4 MG/ML (<i>pantoprazole sodium</i>)	3	
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	3	PA; ST; QL (1 tablet per day.)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 5 MG (<i>esomeprazole magnesium</i>)	3	PA; ST; QL (1 packet per day.)
NEXIUM ORAL PACKET 40 MG (<i>esomeprazole magnesium</i>)	3	PA; ST; QL (1 packet per day)
OMECLAMOX-PAK ORAL 500-500-20 MG (<i>amoxicillin-clarithro-omeprazole</i>)	3	QL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	2	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (<i>vonoprazan fumarate</i>)	3	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	3	PA; QL (1 tablet per day and 62 tablets per 365 days.)
GOLD COMPOUNDS		
GOLD COMPOUNDS		
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	2	PA; SMCS; SP
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	2	PA; SMCS; SP
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	2	PA; SMCS; SP
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	2	PA; SMCS; SP
<i>deferiprone oral tablet 1000 mg</i>	3	PA; SMCS
<i>deferiprone oral tablet 500 mg</i>	3	PA; SMCS; SP
DEPEN TITRATABS ORAL TABLET 250 MG (<i>penicillamine</i>)	2	SMCS; SP
FERRIPROX ORAL SOLUTION 100 MG/ML (<i>deferiprone</i>)	2	PA; SMCS; SP
FERRIPROX ORAL TABLET 1000 MG (<i>deferiprone</i>)	3	PA; SMCS
<i>penicillamine oral tablet 250 mg</i>	2	SMCS; SP
<i>trientine hcl oral capsule 250 mg</i>	3	PA; SMCS; SP
<i>trientine hcl oral capsule 500 mg</i>	3	PA; SMCS
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR ANTAGONISTS		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (<i>setmelanotide acetate</i>)	3	PA; QL (9 mls per month.); SMCS; SP
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (<i>bremelanotide acetate</i>)	3	PA; QL (4 autoinjector pens (1.2mls) per month.)
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (<i>fluticasone-salmeterol</i>)	3	QL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.)
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	3	
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 CREAM 1-1 % (hydrocortisone ace-pramoxine)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (fluticasone furoate)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (fluticasone furoate)	1	QL (1 packet per day.)
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	3	
betamethasone dipropionate aug external ointment 0.05 %	3	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	QL (0.36 grams per day.)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	QL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	2	QL (60 ml (1 box) per 30 days.)
budesonide oral capsule delayed release particles 3 mg	2	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	3	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (hydrocortisone)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORTENEMA RECTAL ENEMA 100 MG/60ML (<i>hydrocortisone</i>)	3	
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>	3	
DIPROLENE EXTERNAL OINTMENT 0.05 % (<i>betamethasone dipropionate aug</i>)	3	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	3	
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external lotion 0.05 %</i>	3	ST; QL (60 ml per prescription.)
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	2	QL (16 grams (1 bottle) per prescription)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
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.)
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>	2	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 external cream 2.5 %	1	
hydrocortisone external lotion 2 %	3	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	2	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	3	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INTRAROSA VAGINAL INSERT 6.5 MG (prasterone)	3	PA; QL (1 insert per day.)
ISTURISA ORAL TABLET 1 MG (osilodrostat phosphate)	3	PA; QL (8 tablets per day.); SMCS; SP
ISTURISA ORAL TABLET 5 MG (osilodrostat phosphate)	3	PA; QL (372 tablets per month.); SMCS; SP
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (methylprednisolone)	3	
MEDROL ORAL TABLET 2 MG (methylprednisolone)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (methylprednisolone)	3	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	3	QL (17 grams (1 bottle) per prescription)
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (prednisolone sodium phosphate)	3	
PEDIAPRED ORAL SOLUTION 5 MG/5ML (prednisolone sodium phosphate)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	3	
<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 10 mg, 15 mg, 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	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (10.6 grams per month.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (42.4 grams per month.)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (<i>budesonide-formoterol fumarate</i>)	3	QL (0.35 grams per day.)
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, 1.5 MG (21) (<i>dexamethasone</i>)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (<i>dexamethasone</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (<i>budesonide</i>)	3	PA; QL (4 capsules per day.); SMCS; SP
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.)
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	2	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	PA; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (<i>budesonide</i>)	3	
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
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>	2	
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, 200 MG/ML (<i>testosterone cypionate</i>)	3	
EC-RX TESTOSTERONE TRANSDERMAL CREAM 0.2 %, 0.4 %, 10 %, 20 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
<i>estratest f.s. 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 100 MG (<i>testosterone undecanoate</i>)	3	PA; QL (2 capsules per day.)
KYZATREX ORAL CAPSULE 150 MG, 200 MG (<i>testosterone undecanoate</i>)	3	PA; QL (4 capsules per day.)
METHITEST ORAL TABLET 10 MG	2	
<i>methyltestosterone oral capsule 10 mg</i>	2	
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	2	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day)
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	
<i>testosterone gel 12.5 mg/act (1%) transdermal</i>	3	PA; QL (300 grams (4 pumps) per month)
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	2	PA; QL (150 grams (2 pumps) per month.)
<i>testosterone transdermal gel 1.62 %</i>	2	PA; QL (150 grams (2 pumps) per month.)
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
<i>colesevelam hcl oral packet 3.75 gm</i>	2	
<i>colesevelam hcl oral tablet 625 mg</i>	2	
CYCLOSET ORAL TABLET 0.8 MG (<i>bromocriptine mesylate</i>)	3	
<i>mifepristone oral tablet 300 mg</i>	3	PA; QL (4 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIESTROGENS - Drugs for Women		
<i>anastrozole oral tablet 1 mg</i>	1	H
<i>exemestane oral tablet 25 mg</i>	2	H
<i>letrozole oral tablet 2.5 mg</i>	1	H
ANTIGONADTROPINS - Hormones		
<i>aftera oral tablet 1.5 mg</i>	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (<i>cetrorelix acetate</i>)	3	PA; ST; QL (14 cartons per 21 days.); SMCS; SP
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML, 200 MG/ML (<i>testosterone cypionate</i>)	3	
<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	SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	3	SMCS; SP
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>ganirelix acetate</i>)	3	QL (7 ml per 21 days.); SMCS; SP
<i>ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous</i>	2	QL (7 ml per 21 days.); SMCS; SP
<i>ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous</i>	3	QL (7 ml per 21 days.); SMCS; SP
<i>her style oral tablet 1.5 mg</i>	1	H
KYZATREX ORAL CAPSULE 100 MG (<i>testosterone undecanoate</i>)	3	PA; QL (2 capsules per day.)
KYZATREX ORAL CAPSULE 150 MG, 200 MG (<i>testosterone undecanoate</i>)	3	PA; QL (4 capsules per day.)
<i>levonorgestrel oral tablet 1.5 mg</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.)
<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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORGOVYX ORAL TABLET 120 MG (<i>relugolix</i>)	3	PA; QL (1 tablet per day); SMCS; SP; CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (<i>elagolix-estradiol-norethind</i>)	2	PA; QL (2 capsules per day.)
ORLISSA ORAL TABLET 150 MG (<i>elagolix sodium</i>)	2	PA; QL (1 tablet per day.)
ORLISSA 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>react oral tablet 1.5 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	3	H
<i>take action oral tablet 1.5 mg</i>	1	H
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	2	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day)
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	
<i>testosterone gel 12.5 mg/act (1%) transdermal</i>	3	PA; QL (300 grams (4 pumps) per month)
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	2	PA; QL (150 grams (2 pumps) per month.)
<i>testosterone transdermal gel 1.62 %</i>	2	PA; QL (150 grams (2 pumps) per month.)
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
<i>diazoxide oral suspension 50 mg/ml</i>	3	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (<i>diazoxide</i>)	3	
ANTIPARATHYROID AGENTS - Drugs for Bones		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	3	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	2	
<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>iodine strong oral solution 5 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	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>	2	
<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>	3	
<i>metformin hcl oral tablet 1000 mg, 500 mg</i>	1	
<i>metformin hcl oral tablet 850 mg</i>	1	H
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	2	QL (3 tablets per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	2	QL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	2	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.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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
<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
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
<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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<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
<i>cryselle-28 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	QL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (<i>medroxyprogesterone acetate</i>)	3	QL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	1	QL (3.25 ml per year.); H
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>dolishale oral tablet 90-20 mcg</i>	1	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg</i>	3	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg</i>	1	H
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	3	
<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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>emzahh oral tablet 0.35 mg</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</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>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 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 (norethindrone acet-ethinyl est)	3	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>	3	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>haloette vaginal ring 0.12-0.015 mg/24hr</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>	2	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	2	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
<i>jasmiel oral tablet 3-0.02 mg</i>	3	
<i>jencycla 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>jolessa oral tablet 0.15-0.03 mg</i>	2	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>leena oral tablet 0.5/1/0.5-35 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 est & eth est oral tablet 42-21-21-7 days</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg</i>	2	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, 0.15-30 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
<i>levora 0.15/30 (28) 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 biphas</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>	3	
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	3	
<i>luteria oral tablet 0.1-20 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
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	QL (5 mL per 365 days.); H
<i>meleya oral tablet 0.35 mg</i>	1	H
<i>merzee oral capsule 1-20 mg-mcg(24)</i>	3	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	H
<i>nikki oral tablet 3-0.02 mg</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>nora-be oral tablet 0.35 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	3	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	3	H
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</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, 1.5-30 mg-mcg</i>	1	H
<i>norethindrone oral tablet 0.35 mg</i>	1	H
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<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</i>	2	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 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>ocella oral tablet 3-0.03 mg</i>	3	
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
OPILL ORAL TABLET 0.075 MG (<i>norgestrel</i>)	1	H
<i>option 2 oral tablet 1.5 mg</i>	1	H
<i>orquidea oral tablet 0.35 mg</i>	1	H
<i>philith 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>pimtreea 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
<i>react oral tablet 1.5 mg</i>	1	H
<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
<i>setlakin oral tablet 0.15-0.03 mg</i>	2	H
<i>sharobel oral tablet 0.35 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	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	3	
<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>	3	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>	2	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	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>	2	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</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>	3	
<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>	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H
YAZ ORAL TABLET 3-0.02 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	3	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	3	
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	2	QL (1 tablet per day.)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	ST; 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.)
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>	2	QL (1 tablet per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	2	QL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	2	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-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.)
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
CLOMID ORAL TABLET 50 MG (<i>clomiphene citrate</i>)	2	
<i>clomiphene citrate oral tablet 50 mg</i>	2	
DUAVEE ORAL TABLET 0.45-20 MG (<i>conj estrogens-bazedoxifene</i>)	3	QL (1 tablet per day.)
OSPHENA ORAL TABLET 60 MG (<i>ospemifene</i>)	3	PA; QL (1 tablet per day.)
<i>raloxifene hcl oral tablet 60 mg</i>	2	H
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H
<i>toremifene citrate oral tablet 60 mg</i>	2	CM
ESTROGENS - Drugs for Women		
<i>abigale lo oral tablet 0.5-0.1 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (estradiol-norethindrone acet)	3	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (estradiol)	3	QL (8 patches (1 box) per 28 days.)
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (drospirenone-estradiol)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (segesterone-ethinyl estradiol)	3	QL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 & 0.01 mg	1	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (estradiol-progesterone)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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-28 oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 & 0.01 mg	1	H
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (estradiol valerate)	3	
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	3	
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (estradiol)	3	
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	2	QL (8 patches (1 box) per 28 days.)
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg	3	H
drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	3	
<i>DUAVEE ORAL TABLET 0.45-20 MG (conj estrogens-bazedoxifene)</i>	3	QL (1 tablet per day.)
<i>EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %</i>	3	PA
<i>EEMT HS ORAL TABLET 0.625-1.25 MG (est estrogens-methyltest)</i>	3	
<i>EEMT ORAL TABLET 1.25-2.5 MG (est estrogens-methyltest)</i>	2	
<i>ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (estradiol)</i>	3	
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H
<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	
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>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</i>	3	
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	3	QL (50 grams (1 box) per month.)
<i>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</i>	2	QL (8 patches (1 box) per 28 days.)
<i>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</i>	1	QL (4 patches (1 carton) per 28 days.)
<i>estradiol vaginal cream 0.1 mg/gm</i>	3	
<i>estradiol vaginal tablet 10 mcg</i>	2	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>estradiol-norethindrone acet oral tablet 0.5-0.1 mg</i>	2	
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	1	
<i>estratest f.s. oral tablet 1.25-2.5 mg</i>	1	
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.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (<i>estradiol</i>)	3	QL (50 grams (1 box) per month.)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	1	H
<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	
<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	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>	3	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>haloette vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	2	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG (<i>estradiol</i>)	2	QL (0.29 vaginal insert per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (estradiol)	2	QL (0.29 insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (estradiol)	2	QL (18 inserts per year.)
<i>introvale oral tablet 0.15-0.03 mg</i>	2	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
<i>jasmiel oral tablet 3-0.02 mg</i>	3	
<i>jinteli oral tablet 1-5 mg-mcg</i>	1	
<i>jolessa oral tablet 0.15-0.03 mg</i>	2	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>leena oral tablet 0.5/1/0.5-35 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 est & eth est oral tablet 42-21-21-7 days</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg	1	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	2	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg	1	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	3	
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	3	
lutra oral tablet 0.1-20 mg-mcg	1	H
lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (8 patches (1 box) per 28 days.)
marlissa oral tablet 0.15-30 mg-mcg	1	H
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (esterified estrogens)	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (estradiol)	3	QL (4 patches (1 carton) per 28 days.)
merzee oral capsule 1-20 mg-mcg(24)	3	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	1	
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-linyah oral tablet 0.25-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	H
<i>nikki oral tablet 3-0.02 mg</i>	3	
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	3	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	3	H
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</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, 1.5-30 mg-mcg</i>	1	H
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<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</i>	2	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ocella oral tablet 3-0.03 mg	3	
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; QL (2 capsules per day.)
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens conjugated)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (estrogens, conjugated)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (conj estrogen-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 estrogen-medroxyprogest ace)	3	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
setlakin oral tablet 0.15-0.03 mg	2	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 & 0.01 mg	1	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	3	
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	3	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	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>	2	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	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</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>	3	
<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>	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H
YAZ ORAL TABLET 3-0.02 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H
<i>yuvaferm vaginal tablet 10 mcg</i>	2	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	3	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GLYCOGENOLYTIC AGENTS - Hormones		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<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 kit 1 mg</i>	2	QL (2 boxes per prescription.)
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	QL (2 boxes per prescription.)
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	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	2	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	SMCS
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (<i>follitropin beta</i>)	2	PA; QL (5.4 mL per 21 days.); SMCS; SP
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.); SMCS; SP
GONAL-F INJECTION SOLUTION RECONSTITUTED 1050 UNIT, 450 UNIT (<i>follitropin alfa</i>)	3	PA; ST; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/0.5ML, 450 UNT/0.75ML, 900 UNT/1.44ML (<i>follitropin alfa</i>)	3	PA; ST; SMCS; SP
GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>follitropin alfa</i>)	3	PA; ST; SMCS; SP
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SMCS
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>menotropins</i>)	3	PA; QL (6 vials per day.); SMCS; SP
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>chorionic gonadotropin</i>)	3	SMCS; SP
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>choriogonadotropin alfa</i>)	3	SMCS; SP
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (<i>chorionic gonadotropin</i>)	3	SMCS
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	2	
INCRETIN MIMETICS - Drugs for Diabetes		
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	2	PA; QL (2.4 ml (one pen) per month.)
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	2	PA; QL (1.2 ml (one pen) per month.)
<i>liraglutide solution pen-injector 18 mg/3ml subcutaneous</i>	2	PA; QL (If member has previous history of Victoza, then member may be eligible to receive 9ml (3 pens) per month (only applies to 3 pack NDC-00169406013). This medication is over-rideable.)
<i>liraglutide solution pen-injector 18 mg/3ml subcutaneous</i>	3	PA; QL (If member has previous history of Victoza, then member may be eligible to receive 9ml (3 pens) per month (only applies to 3 pack NDC-00169406013). This medication is over-rideable.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 2 MG/3ML (semaglutide)	2	PA
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (semaglutide)	2	PA; QL (3 ml per month.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (semaglutide)	2	PA; QL (1 tablet per day.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (liraglutide -weight management)	3	PA; QL (0.6 ml per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (insulin glargine-lixisenatide)	2	QL (18 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (dulaglutide)	2	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (dulaglutide)	2	PA; QL (2 mL per month.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (semaglutide-weight management)	3	PA; QL (0.08 ml per day and 4 ml per 365 days.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (semaglutide-weight management)	3	PA; QL (0.11 ml per day.)
ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (tirzepatide-weight management)	3	PA
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (tirzepatide-weight management)	3	PA; QL (4 pens per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (tirzepatide-weight management)	3	PA; QL (4 pens per month and 8 pens per year.)
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (insulin nph isophane & regular)	2	QL (75 ml per prescription.)
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (insulin nph isophane & regular)	1	QL (70 ml per prescription.)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (insulin nph human (isophane))	2	QL (75 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	1	QL (70 ml per prescription.)
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (<i>metreleptin</i>)	3	PA; QL (0.9 vial per day.); SMCS; SP
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.)
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	1	QL (70 ml per prescription.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	2	QL (18 ml per month.)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	2	QL (75 ml per prescription.)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	2	QL (37.5 ml per prescription.)
MEGLITINIDES - Drugs for Diabetes		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	2	QL (3 tablets per day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	2	QL (4 tablets per day)
<i>repaglinide oral tablet 2 mg</i>	2	QL (8 tablets per day)
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	3	PA; SMCS; SP
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA; SMCS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	3	PA; SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (<i>palopegteriparatide</i>)	3	PA; QL (2 pens (1.12 mL) per 28 days.); SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (<i>palopegteriparatide</i>)	3	PA; QL (2 pens (1.96 mL) per 28 days.); SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (<i>palopegteriparatide</i>)	3	PA; QL (2 pens (2.8 mL) per 28 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (<i>corticotropin</i>)	3	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (21 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (20 ml per 24 days.); SMCS; SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; SMCS; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	3	PA; ST; QL (20 ml per 24 days.); SMCS; SP
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>crinecerfont</i>)	3	PA; QL (62 capsules per month.); SMCS; SP
CRENESSITY ORAL SOLUTION 50 MG/ML (<i>crinecerfont</i>)	3	PA; QL (120 mL (4 bottles) per month.); SMCS; SP
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<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	PA; QL (0.172 ml per day.); SMCS; SP
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.); SMCS
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML (<i>somatropin</i>)	2	PA; QL (9 mL per month.); SMCS; SP
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (<i>somatropin</i>)	2	PA; QL (16 vials per month.); SMCS; SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	3	PA; QL (1 vial per day.); SMCS; SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (<i>lonapegsomatropin-tcgd</i>)	3	PA; QL (0.143 cartridge per day.); SMCS; SP
PROGESTINS - Drugs for Women		
<i>abigale lo oral tablet 0.5-0.1 mg</i>	2	
<i>abigale oral tablet 1-0.5 mg</i>	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (<i>estradiol-norethindrone acet</i>)	3	
<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
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
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (estradiol-progesterone)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	1	H
camrese oral tablet 0.15-0.03 & 0.01 mg	1	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (estradiol-levonorgestrel)	3	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (estradiol-norethindrone acet)	3	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (progesterone)	3	ST
cryselle-28 oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 & 0.01 mg	1	H
deblitane oral tablet 0.35 mg	1	H
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (medroxyprogesterone acetate)	3	QL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (medroxyprogesterone acetate)	3	QL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (medroxyprogesterone acetate)	1	QL (3.25 ml per year.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg	3	H
drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	3	
econtra one-step oral tablet 1.5 mg	1	H
EC-RX PROGESTERONE TRANSDERMAL CREAM 10 %, 20 %	3	PA
elinest oral tablet 0.3-30 mg-mcg	1	H
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	1	QL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
emzahh oral tablet 0.35 mg	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (<i>progesterone</i>)	2	
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H
errin oral tablet 0.35 mg	1	H
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol-norethindrone acet oral tablet 0.5-0.1 mg	2	
estradiol-norethindrone acet oral tablet 1-0.5 mg	1	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	3	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-PROGESTERONE VGS VAGINAL SUPPOSITORY 100 MG, 200 MG (<i>progesterone</i>)	3	PA
<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>	3	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>haloette vaginal ring 0.12-0.015 mg/24hr</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>	2	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	2	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
<i>jasmiel oral tablet 3-0.02 mg</i>	3	
<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>	2	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>leena oral tablet 0.5/1/0.5-35 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 est & eth est oral tablet 42-21-21-7 days</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg</i>	2	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, 0.15-30 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
<i>levora 0.15/30 (28) oral tablet 0.15-30 mg-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
<i>loryna oral tablet 3-0.02 mg</i>	3	
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	3	
<i>lutra oral tablet 0.1-20 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml	1	
megestrol acetate oral suspension 625 mg/5ml	3	
megestrol acetate oral tablet 20 mg, 40 mg	1	
meleya oral tablet 0.35 mg	1	H
merzee oral capsule 1-20 mg-mcg(24)	3	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	1	
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-lynyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix-estradiol-norethind)	2	PA; QL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (estradiol valerate-dienogest)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (drospirenone-estetrol)	3	H
nikki oral tablet 3-0.02 mg	3	
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	3	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</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, 1.5-30 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>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<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</i>	2	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 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>ocella oral tablet 3-0.03 mg</i>	3	
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
OPILL 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.)
<i>orquidea oral tablet 0.35 mg</i>	1	H
<i>philith 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>pimtreea 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	
PROGESTERONE MICRONIZED TRANSDERMAL CREAM 10 %	3	PA
<i>progesterone oral capsule 100 mg, 200 mg</i>	2	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>medroxyprogesterone acetate</i>)	3	
<i>react oral tablet 1.5 mg</i>	1	H
<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
<i>setlakin oral tablet 0.15-0.03 mg</i>	2	H
<i>sharobel oral tablet 0.35 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	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	3	
<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>	3	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-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>	2	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	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>	2	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	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</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>	3	
<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>	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H
YAZ ORAL TABLET 3-0.02 MG (<i>drospirenone-ethinyl estradiol</i>)	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	3	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	3	
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.)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml (25 pens) per prescription.)
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.)
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.)
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	1	QL (70 ml per prescription.)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.)
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.)
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.)
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	QL (70 ml per prescription.)
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.)
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	QL (75 ml per prescription.)
KIRSTY INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart-xjhz</i>)	3	
KIRSTY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart-xjhz</i>)	3	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin lispro-aabc</i>)	2	QL (75 ml per prescription.)
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro-aabc</i>)	1	QL (70 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.)
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	1	QL (70 ml per prescription.)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	2	QL (75 mL per prescription.)
HUMULIN R U-500 VIAL SUBCUTANEOUS SOLUTION 500 UNIT/ML (<i>insulin regular human</i>)	1	QL (80 ml per prescription.)
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	1	QL (70 ml per prescription.)
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (<i>insulin regular(human) in nacl</i>)	3	
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	2	ST; QL (75 ml per prescription.)
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	2	ST; QL (75 ml per prescription.)
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (<i>bexagliflozin</i>)	3	ST; QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	ST; 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linaglip-metform</i>)	2	QL (2 tablets per day.)
SOMATOSTATIN AGONISTS - Hormones		
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA; SMCS
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA; SMCS
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (<i>pasireotide diaspertate</i>)	3	PA; QL (2 ampules per day.); SMCS; SP
SOMATOTROPIN AGONISTS - Hormones		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (<i>tesamorelin acetate</i>)	3	PA; QL (1 vial per day.); SMCS
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (<i>tesamorelin acetate</i>)	3	SMCS; SP
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (<i>mecasermin</i>)	2	PA; QL (52 vials per month.); SMCS; SP
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.); SMCS
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML (<i>somatropin</i>)	2	PA; QL (9 mL per month.); SMCS; SP
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (13.5 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	2	PA; QL (27 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (<i>somatropin</i>)	2	PA; QL (16 vials per month.); SMCS; SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	3	PA; QL (1 vial per day.); SMCS; SP
SOMATOTROPIN ANTAGONISTS - Hormones		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (<i>pegvisomant</i>)	3	PA; QL (1 vial per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (<i>pioglitazone hcl-glimepiride</i>)	3	QL (1 tablet per day)
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<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>	2	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 5 MG (<i>glipizide</i>)	3	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	1	
<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	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>	2	QL (3 tablets per day)
THYROID AGENTS - Drugs for the Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (<i>thyroid</i>)	3	
ERMEZA ORAL SOLUTION 150 MCG/5ML (<i>levothyroxine sodium</i>)	2	PA
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	2	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	2	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (thyroid)	3	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (resmetirom)	3	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 solution prefilled syringe 20 mg/ml subcutaneous	1	PA; QL (30 ml per month.); SMCS
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	2	PA; QL (30 ml per month.); SMCS
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	1	PA; QL (12 ml per 21 days.); SMCS
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	2	PA; QL (12 ml per 21 days.); SMCS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	2	PA; QL (30 ml per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	2	PA; QL (12 ml per 21 days.); SMCS
ANTIMETABOLITES		
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
<i>teriflunomide oral tablet 14 mg</i>	2	PA; QL (1 tablet per day.); SMCS
<i>teriflunomide oral tablet 7 mg</i>	2	PA; QL (31 tablets per month.); SMCS
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine oral tablet 50 mg</i>	1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	1	
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>engraf oral capsule 100 mg, 25 mg</i>	1	
<i>engraf oral solution 100 mg/ml</i>	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3	PA
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	3	PA; QL (60 vials per prescription.)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	2	QL (30 grams per prescription.)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	3	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.); SMCS; SP
TAVNEOS ORAL CAPSULE 10 MG (<i>avacopan</i>)	3	PA; QL (6 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (<i>zilucoplan sodium</i>)	3	PA; QL (0.416 ml per day.); SMCS; SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (<i>zilucoplan sodium</i>)	3	PA; QL (0.574 ml per day.); SMCS; SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (<i>zilucoplan sodium</i>)	3	PA; QL (0.81 ml per day.); SMCS; SP
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.); SMCS; SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	3	PA; ST; QL (4 autoinjectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	3	PA; ST; QL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (<i>abatacept</i>)	3	PA; ST; QL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (<i>abatacept</i>)	3	PA; ST; QL (0.1 ml per day.); SMCS; SP
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3	
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3	PA; 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 10 MG/0.2ML (<i>methotrexate (anti-rheumatic)</i>)	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (<i>methotrexate (anti-rheumatic)</i>)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	SMCS; SP
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
TREMFYA CROHNS INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	2	PA; QL (4 ml (2 pens/1 box) per month.); SMCS
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	2	PA; QL (2ml (1 auto-injector) per month.); SMCS
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 syringe) every 8 weeks.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	2	PA; QL (2ml (1 syringe) per month.); 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	PA; QL (4 ml per day.); CM
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	2	PA; QL (4 capsules per day.); SMCS; SP
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; QL (56 capsules per year.); SMCS
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; QL (2 capsules per day.); 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.); SMCS
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.); SMCS; SP
IMMUNOMODULATORY AGENTS (90:00)		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	3	
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>everolimus oral tablet 2.5 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; CM
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	1	SMCS; SP; CM
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	3	SMCS; SP; CM
<i>torpenz oral tablet 10 mg, 7.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP; CM
<i>torpenz oral tablet 2.5 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP; 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.); SMCS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	2	PA; QL (4 syringes (1 box) per month.); SMCS; SP
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	2	PA; QL (14 vials per month.); SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	2	SMCS; SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	2	SMCS; SP
INTERLEUKIN INHIBITOR AGENTS, MISC		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (2 auto injectors per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	3	PA; ST; SMCS; SP
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	3	PA; ST; SMCS; SP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-kfce</i>)	2	PA; QL (1 single-dose vial every 3 months.); SMCS; SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-kfce</i>)	2	PA; QL (1 syringe every 3 months.); SMCS; SP
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
OLUMIANT ORAL TABLET 1 MG, 4 MG (<i>baricitinib</i>)	3	PA; ST; QL (1 tablet per day.); SMCS
OLUMIANT ORAL TABLET 2 MG (<i>baricitinib</i>)	3	PA; ST; QL (1 tablet per day.); SMCS; SP
RINVOQ LQ ORAL SOLUTION 1 MG/ML (<i>upadacitinib</i>)	2	PA; QL (360 mL (2 bottles) per month.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	2	PA; QL (84 tablets per 365 days.); SMCS; SP
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	2	PA; QL (8 mL per day.); SMCS; SP
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.); SMCS
MONOCARBOXYLIC ACID AMIDE AGENTS		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>satralizumab-mwge</i>)	3	PA; QL (0.04 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3	PA; QL (10 g per 23 days.)
<i>sirolimus oral solution 1 mg/ml</i>	2	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	2	PA; QL (60 tablets per month.); SMCS
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack per year.); SMCS
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.); SMCS
GILENYA ORAL CAPSULE 0.25 MG (<i>fingolimod hcl</i>)	3	PA; QL (1 capsule per day.); SMCS
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (4 tablets per day.); SMCS
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT ORAL TABLET 2 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (12 tablets per 365 days.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (7 tablets per 365 days.); SMCS
T-CELL BLOCKERS (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG (<i>voclosporin</i>)	3	PA; QL (6 capsules per day.); SMCS; SP
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA (2 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA-PSORIASIS/UEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	2	PA; QL (3 pens per year.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (<i>tetracaine hcl</i>)	3	
LETS KIT	3	PA
<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>	2	
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	2	
<i>finasteride oral tablet 5 mg</i>	1	
<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	ST
<i>glucagon emergency kit injection kit 1 mg</i>	2	QL (2 boxes per prescription.)
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	QL (2 boxes per prescription.)
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	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	2	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	3	ST
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	
<i>naltrexone hcl oral tablet 50 mg</i>	1	
<i>phytonadione oral tablet 5 mg</i>	3	QL (5 tablets per prescription.)
RADIOGARDASE ORAL CAPSULE 0.5 GM (<i>prussian blue insoluble</i>)	3	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	2	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	2	
<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	
VISTOGARD ORAL PACKET 10 GM (<i>uridine triacetate</i>)	2	QL (20 packets per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 ml per prescription.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	2	QL (1 ml per prescription.)
ANTIGOUT AGENTS - Drugs for Gout		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	
<i>colchicine oral capsule 0.6 mg</i>	2	
<i>colchicine oral tablet 0.6 mg</i>	2	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG (<i>naproxen</i>)	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	3	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (<i>colchicine</i>)	3	PA
INDOCIN ORAL SUSPENSION 25 MG/5ML (<i>indomethacin</i>)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INDOCIN RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	3	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	3	PA
<i>indomethacin rectal suppository 50 mg</i>	3	PA
MITIGARE ORAL CAPSULE 0.6 MG (<i>colchicine</i>)	2	
<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>	2	
<i>probenecid oral tablet 500 mg</i>	1	
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (<i>sodium oxybate</i>)	3	PA; QL (1 packet per day.); SMCS; SP
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	3	PA; QL (1 box (28 packets) per year.); SMCS; SP
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3	PA; QL (18 ml per day.); SMCS; SP
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	3	PA; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (<i>eplontersen sodium</i>)	2	PA; QL (0.029 ml per day.); SMCS; SP
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	3	PA; SMCS; SP
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA; SMCS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	3	PA; SMCS; SP
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
calcitonin (salmon) injection solution 200 unit/ml	3	
calcitonin (salmon) nasal solution 200 unit/act	2	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (estradiol valerate)	3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	3	
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (estradiol)	3	
dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (8 patches (1 box) per 28 days.)
EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %	3	PA
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (estradiol)	3	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm	3	
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	3	QL (50 grams (1 box) per month.)
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (8 patches (1 box) per 28 days.)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 patches (1 carton) per 28 days.)
estradiol vaginal cream 0.1 mg/gm	3	
estradiol vaginal tablet 10 mcg	2	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	
ESTRING VAGINAL RING 7.5 MCG/24HR (estradiol)	2	QL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (estradiol)	3	QL (50 grams (1 box) per month.)
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (estradiol)	2	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (estradiol acetate)	3	QL (1 ring per 3 months.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FOSAMAX ORAL TABLET 70 MG (<i>alendronate sodium</i>)	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (<i>alendronate-cholecalciferol</i>)	3	
<i>ibandronate sodium oral tablet 150 mg</i>	2	
<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>	2	QL (8 patches (1 box) per 28 days.)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (<i>esterified estrogens</i>)	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (<i>estradiol</i>)	3	QL (4 patches (1 carton) per 28 days.)
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (<i>calcitonin (salmon)</i>)	3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (<i>estrogens conjugated</i>)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	3	
<i>raloxifene hcl oral tablet 60 mg</i>	2	H
<i>risedronate sodium oral tablet 150 mg</i>	3	QL (1 tablet per month)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	3	
<i>risedronate sodium oral tablet 35 mg</i>	3	QL (4 tablets per 28 days.)
<i>yuvaferm vaginal tablet 10 mcg</i>	2	
BRADYKININ RECEPTOR ANTAGONISTS		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	2	PA; QL (0.6 ml per day.); SMCS; SP
CARBONIC ANHYDRASE INHIBITORS (MISC.)		
<i>dichlorphenamide oral tablet 50 mg</i>	2	PA; QL (4 tablets per day.); SMCS; SP
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	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	3	
EASYGEL DENTAL GEL 0.4 % (<i>stannous fluoride</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (sodium fluoride-vitamin d)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (pediatric multivitamins-fl)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (stannous fluoride)	3	
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	
FRAICHE 5000 DENTAL DENTAL GEL 1.1 %	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (ped multivitamins-fl-iron)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (ped multivitamins-fl-iron)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (sodium fluoride)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	3	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (pediatric multivitamins-fl)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	
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	PA; ST; QL (0.4 boxes per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	2	PA; QL (0.018 ml per day.); SMCS; SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
<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	SMCS; SP
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA-PSORIASIS/UEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	2	PA; QL (3 pens per year.); SMCS; SP
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3	PA; CM
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	3	PA; ST; QL (2.28 ml per month.); SMCS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	3	PA; ST; QL (2.28 ml per month.); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	3	PA; ST; QL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
OLUMIANT ORAL TABLET 1 MG, 4 MG (baricitinib)	3	PA; ST; QL (1 tablet per day.); SMCS
OLUMIANT ORAL TABLET 2 MG (baricitinib)	3	PA; ST; QL (1 tablet per day.); SMCS; SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	3	PA; ST; QL (4 autoinjectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	3	PA; ST; QL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (abatacept)	3	PA; ST; QL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (abatacept)	3	PA; ST; QL (0.1 ml per day.); SMCS; SP
OTEZLA ORAL TABLET 30 MG (apremilast)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
penicillamine oral tablet 250 mg	2	SMCS; SP
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (methotrexate (anti-rheumatic))	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (methotrexate (anti-rheumatic))	2	QL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (methotrexate (anti-rheumatic))	2	QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (methotrexate (anti-rheumatic))	2	QL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (methotrexate (anti-rheumatic))	2	QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (methotrexate (anti-rheumatic))	2	QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (methotrexate (anti-rheumatic))	2	QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (methotrexate (anti-rheumatic))	2	QL (2.4 ml (4 auto-injectors) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (<i>methotrexate (anti-rheumatic)</i>)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	2	PA; QL (84 tablets per 365 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 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	PA; QL (4 ml per day.); CM
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	2	PA; QL (8 mL per day.); SMCS; SP
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (<i>tofacitinib citrate</i>)	2	PA; QL (1 tablet per day.); SMCS
IGA NEPHROPATHY		
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3	PA; QL (1 tablet per day.); SMCS; SP
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	3	PA; QL (30 tablets per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	3	PA; ST; QL (3.6 ml per 21 days.); SMCS; SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	3	PA; ST; QL (4 syringes (3.6 ml) per month.); SMCS; SP
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (<i>interferon gamma-1b</i>)	2	PA; QL (8.5 mls per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	2	PA; SMCS; SP
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	2	PA; QL (4 pens (1 box) per month.); SMCS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	2	PA; QL (4 syringes (1 box) per month.); SMCS; SP
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	3	
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	3	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	2	PA; QL (4 capsules per day.); SMCS; SP
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>ropeginterferon alfa-2b-njft</i>)	3	PA; QL (0.08 ml per day.); SMCS; SP; CM
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	2	PA; QL (14 vials per month.); SMCS
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	2	PA; QL (1 kit per 21 days.); SMCS; SP
<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>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; QL (56 capsules per year.); SMCS
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; QL (2 capsules per day.); 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.); SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>satralizumab-mwge</i>)	3	PA; QL (0.04 ml per day.); SMCS; SP
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
gengraf oral solution 100 mg/ml	1	
GILENYA ORAL CAPSULE 0.25 MG (<i>fingolimod hcl</i>)	3	PA; QL (1 capsule per day.); SMCS
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	1	PA; QL (30 ml per month.); SMCS
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	2	PA; QL (30 ml per month.); SMCS
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	1	PA; QL (12 ml per 21 days.); SMCS
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	2	PA; QL (12 ml per 21 days.); SMCS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	2	PA; QL (30 ml per month.); SMCS
glatopa subcutaneous solution prefilled syringe 40 mg/ml	2	PA; QL (12 ml per 21 days.); SMCS
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	2	PA; QL (4 pens per 365 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA-PSORIASIS/VEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	2	PA; QL (3 pens per year.); SMCS; SP
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JOENJA ORAL TABLET 70 MG (<i>leniolisib phosphate</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (<i>ofatumumab</i>)	2	PA; QL (0.02 ml per day.); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	3	PA; ST; QL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	2	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
lenalidomide oral capsule 20 mg, 25 mg	2	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (4 tablets per day.); SMCS
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT ORAL TABLET 2 MG (<i>siponimod fumarate</i>)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (12 tablets per 365 days.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; QL (7 tablets per 365 days.); SMCS
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	3	PA; ST; QL (4 autoinjectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	3	PA; ST; QL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (abatacept)	3	PA; ST; QL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (abatacept)	3	PA; ST; QL (0.1 ml per day.); SMCS; SP
OTEZLA ORAL TABLET 20 MG (apremilast)	2	PA; QL (60 tablets per month.); SMCS
OTEZLA ORAL TABLET 30 MG (apremilast)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (apremilast)	2	PA; QL (1 starter pack per year.); SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	2	SMCS; SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (peginterferon alfa-2a)	2	SMCS; SP
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (peginterferon beta-1a)	3	PA; QL (1 ml per month.); SMCS
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (peginterferon beta-1a)	3	PA; QL (2 ml per year without additional quantity notification.); SMCS; SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (peginterferon beta-1a)	3	PA; QL (2 ml per year without additional quantity notification.); SMCS; SP
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (peginterferon beta-1a)	3	PA; QL (1 ml per month.); SMCS; SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (peginterferon beta-1a)	3	PA; QL (1 ml per month.); SMCS; SP
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	3	PA; QL (21 capsules per 21 days.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>lenalidomide</i>)	2	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 20 MG, 25 MG (<i>lenalidomide</i>)	2	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
RIDAURA ORAL CAPSULE 3 MG (<i>auranofin</i>)	3	SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	2	PA; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	2	PA; QL (0.5 ml (1 syringe) per month); SMCS; SP
<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>	2	PA; QL (1 tablet per day.); SMCS
<i>teriflunomide oral tablet 7 mg</i>	2	PA; QL (31 tablets per month.); SMCS
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	2	PA; QL (28 capsules per prescription.); SMCS; SP; CM
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	PA; QL (4 ml per day.); CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (<i>ozanimod hcl</i>)	3	PA; ST; QL (7 capsules per year.); SMCS
ZEPOSIA ORAL CAPSULE 0.92 MG (<i>ozanimod hcl</i>)	3	PA; ST; QL (1 capsule per day.); SMCS
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) (<i>ozanimod hcl</i>)	3	PA; ST; QL (1 starter kit (28 capsules) per year.); SMCS
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	3	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine 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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.); SMCS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	2	PA; QL (4 ml per month.); SMCS; SP
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
<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>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	3	
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	3	PA; CM
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
LUPKYNIS ORAL CAPSULE 7.9 MG (<i>voclosporin</i>)	3	PA; QL (6 capsules per day.); SMCS; SP
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	1	SMCS; SP; 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>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>mycophenolic acid oral tablet delayed release 180 mg, 360 mg</i>	2	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (<i>mycophenolate mofetil</i>)	1	
<i>pimecrolimus external cream 1 %</i>	3	QL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	3	SMCS; SP; CM
<i>sirolimus oral solution 1 mg/ml</i>	2	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	2	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	PA; QL (4 ml per day.); CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.0375 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (<i>levacetylleucine</i>)	3	PA; QL (112 packets per month.); SMCS; SP
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	2	PA; QL (4 vials per 21 days.); SMCS; SP
<i>betaine oral powder</i>	2	SMCS; SP
CARNITOR ORAL SOLUTION 1 GM/10ML (<i>levocarnitine</i>)	3	
CARNITOR ORAL TABLET 330 MG (<i>levocarnitine</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CARNITOR SF ORAL SOLUTION 1 GM/10ML (<i>levocarnitine</i>)	3	
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	2	PA; SMCS; SP
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (<i>prenat-fecb-fefum-fa-dha w/o a</i>)	3	
COMPLEX ESSENTIAL MSD ORAL POWDER (<i>nutritional supplements</i>)	3	
CYSTADANE ORAL POWDER (<i>betaine</i>)	3	SMCS; SP
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (<i>cysteamine bitartrate</i>)	2	SMCS; SP
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	2	PA; QL (2 tablets per day); SMCS
DEMSEER ORAL CAPSULE 250 MG (<i>metirosine</i>)	3	PA
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	PA; QL (420 mL per month.); SMCS; SP
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (<i>prasterone (dhea)</i>)	3	
ELMIRON ORAL CAPSULE 100 MG (<i>pentosan polysulfate sodium</i>)	3	ST
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	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.); SMCS; SP
EVRYSDI ORAL TABLET 5 MG (<i>risdiplam</i>)	2	PA; QL (30 tablets per month.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3	PA; QL (1 tablet per day.); SMCS; SP
FIRDAPSE ORAL TABLET 10 MG (<i>amifampridine phosphate</i>)	2	PA; QL (300 tablets per month.); SMCS; SP
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	3	PA; QL (14 capsules per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ISTURISA ORAL TABLET 1 MG (<i>osilodrostat phosphate</i>)	3	PA; QL (8 tablets per day.); SMCS; SP
ISTURISA ORAL TABLET 5 MG (<i>osilodrostat phosphate</i>)	3	PA; QL (372 tablets per month.); SMCS; SP
<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>	3	PA; QL (6 packets per day.)
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	3	QL (1 tablet per day.)
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>metyrosine oral capsule 250 mg</i>	3	PA
<i>miglustat oral capsule 100 mg</i>	2	SMCS
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.); SMCS; SP
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	2	PA; SMCS; SP
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	2	PA; SMCS; SP
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	
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	
PREZCOBIX ORAL TABLET 800-150 MG (<i>darunavir-cobicistat</i>)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (<i>cysteamine bitartrate</i>)	3	PA; ST; SMCS; SP
PROCYSBI ORAL PACKET 300 MG, 75 MG (<i>cysteamine bitartrate</i>)	3	SMCS; SP
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (<i>belumosudil mesylate</i>)	3	PA; QL (1 tablet per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (<i>nedosiran sodium</i>)	3	PA; QL (0.04 ml per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (<i>nedosiran sodium</i>)	3	PA; QL (0.03 ml per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>nedosiran sodium</i>)	3	PA; QL (0.04 ml per day.); SMCS; SP
<i>sapropterin dihydrochloride oral packet 100 mg</i>	2	PA; QL (16 packets per day.); SMCS; SP
<i>sapropterin dihydrochloride oral packet 500 mg</i>	2	PA; QL (4 packets per day.); SMCS; SP
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	2	PA; QL (16 tablets per day.); SMCS; SP
SKYCLARYS ORAL CAPSULE 50 MG (<i>omaveloxolone</i>)	2	PA; QL (3 capsules per day.); SMCS; SP
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (<i>palovarotene</i>)	3	PA; QL (1 capsule per day.); SMCS; SP
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	2	QL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	2	QL (1 tablet per day.)
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG (<i>tiopronin</i>)	3	SMCS; SP
THIOLA ORAL TABLET 100 MG (<i>tiopronin</i>)	3	SMCS; SP
<i>tiopronin oral tablet 100 mg</i>	2	SMCS; SP; CM
<i>tiopronin oral tablet delayed release 100 mg, 300 mg</i>	2	SMCS; SP; CM
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	3	
uretron d/s oral tablet 81.6 mg	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	PA; QL (28 packets (1 carton) per month.); SMCS; SP
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (<i>alpelisib</i>)	3	PA; QL (28 tablets (1 blister pack) per month.); SMCS; SP
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (<i>alpelisib</i>)	3	PA; QL (56 tablets (2 blister packs) per month.); SMCS; SP
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	PA; QL (12 capsules per 365 days.); SMCS; SP
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (<i>vosoritide</i>)	3	PA; QL (1 vial per day.); SMCS; SP
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	2	PA; QL (1 capsule per day.); SMCS; SP
VYNDAQEL ORAL CAPSULE 20 MG (<i>tafamidis meglumine (cardiac)</i>)	2	PA; QL (4 capsules per day.); SMCS; SP
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
XURIDEN ORAL PACKET 2 GM (<i>uridine triacetate</i>)	2	PA; QL (30 packets per month.); SMCS; SP
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	2	PA; QL (5 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP
PROTECTIVE AGENTS		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	3	QL (45 grams per prescription)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	3	QL (45 grams per prescription.)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	2	PA; QL (2 tablets per day); SMCS
<i>mesna oral tablet 400 mg</i>	2	SMCS; SP; CM
MESNEX ORAL TABLET 400 MG (<i>mesna</i>)	3	SMCS; SP; CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	3	H
CONDOMS	3	QL (1 box of 12 condoms per 30 days.); H
DUREX EXTRA SENSITIVE THIN (<i>condoms latex lubricated</i>)	3	QL (1 box of 12 condoms per 30 days.); H
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	3	QL (1 box of 12 condoms per 30 days.); H
DUREX TROPICAL (<i>condoms latex lubricated</i>)	3	QL (1 box of 12 condoms per 30 days.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (<i>nonoxynol-9</i>)	E	H
FC2 FEMALE CONDOM (<i>condoms - female</i>)	E	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
PHEXXI VAGINAL GEL 1.8-1-0.4 % (<i>lactic ac-citric ac-pot bitart</i>)	3	H
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	E	H
TRUE COVER DEVICE	3	QL (1 box of 12 condoms per 30 days.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 FILM 28 % (<i>nonoxynol-9</i>)	E	H
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	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (<i>transdermal base</i>)	3	
RESPIRATORY TRACT AGENTS		
DUAL PHOSPHODIESTERASE INHIBITOR (48:34)		
OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (<i>ensifentrine</i>)	3	PA; QL (150 mL per month.)
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl</i> (<i>nasal</i>))	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (<i>epinephrine</i>)	2	QL (2 pens per prescription.)
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.)
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml</i>	1	QL (2 injections per prescription.)
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.)
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (<i>epinephrine</i>)	3	QL (2 injections per prescription.)
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	QL (0.87 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	3	QL (0.28 grams per day.)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (<i>aclidinium br- formoterol fum</i>)	3	QL (0.04 mcg per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (hyoscyamine sulfate)	3	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	3	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (hyoscyamine sulfate)	3	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (hyoscyamine sulfate)	3	
OSCIMIN ORAL TABLET 0.125 MG	3	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (tiotropium bromide monohydrate)	2	QL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (tiotropium bromide monohydrate)	2	QL (0.15 grams per day.)
YUPELRI INHALATION SOLUTION 175 MCG/3ML (revefenacin)	3	PA; QL (3 ml per day.)
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
OFEV ORAL CAPSULE 100 MG, 150 MG (nintedanib esylate)	3	PA; QL (2 capsules per day.); SMCS; SP
pirfenidone oral capsule 267 mg	2	PA; QL (9 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>pirfenidone oral tablet 267 mg</i>	2	PA; QL (9 tablets per day.); SMCS; SP
<i>pirfenidone oral tablet 534 mg</i>	2	PA; QL (3 tablets per day.); SMCS
<i>pirfenidone oral tablet 801 mg</i>	2	PA; QL (3 tablets per day.); SMCS; SP
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	3	PA; QL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	3	PA; QL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	3	PA; QL (0.015 ml per day.); SMCS
ANTITUSSIVES - Drugs for Cough and Cold		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	1	
<i>bromphen-pseudoeph-dm oral syrup 2-30-10 mg/5ml</i>	1	
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	1	NTT
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<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>	3	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>hydromet oral solution 5-1.5 mg/5ml</i>	1	PA; QL (120 mL per prescription and 360 ml per month.)
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>promethazine-codeine oral solution 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	
CORTICOSTEROIDS (RESPIRATORY TRACT) - 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.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 packet per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	3	QL (2 blisters per day.)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	2	QL (120 ml (2 boxes) per 30 days.)
<i>budesonide inhalation suspension 1 mg/2ml</i>	2	QL (60 ml (1 box) per 30 days.)
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	3	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	2	QL (16 grams (1 bottle) per prescription)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
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.)
<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>	3	QL (17 grams (1 bottle) per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	1	QL (42.4 grams per month.)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.)
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.)
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (<i>vanzacraft-tezacraft-deutivacraft</i>)	3	PA; QL (56 tablets per month.); SMCS; SP
ALYFTREK ORAL TABLET 4-20-50 MG (<i>vanzacraft-tezacraft-deutivacraft</i>)	3	PA; QL (84 tablets per month.); SMCS; SP
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (728 packets per 356 days.); SMCS; SP
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (2 packets per day and 56 packets per 21 days.); SMCS
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (1456 tablets per 356 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (<i>tezacaftor-ivacaftor</i>)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.); SMCS
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.); SMCS; SP
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.); SMCS; SP
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.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.); SMCS; SP
ENDOTHELIN RECEPTOR ANTAGONISTS - Drugs for the Lungs		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	3	PA; QL (1 tablet per day.); SMCS; SP
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	2	PA; QL (4 tablets per day.); SMCS; SP
TRYVIO ORAL TABLET 12.5 MG (<i>aprocitentan</i>)	3	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	3	PA; QL (30 tablets per month.); SMCS; SP
EXPECTORANTS - Drugs for the Lungs		
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>iodine strong oral solution 5 %</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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>clemastine fumarate oral tablet 2.68 mg</i>	1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (<i>diphenhydramine hcl</i>)	3	PA
<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 syrup 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.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.); SMCS; SP
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	3	PA; QL (1 pen every 2 months.); SMCS
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	3	PA; QL (0.07 ml per day.); SMCS; SP
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
ACCOLATE ORAL TABLET 10 MG, 20 MG (<i>zafirlukast</i>)	3	
<i>montelukast sodium oral packet 4 mg</i>	2	
<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>	3	
ZYFLO ORAL TABLET 600 MG (<i>zileuton</i>)	3	
MAST-CELL STABILIZERS - Drugs for Inflammation		
ALOCRIAL OPHTHALMIC SOLUTION 2 % (<i>nedocromil sodium</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	
<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.); SMCS; SP
<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>	3	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	2	QL (16 grams (1 bottle) per prescription)
<i>mometasone furoate nasal suspension 50 mcg/act</i>	3	QL (17 grams (1 bottle) per prescription)
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.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	1	QL (1 packet per day.)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	2	QL (120 ml (2 boxes) per 30 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
budesonide inhalation suspension 1 mg/2ml	2	QL (60 ml (1 box) per 30 days.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	1	QL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (beclomethasone diprop hfa)	1	QL (42.4 grams per month.)
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
roflumilast oral tablet 250 mcg	2	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	2	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (roflumilast)	3	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (roflumilast)	3	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (roflumilast)	3	PA; QL (60 grams per prescription.)
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
alyq oral tablet 20 mg	2	PA; QL (2 tablets per day); SMCS; SP
sildenafil citrate oral suspension reconstituted 10 mg/ml	3	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	2	QL (0.5 tablet per day.)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
tadalafil oral tablet 10 mg, 20 mg	2	QL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	2	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (tadalafil (pah))	3	PA; QL (10 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	PA; QL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3	PA; QL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	3	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	3	PA; QL (6 tablets per day.); SMCS; SP
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (<i>iloprost</i>)	2	PA; SMCS; SP
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (<i>mannitol (cystic fibrosis)</i>)	3	PA; ST; QL (20 capsules per day.); SMCS; SP; CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (<i>mannitol (cystic fibrosis)</i>)	3	PA; ST; QL (20 capsules per day.); SMCS; SP; CM
<i>pirfenidone oral capsule 267 mg</i>	2	PA; QL (9 capsules per day.); SMCS; SP
<i>pirfenidone oral tablet 267 mg</i>	2	PA; QL (9 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>pirfenidone oral tablet 534 mg</i>	2	PA; QL (3 tablets per day.); SMCS
<i>pirfenidone oral tablet 801 mg</i>	2	PA; QL (3 tablets per day.); SMCS; SP
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	3	PA; QL (0.07 ml per day.); SMCS; SP
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (<i>sotatercept-csrk</i>)	3	PA; QL (1 kit every 3 weeks.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (2 auto injectors per month.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	2	PA; QL (0.08 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	2	PA; QL (0.04 ml per day.); SMCS; SP
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	2	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	
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.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per copay.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (18 grams per prescription.)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (6.7 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	2	QL (8.5 grams per prescription.)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	3	PA
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	3	QL (2 nebules per day)
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (arformoterol tartrate)	3	QL (2 nebules per day)
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	3	QL (2 vials per day.)
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	3	QL (90 ml per prescription.)
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	3	QL (30 vials per prescription)
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.)
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (formoterol fumarate)	3	QL (2 vials per day.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (salmeterol xinafoate)	2	QL (1 diskus (60 blisters) per month.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (olodaterol hcl)	2	QL (0.15 grams per day.)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (levalbuterol tartrate)	3	QL (15 grams per prescription.)
VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (riociguat)	2	PA; QL (3 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>alyq oral tablet 20 mg</i>	2	PA; QL (2 tablets per day); SMCS; SP
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	2	PA; QL (1 tablet per day.); SMCS; SP
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	2	PA; QL (2 tablets per day.); SMCS; SP
<i>bosentan oral tablet soluble 32 mg</i>	1	PA; QL (4 tablets per day.); SMCS; SP
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3	PA; QL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	3	PA; QL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	3	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	3	PA; QL (6 tablets per day.); SMCS; SP
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	3	PA; QL (186 ml per month.); SMCS; SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (0.5 tablet per day.)
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.); SMCS
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day); SMCS; SP
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	3	PA; QL (10 ml per day.); SMCS; SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	2	PA; QL (4 tablets per day.); SMCS; SP
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	2	PA; QL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	2	PA; SMCS; SP
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	3	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3	PA; QL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	3	PA; QL (200 tablets per year.); SMCS; SP
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (<i>iloprost</i>)	2	PA; SMCS; SP
VASODILATING AGENTS, MISC - 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.); SMCS; SP
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	3	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3	PA; QL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	3	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	3	PA; QL (200 tablets per year.); SMCS; SP
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 12 hour 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	
SKIN AND MUCOUS MEMBRANE AGENTS		
ANTIPROLIFERANTS		
AMELUZ EXTERNAL GEL 10 % (<i>aminolevulinic acid hcl</i>)	3	
<i>bexarotene external gel 1 %</i>	3	QL (60 grams per prescription.); SMCS; SP
<i>bexarotene oral capsule 75 mg</i>	2	SMCS; 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	ST; QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3	ST; 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.); SMCS; SP
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>)	2	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	3	QL (10 ml per prescription)
<i>brimonidine tartrate external gel 0.33 %</i>	3	PA; QL (30 grams per prescription.)
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	2	QL (10 ml per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
brimonidine tartrate ophthalmic solution 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (brimonidine tartrate-timolol)	2	QL (5 ml per prescription)
MIRVASO EXTERNAL GEL 0.33 % (brimonidine tartrate)	2	PA; QL (30 grams per prescription.)
RHOFADE EXTERNAL CREAM 1 % (oxymetazoline hcl)	3	PA; QL (30 grams per prescription.)
ANTIBACTERIALS (84:04) - Drugs for the Skin		
AMZEEQ EXTERNAL FOAM 4 % (minocycline hcl micronized)	3	QL (30 grams per prescription.)
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (sulfacetamide sodium-sulfur)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (sulfacetamide sodium-sulfur)	3	
AVIDOXY ORAL TABLET 100 MG	3	
azelaic acid external gel 15 %	3	
AZELEX EXTERNAL CREAM 20 % (azelaic acid)	3	QL (30 grams per prescription.)
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (benzoyl peroxide-erythromycin)	2	QL (23.3 grams per prescription.)
benzoyl peroxide-erythromycin external gel 5-3 %	1	QL (23.3 grams per prescription.)
bp 10-1 external emulsion 10-1 %	1	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (clindamycin hcl)	3	
CLEOCIN ORAL CAPSULE 75 MG (clindamycin hcl)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (clindamycin palmitate hcl)	3	
CLEOCIN VAGINAL CREAM 2 % (clindamycin phosphate)	3	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (clindamycin phosphate)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CLEOCIN-T EXTERNAL LOTION 1 % (<i>clindamycin phosphate</i>)	3	
<i>clindacin etz external swab 1 %</i>	1	
<i>clindacin external foam 1 %</i>	3	
<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>	2	
<i>clindamycin phos (once-daily) external gel 1 %</i>	2	QL (75 grams per prescription.)
<i>clindamycin phos (twice-daily) external gel 1 %</i>	2	QL (75 grams per prescription.)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	3	QL (1 bottle (45 grams) per month.)
<i>clindamycin phosphate external foam 1 %</i>	3	
<i>clindamycin phosphate external lotion 1 %</i>	3	
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>clindamycin phosphate vaginal cream 2 %</i>	2	
CLINDESSE VAGINAL CREAM 2 % (<i>clindamycin phosphate (1 dose)</i>)	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (<i>clindamycin-tretinoin-cholesty</i>)	3	PA
<i>dapsone external gel 5 %, 7.5 %</i>	3	QL (60 grams per prescription.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg</i>	2	
<i>doxycycline hyclate oral tablet 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>	3	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 %	1	
ERYGEL EXTERNAL GEL 2 % (erythromycin)	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
FINACEA EXTERNAL FOAM 15 % (azelaic acid)	3	
gentamicin sulfate external cream 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate external ointment 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate ophthalmic solution 0.3 %	1	QL (15 ml per prescription.)
KLARON EXTERNAL LOTION 10 % (sulfacetamide sodium (acne))	3	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	3	
METROCREAM EXTERNAL CREAM 0.75 % (metronidazole)	3	
METROLOTION EXTERNAL LOTION 0.75 % (metronidazole)	3	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	2	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	2	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
moxifloxacin hcl oral tablet 400 mg	3	
mupirocin calcium external cream 2 %	3	QL (15 grams per prescription)
mupirocin external ointment 2 %	1	QL (22 grams per prescription.)
neomycin sulfate oral tablet 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (<i>bacitracin-polymyx-neo-hc</i>)	3	
<i>neuac external gel 1.2-5 %</i>	3	QL (1 bottle (45 grams) per month.)
OVACE PLUS EXTERNAL SHAMPOO 10 % (<i>sulfacetamide sodium</i>)	3	
OVACE PLUS WASH EXTERNAL GEL 10 % (<i>sulfacetamide sodium</i>)	3	
OVACE PLUS WASH EXTERNAL LIQUID 10 % (<i>sulfacetamide sodium</i>)	3	
OVACE WASH EXTERNAL LIQUID 10 % (<i>sulfacetamide sodium</i>)	3	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM (<i>bacitracin-polymyxin b</i>)	3	
<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	
SSS 10-5 EXTERNAL FOAM 10-5 %	3	
<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 liquid 10-5 %, 9-4 %</i>	1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	1	
<i>sulfacetamide sod-sulfur wash external liquid 9-4 %</i>	1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	1	
<i>sulfamez wash external emulsion 10-1 %</i>	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	3	
SUMAXIN EXTERNAL PAD 10-4 % (<i>sulfacetamide sodium-sulfur</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 hcl oral capsule 250 mg, 500 mg	3	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	3	
XACIATO VAGINAL GEL 2 % (clindamycin phosphate)	2	QL (1 gel tube (8 grams) per prescription.)
ZILXI EXTERNAL FOAM 1.5 % (minocycline hcl micronized)	3	PA; ST; 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	ST; QL (60 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (tapinarof)	3	PA; QL (60 grams per prescription.)
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	3	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (hydrocortisone ace-pramoxine)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	3	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (lidocaine-benzalkonium (pod))	3	
doxepin hcl external cream 5 %	3	PA; QL (45 grams per prescription.)
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral concentrate 10 mg/ml	1	
DYCLOPRO EXTERNAL SOLUTION 0.5 %	3	
ENOVARX-LIDOCAINE HCL EXTERNAL CREAM 10 %, 5 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (pramoxine-hc)	2	
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
glydo external prefilled syringe 2 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	3	PA
lidocaine external ointment 5 %	2	QL (1.19 grams per day.)
lidocaine external patch 5 %	3	PA; QL (3 patches per day)
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external gel 2 %	1	
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	1	
LIDOPIN EXTERNAL CREAM 3.25 %	3	
LIDTOPIC MAX EXTERNAL CREAM 10 % (lidocaine)	3	PA
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (pramoxine-hc)	3	
premium lidocaine external ointment 5 %	2	QL (1.19 grams per day.)
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
PYRIDIDIUM ORAL TABLET 100 MG, 200 MG (phenazopyridine hcl)	3	
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	3	QL (15 grams per prescription.)
<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	
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.)
CUVPOSA ORAL SOLUTION 1 MG/5ML (<i>glycopyrrolate</i>)	3	
DRYSOL EXTERNAL SOLUTION 20 % (<i>aluminum chloride</i>)	3	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	3	
<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 strong oral solution 5 %</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	
<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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
econazole nitrate external cream 1 %	2	
EXELDERM EXTERNAL CREAM 1 % (sulconazole nitrate)	3	
EXELDERM EXTERNAL SOLUTION 1 % (sulconazole nitrate)	3	
GYNAZOLE-1 VAGINAL CREAM 2 % (butoconazole nitrate (1 dose))	3	
JUBLIA EXTERNAL SOLUTION 10 % (efinaconazole)	3	PA; ST; QL (4 ml per month.)
ketconazole external cream 2 %	1	QL (30 grams per prescription.)
ketconazole external foam 2 %	3	ST
ketconazole external shampoo 2 %	1	
ketodan external foam 2 %	3	ST
miconazole 3 vaginal suppository 200 mg	1	
ORAVIG BUCCAL TABLET 50 MG (miconazole)	3	
oxiconazole nitrate external cream 1 %	3	QL (30 grams per prescription.)
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
XOLEGEL COREPAK EXTERNAL KIT 2 & 1 % (ketconazole-hydrocortisone)	3	
XOLEGEL DUO/HEAD & SHOULDERS EXTERNAL KIT 2 & 1 % (ketconazole & pyrithione zinc)	3	
XOLEGEL DUO/XOLEX EXTERNAL KIT 2 & 1 % (ketconazole & pyrithione zinc)	3	
BASIC LOTIONS AND LINIMENTS - Drugs for the Skin		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (salicylic acid-lactic acid)	2	
methyl salicylate external liquid	1	
PRONAL EXTERNAL GEL 40-10 % (urea-lactic acid)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (<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	
ARTISS EXTERNAL SOLUTION (<i>fibrin sealant component</i>)	3	
<i>calcipotriene external cream 0.005 %</i>	2	QL (60 grams per prescription)
<i>calcipotriene external ointment 0.005 %</i>	2	
<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	QL (60 grams per prescription.)
<i>nitroglycerin rectal ointment 0.4 %</i>	3	QL (30 grams per month.)
RECTIV RECTAL OINTMENT 0.4 % (<i>nitroglycerin</i>)	3	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>)	3	QL (60 grams per prescription.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	3	PA; QL (60 grams per prescription.)
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
<i>benzoin compound external tincture</i>	1	
<i>benzoin external tincture</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin		
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (<i>clindamycin-tretinoin-cholesty</i>)	3	PA
<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>	3	QL (20 grams per prescription.)
<i>tretinoin oral capsule 10 mg</i>	2	QL (279 capsules per prescription.); SMCS; SP; CM
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	3	
<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>	3	
<i>amcinonide external ointment 0.1 %</i>	1	
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	3	
<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>	3	
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	3	
<i>betamethasone dipropionate external cream 0.05 %</i>	2	
<i>betamethasone dipropionate external lotion 0.05 %</i>	1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	2	
<i>betamethasone valerate external cream 0.1 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>betamethasone valerate external lotion 0.1 %</i>	1	
<i>betamethasone valerate external ointment 0.1 %</i>	1	
<i>budesonide rectal foam 2 mg, 2 mg/act</i>	2	
<i>clobetasol propionate e external cream 0.05 %</i>	2	QL (30 grams per prescription.)
<i>clobetasol propionate external cream 0.05 %</i>	2	QL (30 grams per prescription.)
<i>clobetasol propionate external gel 0.05 %</i>	2	QL (30 grams per prescription.)
<i>clobetasol propionate external liquid 0.05 %</i>	1	QL (59 ml per prescription)
<i>clobetasol propionate external ointment 0.05 %</i>	2	QL (30 grams per prescription.)
<i>clobetasol propionate external solution 0.05 %</i>	1	QL (25 ml per prescription.)
<i>clocortolone pivalate external cream 0.1 %</i>	3	ST; QL (75 grams per prescription.)
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (<i>flurandrenolide</i>)	3	QL (1 packet per prescription.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	3	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (<i>hydrocortisone</i>)	3	
CORTENEMA RECTAL ENEMA 100 MG/60ML (<i>hydrocortisone</i>)	3	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	2	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	3	QL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	3	
DERMOTIC OTIC OIL 0.01 % (<i>fluocinolone acetonide</i>)	3	
<i>desonide external cream 0.05 %</i>	2	QL (15 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>desonide external gel 0.05 %</i>	3	ST; QL (60 grams per prescription)
<i>desonide external lotion 0.05 %</i>	3	QL (60 ml per prescription.)
<i>desonide external ointment 0.05 %</i>	2	QL (15 grams per prescription.)
DESOWEN EXTERNAL CREAM 0.05 % (<i>desonide</i>)	3	QL (15 grams per prescription.)
<i>desoximetasone external cream 0.05 %</i>	1	QL (60 gm per prescription.)
<i>desoximetasone external cream 0.25 %</i>	1	QL (15 grams per prescription.)
<i>desoximetasone external gel 0.05 %</i>	3	QL (15 grams per prescription.)
<i>desoximetasone external ointment 0.05 %</i>	3	QL (60 grams per prescription.)
<i>desoximetasone external ointment 0.25 %</i>	3	QL (15 grams per prescription.)
<i>diflorasone diacetate external cream 0.05 %</i>	3	QL (30 grams per prescription.)
DIPROLENE EXTERNAL OINTMENT 0.05 % (<i>betamethasone dipropionate aug</i>)	3	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	3	QL (60 grams per prescription.)
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	2	
<i>fluocinolone acetonide body external oil 0.01 %</i>	3	QL (118.28 ml per prescription.)
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	3	QL (15 grams per prescription.)
<i>fluocinolone acetonide external ointment 0.025 %</i>	2	QL (15 grams per prescription.)
<i>fluocinolone acetonide external solution 0.01 %</i>	1	QL (60 ml per prescription.)
<i>fluocinolone acetonide otic oil 0.01 %</i>	1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	3	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>fluocinonide external ointment 0.05 %</i>	1	
<i>fluocinonide external solution 0.05 %</i>	1	
<i>flurandrenolide external lotion 0.05 %</i>	3	ST; QL (120 ml per prescription.)
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external lotion 0.05 %</i>	3	ST; QL (60 ml per prescription.)
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>halcinonide external cream 0.1 %</i>	3	ST; QL (30 grams per prescription.)
<i>halobetasol propionate external cream 0.05 %</i>	2	QL (15 grams per prescription.)
<i>halobetasol propionate external foam 0.05 %</i>	3	QL (50 grams per prescription.)
<i>halobetasol propionate external ointment 0.05 %</i>	2	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>	2	
<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 %</i>	3	
<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>	2	QL (15 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 valerate external ointment 0.2 %	3	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocortisone-iodoquinol external cream 1-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
KOURZEQ MOUTH/THROAT PASTE 0.1 % (triamcinolone acetonide)	2	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
ORALONE MOUTH/THROAT PASTE 0.1 % (triamcinolone acetonide)	2	
PRAMOSONE EXTERNAL CREAM 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (pramoxine-hc)	3	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (hc & sal acid-sulfur & shampoo)	3	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (calcipotriene-betameth diprop)	3	QL (60 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	2	
TOPICORT EXTERNAL OINTMENT 0.05 % (<i>desoximetasone</i>)	3	QL (60 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.25 % (<i>desoximetasone</i>)	3	QL (15 grams per prescription.)
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	2	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.)
XOLEGEL COREPAK EXTERNAL KIT 2 & 1 % (<i>ketoconazole-hydrocortisone</i>)	3	
EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin		
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % (<i>benzoyl perox-salicyl ac-vit e</i>)	3	
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % (<i>benzoyl perox-salicyl ac-vit e</i>)	3	
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % (<i>benzoyl peroxide-vitamin e</i>)	3	
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>	2	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IMMUNOMODULATORY AGENTS (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.); SMCS; SP
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (1 auto-injector per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (2 ml (1 syringe) per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (1 syringe per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (2 ml (1 syringe) per month.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	2	PA; QL (2 mL (1 pen) per month.); SMCS; SP
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	2	PA; QL (2 mL (1 syringe) per month.); SMCS; SP
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3	PA; QL (10 g per 23 days.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (<i>nemolizumab-ilto</i>)	2	PA; QL (2 pens every 4 weeks.); SMCS; SP
<i>pimecrolimus external cream 1 %</i>	3	QL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	3	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	3	PA
<i>sirolimus oral solution 1 mg/ml</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (risankizumab-rzaa)	2	PA; QL (1 ml per 63 days.); SMCS; SP
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (spesolimab-sbzo)	3	PA; QL (2 Prefilled syringes per month.); SMCS; SP
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (spesolimab-sbzo)	3	PA; SMCS; SP
tacrolimus external ointment 0.03 %, 0.1 %	2	QL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREMFYA CROHNS INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (guselkumab)	2	PA; QL (4 ml (2 pens/1 box) per month.); SMCS
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (guselkumab)	2	PA; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (guselkumab)	2	PA; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (guselkumab)	2	PA; QL (2ml (1 auto-injector) per month.); SMCS
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (guselkumab)	2	PA; QL (1 mL (1 syringe) every 8 weeks.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (guselkumab)	2	PA; QL (2ml (1 syringe) per month.); SMCS
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (abrocitinib)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (ruxolitinib phosphate)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
LITFULO ORAL CAPSULE 50 MG (ritlecitinib tosylate)	3	PA; QL (1 capsule per day.); SMCS; SP
OPZELURA EXTERNAL CREAM 1.5 % (ruxolitinib phosphate)	3	PA; QL (240 grams per prescription and 1200 grams per 365 days.); SMCS; SP
roflumilast oral tablet 250 mcg	2	QL (31 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
roflumilast oral tablet 500 mcg	2	QL (1 tablet per day)
SOTYKTU ORAL TABLET 6 MG (deucravacitinib)	2	PA; QL (1 tablet per day.); SMCS; SP
ZORYVE EXTERNAL CREAM 0.15 % (roflumilast)	3	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (roflumilast)	3	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (roflumilast)	3	PA; QL (60 grams per prescription.)
KERATOLYTIC AGENTS - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	3	QL (45 grams per prescription)
adapalene-benzoyl peroxide external gel 0.3-2.5 %	3	QL (45 grams per prescription.)
AKLIEF EXTERNAL CREAM 0.005 % (trifarotene)	3	PA; QL (45 grams per prescription.)
amnestem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (sulfacetamide sodium-sulfur)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (sulfacetamide sodium-sulfur)	3	
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline-sunscreen-sal acid)	3	
bp 10-1 external emulsion 10-1 %	1	
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
CONDYLOX EXTERNAL GEL 0.5 % (podofilox)	3	
EXODERM EXTERNAL LOTION 25-1 % (sod thiosulfate-salicylic acid)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (salicylic acid-lactic acid)	2	
HYDRO 40 EXTERNAL FOAM 40 % (urea)	3	
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % (benzoyl perox-salicyl ac-vit e)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % (benzoyl perox-salicyl ac-vit e)	3	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
PODOCON-25 EXTERNAL SOLUTION 25 % (podophyllum resin)	3	
podofilox external gel 0.5 %	3	
podofilox external solution 0.5 %	1	
PRONAL EXTERNAL GEL 40-10 % (urea-lactic acid)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RAYASAL EXTERNAL CREAM 5.9 %	3	
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	
SSS 10-5 EXTERNAL FOAM 10-5 %	3	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	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	
sulfamez wash external emulsion 10-1 %	1	
SUMAXIN EXTERNAL PAD 10-4 % (sulfacetamide sodium-sulfur)	3	
tazarotene external cream 0.05 %, 0.1 %	3	PA; QL (30 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	3	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (tazarotene)	3	PA; QL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (<i>tazarotene</i>)	3	PA; QL (30 grams per prescription.)
<i>urea external cream 20 %, 40 %, 45 %</i>	1	
<i>urea external lotion 40 %</i>	1	
<i>urea nail external gel 45 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
VEREGEN EXTERNAL OINTMENT 15 % (<i>sinecatechins</i>)	3	ST; QL (30 grams per prescription.)
XIRUN EXTERNAL GEL 40-10 %	3	
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
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>	3	QL (45 grams per prescription)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	3	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>	3	QL (1 bottle (45 grams) per month.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid-oxyquinoline)	3	
hydrocortisone-iodoquinol external cream 1-1 %	1	
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % (benzoyl perox-salicyl ac-vit e)	3	
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % (benzoyl perox-salicyl ac-vit e)	3	
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % (benzoyl peroxide-vitamin e)	3	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
neuac external gel 1.2-5 %	3	QL (1 bottle (45 grams) per month.)
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (chlorhexidine gluconate)	3	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (silver sulfadiazine)	3	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (mafenide acetate)	3	
XOLEGEL DUO/HEAD & SHOULDERS EXTERNAL KIT 2 & 1 % (ketoconazole & pyrithione zinc)	3	
XOLEGEL DUO/XOLEX EXTERNAL KIT 2 & 1 % (ketoconazole & pyrithione zinc)	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (benzoyl peroxide-hyaluronate)	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
diclofenac sodium external gel 3 %	2	PA; QL (100 grams per prescription.)
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ENOVARX-IBUPROFEN EXTERNAL CREAM 10 %	3	PA
ENOVARX-NAPROXEN EXTERNAL CREAM 10 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FROTEK EXTERNAL CREAM 10 % (<i>ketoprofen</i>)	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (<i>ketoprofen-baclofen-gabap-lido</i>)	3	PA
KETORUB EXTERNAL CREAM 10 % (<i>ketoprofen</i>)	3	PA
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
OXABOROLES - Drugs for the Skin		
<i>tavaborole external solution 5 %</i>	3	PA; ST; QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	3	ST; QL (60 grams per prescription.)
<i>roflumilast oral tablet 250 mcg</i>	2	QL (31 tablets per year.)
<i>roflumilast oral tablet 500 mcg</i>	2	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	3	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3	PA; QL (60 grams per 30 days.)
PIGMENTING AGENTS - Drugs for the Skin		
<i>methoxsalen rapid oral capsule 10 mg</i>	1	
POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
<i>klayesta external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
<i>nyamyc 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>	2	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	2	
<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	
ELIMITE EXTERNAL CREAM 5 % (<i>permethrin</i>)	3	
<i>malathion external lotion 0.5 %</i>	1	
OVIDE EXTERNAL LOTION 0.5 % (<i>malathion</i>)	3	
<i>permethrin external cream 5 %</i>	1	
PRURADIK EXTERNAL LOTION 10 % (<i>crotamiton</i>)	3	
SOOLANTRA EXTERNAL CREAM 1 % (<i>ivermectin</i>)	3	QL (45 grams per prescription.)
<i>spinosad external suspension 0.9 %</i>	3	
<i>sulfurated lime external solution</i>	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
A.A.G.C. KIT IN TERODERM EXTERNAL CREAM 8-4-10-4 % (<i>amantad-amitrip-gabap-cycloben</i>)	3	PA
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	3	QL (45 grams per prescription)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	3	QL (45 grams per prescription.)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AKLIEF EXTERNAL CREAM 0.005 % (<i>trifarotene</i>)	3	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>	2	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
ARTISS EXTERNAL SOLUTION (<i>fibrin sealant component</i>)	3	
<i>azelaic acid external gel 15 %</i>	3	
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>	3	QL (60 grams per prescription.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (1 auto-injector per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	3	PA; ST; QL (1 syringe per month.); SMCS; SP
<i>brimonidine tartrate external gel 0.33 %</i>	3	PA; QL (30 grams per prescription.)
<i>calcipotriene external cream 0.005 %</i>	2	QL (60 grams per prescription)
<i>calcipotriene external ointment 0.005 %</i>	2	
<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.); SMCS; SP; CM
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (<i>clindamycin-tretinoin-cholesty</i>)	3	PA
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COPASIL EXTERNAL GEL (<i>scar treatment products</i>)	3	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	2	PA; QL (0.018 ml per day.); SMCS; SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	2	PA; QL (0.036 ml per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	2	PA; QL (0.072 ml per day.); SMCS; SP
dapsone external gel 5 %, 7.5 %	3	QL (60 grams per prescription.)
dapsone oral tablet 100 mg, 25 mg	2	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (<i>dupilumab</i>)	2	PA; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>dupilumab</i>)	2	PA; QL (0.15 ml per day.); SMCS; SP
ENDARI ORAL PACKET 5 GM (<i>glutamine (sickle cell)</i>)	3	PA; QL (6 packets per day.)
ENOVARX-TRAMADOL EXTERNAL CREAM 5 %	3	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	3	QL (60 grams per prescription.)
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FEM PH VAGINAL GEL 0.9-0.025 % (<i>acetic acid-oxyquinoline</i>)	3	
FILSUVEZ EXTERNAL GEL 10 % (<i>birch triterpenes</i>)	3	PA; QL (14.4 grams per day.); SMCS; SP
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	3	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HALUCORT EXTERNAL GEL (<i>dermatological products, misc.</i>)	3	PA
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	3	PA; QL (10 g per 23 days.)
<i>imiquimod external cream 5 %</i>	1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (<i>ketoprofen-baclofen-gabap-lido</i>)	3	PA
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3	ST; QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	3	ST; 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>	3	PA; QL (6 packets per day.)
LITFULO ORAL CAPSULE 50 MG (<i>ritlecitinib tosylate</i>)	3	PA; QL (1 capsule per day.); SMCS; SP
MEDERMA SPF 30 EXTERNAL CREAM (<i>scar treatment products</i>)	3	PA
<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>	2	
MIRVASO EXTERNAL GEL 0.33 % (<i>brimonidine tartrate</i>)	2	PA; QL (30 grams per prescription.)
<i>nitroglycerin rectal ointment 0.4 %</i>	3	QL (30 grams per month.)
OPZELURA EXTERNAL CREAM 1.5 % (<i>ruxolitinib phosphate</i>)	3	PA; QL (240 grams per prescription and 1200 grams per 365 days.); SMCS; SP
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	2	PA; QL (60 tablets per month.); SMCS
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	2	PA; QL (1 starter pack per year.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PANRETIN EXTERNAL GEL 0.1 % (<i>alitretinoin</i>)	3	
<i>pimecrolimus external cream 1 %</i>	3	QL (30 grams per prescription.)
PODOCON-25 EXTERNAL SOLUTION 25 % (<i>podophyllum resin</i>)	3	
<i>podofilox external gel 0.5 %</i>	3	
<i>podofilox external solution 0.5 %</i>	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % (<i>nitroglycerin</i>)	3	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	3	PA; QL (30 grams per prescription.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	3	QL (90 grams per prescription.)
SCARCIN EXTERNAL CREAM	3	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>risankizumab-rzaa</i>)	2	PA; QL (1 ml per 63 days.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>risankizumab-rzaa</i>)	2	PA; QL (1 ml per 63 days.); SMCS; SP
SOTYKTU ORAL TABLET 6 MG (<i>deucravacitinib</i>)	2	PA; QL (1 tablet per day.); SMCS; SP
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	3	QL (60 grams per prescription.)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	2	QL (30 grams per prescription.)
<i>tazarotene external cream 0.05 %, 0.1 %</i>	3	PA; QL (30 grams per prescription.)
<i>tazarotene external gel 0.05 %, 0.1 %</i>	3	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (<i>tazarotene</i>)	3	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (<i>tazarotene</i>)	3	PA; QL (30 grams per prescription.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	2	PA; QL (1 mL (1 syringe) every 8 weeks.); SMCS; SP
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VALCHLOR EXTERNAL GEL 0.016 % (<i>mechlorethamine hcl (topical)</i>)	2	PA; QL (120 grams per prescription.); SMCS; SP
VENELEX EXTERNAL OINTMENT (<i>balsam peru-castor oil</i>)	3	
VEREGEN EXTERNAL OINTMENT 15 % (<i>sinecatechins</i>)	3	ST; QL (30 grams per prescription.)
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	3	PA; QL (60 grams per prescription.)
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	3	PA; QL (60 grams per prescription.)
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	3	
THIOCARBAMATES(SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
MYCOZYL AL EXTERNAL SOLUTION 1 % (<i>tolnaftate</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	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (<i>xanomeline-trospium chloride</i>)	3	PA; QL (1 starter pack per year.)
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	3	
<i>flavoxate hcl oral tablet 100 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	2	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride oral tablet 2.5 mg</i>	3	
<i>oxybutynin chloride oral tablet 5 mg</i>	1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	2	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	3	
<i>tropium chloride oral tablet 20 mg</i>	3	
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>	3	PA; QL (186 ml per month.); SMCS; SP
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.); SMCS
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 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>	3	ST
VITAMINS		
MULTIVITAMIN PREPARATIONS		
ATABEX OB ORAL TABLET 29-1 MG (<i>prenatal vit w/ fe bisg-fa</i>)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (<i>prenat-fecb-fefum-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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
FOLATEXCEL ORAL TABLET 1 MG	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>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</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	
NEO-VITAL RX ORAL TABLET 1 MG	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	
<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 highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (<i>pediatric multivitamins-fl</i>)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</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	
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-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	
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	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN A		
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
VITAMIN B COMPLEX		
ATABEX OB ORAL TABLET 29-1 MG (<i>prenatal vit w/ fe bisg-fa</i>)	3	
CALCIFOL ORAL WAFER 1342-1.6 MG (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (<i>prenat-fecb-fefum-fa-dha w/o a</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>	3	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg</i>	3	H
<i>drospiren-eth estrad-levomefol oral tablet 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	
FOLATEXCEL ORAL TABLET 1 MG	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
<i>hematinic/folic acid oral tablet 324-1 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	3	
NEO-VITAL RX ORAL TABLET 1 MG	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	
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	2	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	
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	
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 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<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	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN C		
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	3	QL (1 kit per prescription.)
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	3	QL (1 kit per prescription.)
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	3	QL (1 kit per prescription.)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	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 (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	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) (<i>ergocalciferol</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (<i>sodium fluoride-vitamin d</i>)	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (<i>alendronate-cholecalciferol</i>)	3	
<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	
ROCALTROL ORAL SOLUTION 1 MCG/ML (<i>calcitriol</i>)	3	
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), 50000 unit</i>	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (<i>paricalcitol</i>)	3	
VITAMIN E		
<i>wheat germ oil oral oil</i>	1	
VITAMIN K ACTIVITY		
<i>phytonadione oral tablet 5 mg</i>	3	QL (5 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you 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

A.A.G.C. KIT IN TERODERM.....	344	adapalene-benzoyl peroxide	304, 339, 341, 344	ALCOHOL PREP PADS.....	172
abacavir sulfate	36	ADASUVE.....	136, 144	ALECENSA.....	47
abacavir sulfate-lamivudine ...	36	ADBRY.....	337, 344	alendronate sodium	281
abigale	242, 256	ADDYI.....	143	alfuzosin hcl er	75
abigale lo	241, 256	adefovir dipivoxil	41	ALHEMO.....	83
abiraterone acetate	47	ADEMPAS.....	318, 320	aliskiren fumarate	117
ABRYSVO.....	62	ADIPEX-P.....	121	allopurinol	280
acamprosate calcium	16, 143	ADRENALIN.....	66, 210, 306	almotriptan malate	163
acarbose	228	ADVAIR HFA....	75, 202, 223, 309	ALOCRI.....	197, 313
ACCOLATE.....	313	ADVATE.....	82	ALOGLIPTIN BENZOATE.....	240
ACCU-CHEK AVIVA.....	171	ADVOCATE SAFETY		ALOGLIPTIN-METFORMIN	
ACCU-CHEK FASTCLIX		LANCETS 21G.....	171	HCL.....	232, 240
LANCET KIT.....	171	ADVOCATE SAFETY		ALOGLIPTIN-PIOGLITAZONE	
ACCU-CHEK GUIDE.....	171	LANCETS 23G.....	171	.....	241, 268
ACCU-CHEK GUIDE		ADVOCATE SAFETY		ALORA.....	242, 281
CONTROL.....	171	LANCETS 28G.....	171	alose tron hcl	213
ACCU-CHEK GUIDE ME.....	171	ADYNOVATE.....	82	ALPHAGAN P.....	196, 321
ACCU-CHEK GUIDE TEST....	182	AEROCHAMBER HOLDING		ALPHANATE.....	83
ACCU-CHEK SMARTVIEW		CHAMBER.....	172	ALPHANINE SD.....	83
CONTROL.....	171	AEROCHAMBER PLS FLOVU		alprazolam	140
ACCU-CHEK SOFTCLIX		MTHPIECE.....	172	alprazolam er	140
LANCET DEVICE KIT.....	171	AEROCHAMBER PLUS FLO-		alprazolam intensol	140
ACCURETIC.....	96, 193	VU INTERM.....	172	alprazolam xr	141
accutane	339, 344	AEROCHAMBER PLUS FLO-		ALPROLIX.....	83
ACD-A NOCLOT-50.....	79	VU LARGE.....	172	ALREX.....	202
acebutolol hcl		AEROCHAMBER PLUS FLO-		ALTACAIN.....	208, 278
.....	77, 98, 104, 106, 113	VU MEDIUM.....	172	altafrin	209, 210
acetaminophen-codeine		AEROCHAMBER PLUS FLO-		altavera	233, 242, 256
.....	122, 150, 152	VU SMALL.....	172	ALTUVIIIO.....	83
acetazolamide		AEROCHAMBER2GO ANTI-		ALUNBRIG.....	48
.....	92, 103, 126, 188, 202	STATIC.....	172	ALVAIZ.....	80
acetazolamide er		afirmelle	233, 242, 256	alvimopan	211, 218
.....	92, 103, 126, 188, 202	AFLURIA.....	62	alyacen 1/35	233, 242, 256
acetic acid	207	AFLURIA PRESERVATIVE		alyacen 7/7/7	233, 242, 256
acetylcysteine	16, 279, 314	FREE.....	62	ALYFTREK.....	310, 311
acitretin	339, 344	AFSTYLA.....	83	alyq	115, 116, 315, 319
ACTEMRA.....	274, 287, 292	aftera	230, 233, 256	amantadine hcl	22, 121
ACTEMRA ACTPEN		AIMOVIG.....	142	ambrisentan	118, 312, 319
.....	274, 287, 292	AIRSUPRA		amcinonide	331
ACTHAR.....	182, 255	.....	75, 202, 223, 309, 314, 317	AMELUZ.....	321, 345
ACTHAR GEL.....	182, 255	AKEEGA.....	47	amethyst	233, 242, 256
ACTHIB.....	62	AKLIEF.....	339, 345	amiloride hcl	93, 117, 190
ACTIMMUNE.....	292	AKTEN.....	208	amiloride-	
ACTIVELLA.....	242, 256	AKYNZEO.....	211, 221	hydrochlorothiazide	190, 193
ACTOPLUS MET.....	232, 268	ALA SCALP.....	202, 223, 331	aminocaproic acid	83
ACULAR.....	160, 208	albendazole	24	amiodarone hcl	108
ACULAR LS.....	160, 208	albuterol sulfate	75, 318	amitriptyline hcl	166
acyclovir	41, 328	ALBUTEROL SULFATE...	75, 318	AMJEVITA.....	218, 277, 287, 292
ADACEL.....	61, 62	albuterol sulfate hfa	75, 317, 318	AMJEVITA-PED 15KG TO	
ADALIMUMAB-ADAZ		ALCAINE.....	208	<30KG	218, 277, 287, 292
.....	217, 218, 276, 277, 287, 292	alclometasone dipropionate	331		

AMLODIPINE		<i>aranelle</i> 233, 242, 256	<i>atovaquone-proguanil hcl</i> 25
BES+SYRSPEND SF		ARANESP (ALBUMIN FREE)	<i>atropine sulfate</i> . 16, 68, 209, 306
..... 109, 110, 118		 78, 81	ATROVENT HFA..... 68, 306
<i>amlodipine besylate</i>		ARCALYST..... 299, 313	<i>aubra eq</i> 233, 242, 256
..... 109, 110, 118		AREXVY..... 62	AUGTYRO..... 48
<i>amlodipine besylate-</i>		<i>arformoterol tartrate</i> 76, 318	AUM INSULIN SAFETY PEN
<i>benazepril hcl</i> 96, 109		ARIKAYCE..... 23	NEEDLE..... 172
<i>amlodipine besylate-</i>		<i>aripiprazole</i> 131, 137	AUM MINI INSULIN PEN
<i>valsartan</i> 95, 109		<i>armodafinil</i> 167	NEEDLE..... 172
<i>amnesteem</i> 339, 345		ARMOUR THYROID..... 268	AUM PEN NEEDLE..... 172
<i>amoxapine</i> 166		ARNUITY ELLIPTA	AUM READYGARD DUO PEN
<i>amoxicillin</i> 24, 214		 202, 224, 309, 314	NEEDLE..... 172
<i>amoxicillin-potassium</i>		ARTISS..... 330, 345	AUM SAFETY PEN NEEDLE. 172
<i>clavulanate</i> 24		ARZOL SILVER NIT	<i>aurovela 1.5/30</i> 233, 242, 256
<i>amphetamine sulfate</i> 122		APPLICATORS..... 200	<i>aurovela 1/20</i> 233, 242, 256
<i>amphetamine-</i>		<i>ascomp-codeine</i>	<i>aurovela 24 fe</i> 233, 242, 256
<i>dextroamphetamine</i> 122		 139, 152, 158, 162	<i>aurovela fe 1.5/30</i> .. 233, 242, 256
<i>amphetamine-</i>		<i>asenapine maleate</i> 131, 137	<i>aurovela fe 1/20</i> 233, 242, 256
<i>dextroamphetamine er</i> 122		<i>ashlyna</i> 233, 242, 256	AUSTEDO..... 167
<i>amphet-dextroamphet 3-</i>		<i>aspirin</i> 90, 91, 134, 162	AUSTEDO XR..... 167
<i>bead er</i> 122		<i>aspirin 81</i> 90, 91, 134, 162	AUSTEDO XR PATIENT
<i>ampicillin</i> 24		<i>aspirin adult low dose</i>	TITRATION..... 167
AMZEEQ..... 25, 46, 197, 322		 90, 91, 134, 162	AUTOLET LANCING DEVICE 172
<i>anagrelide hcl</i> 91		<i>aspirin adult low strength</i>	AUTOLET LITE LANCING
ANALPRAM HC		 90, 91, 134, 162	DEVICE..... 172
..... 202, 223, 326, 331		<i>aspirin childrens</i> 90, 91, 134, 162	AUVELITY..... 130
ANALPRAM-HC		<i>aspirin ec adult low dose</i>	AUVI-Q..... 66, 306
..... 202, 224, 326, 331		 90, 91, 134, 162	<i>avanafil</i> 115, 116
<i>anastrozole</i> 48, 230		<i>aspirin ec low dose</i>	AVAR CLEANSER..... 322, 339
ANCOBON..... 44		 90, 91, 134, 162	AVAR-E EMOLLIENT..... 322, 339
ANGELIQ..... 242, 256		<i>aspirin ec low strength</i>	<i>aviane</i> 233, 242, 256
ANNOVERA..... 233, 242, 256		 90, 91, 134, 162	AVIDOXY..... 25, 46, 322
ANORO ELLIPTA..... 68, 75		<i>aspirin low dose</i> 90, 91, 134, 162	AVIDOXY DK..... 46, 339, 349
ANTICOAGULANT SODIUM		<i>aspirin regimen</i> . 90, 91, 134, 162	AVMAPKI FAKZYNJA CO-
CITRATE..... 79		<i>aspirin-dipyridamole er</i>	PACK..... 48
ANUCORT-HC..... 202, 224, 331		 90, 115, 162, 182	AVONEX PEN..... 273, 292
ANUSOL-HC..... 202, 224, 331		ASPRUZYO SPRINKLE..... 103	AVONEX PREFILLED... 273, 292
ANZEMET..... 211		ASSURE ID DUO PRO PEN	<i>ayuna</i> 233, 242, 256
<i>apap-caff-dihydrocodeine</i>		NEEDLES..... 172	AYVAKIT..... 48
..... 123, 150, 152, 158		ASSURE ID PRO PEN	AZASAN..... 270, 287, 292, 297
APOKYN..... 149		NEEDLES..... 172	AZASITE..... 197
<i>apomorphine hcl</i> 149		ASTRINGYN..... 83	<i>azathioprine</i> ... 270, 287, 292, 297
<i>apraclonidine hcl</i> 196, 207		ATABEX OB..... 88, 350, 353	<i>azelaic acid</i> 322, 345
<i>aprepitant</i> 221		<i>atazanavir sulfate</i> 38	<i>azelastine hcl</i> 197, 317
<i>apri</i> 233, 242, 256		<i>atenolol</i> 77, 98, 104, 106, 113	AZELEX..... 322, 345
APRISO..... 213		ATENOLOL+SYRSPEND SF	<i>azithromycin</i> 42, 43
APTOM..... 126, 147		 77, 98, 104, 106, 113	AZSTARYS..... 158
APTIVUS..... 38		<i>atenolol-chlorthalidone</i>	AZULFIDINE
AQ INSULIN SYRINGE..... 172		 98, 104, 194	 45, 213, 271, 288, 293
AQINJECT PEN NEEDLE..... 172		<i>atomoxetine hcl</i> 143, 158	AZULFIDINE EN-TABS
AQNEURSA..... 299		ATORVALIQ..... 111	 45, 213, 271, 288, 293
AQUORAL..... 207		<i>atorvastatin calcium</i> 111	<i>azurette</i> 233, 242, 257
ARAKODA..... 25		<i>atovaquone</i> 26	B & C..... 345

bac (butalbital-acetamin-caff)	123, 139, 150, 159
bacitracin	30, 197, 322
bacitracin-polymyxin b	30, 197, 322
bacitra-neomycin-polymyxin-hc ...	30, 197, 202, 322
baclofen	72
BACTRIM.....	26, 45, 46
BACTRIM DS.....	26, 45, 46
BAFIERTAM.....	272, 293
balsalazide disodium	213
balsam peru-castor oil	345
BALVERSA.....	48
balziva	233, 242, 257
BANZEL.....	126, 147
BAQSIMI ONE PACK	16, 251, 279
BAQSIMI TWO PACK.....	16, 251, 279
BARACLUDE.....	41
BAXDELA.....	44
BD AUTOSHIELD DUO PEN NEEDLES.....	173
BD ECLIPSE LUER-LOK NEEDLE.....	173
BD ECLIPSE NEEDLE.....	173
BD PEN NEEDLE MICRO ULTRAFINE.....	173
BD PEN NEEDLE MINI ULTRAFINE.....	173
BD PEN NEEDLE NANO ULTRAFINE.....	173
BD PEN NEEDLE ORIG ULTRAFINE.....	173
BD PEN NEEDLE SHORT ULTRAFINE.....	173
BD SAFETYGLIDE NEEDLE..	173
BD SHARPS COLLECTOR....	173
BD ULTRA-FINE INSULIN SYRINGES.....	173
BD ULTRA-FINE PEN NEEDLES.....	173
BD VEO INSULIN SYR ULTRAFINE.....	173
BELBUCA.....	157
BELSOMRA.....	136, 158
benazepril hcl	96
benazepril-hydrochlorothiazide	96, 193
BENEFIX.....	83
BENLYSTA.....	272, 273, 298
benzalkonium chloride	328, 341
BENZAMYCIN.....	322, 341
BENZHYDROCODONE-ACETAMINOPHEN.....	123, 150, 152
BENZNIDAZOLE.....	27, 40
benzoin	330
benzoin compound	330
benzonatate	308
benzoyl peroxide-erythromycin	322, 341
benzphetamine hcl	122
benztropine mesylate	70, 125
BERINERT.....	285, 286
BESIVANCE.....	197
BESREMI.....	38, 48, 293
BETADINE OPHTHALMIC PREP.....	200
betaine	299
betamethasone dipropionate	224, 331
betamethasone dipropionate aug	224, 331
betamethasone valerate	224, 331, 332
BETAPACE AF.....	72, 98, 104, 106, 108, 113
BETASERON.....	273, 293
betaxolol hcl	77, 98, 104, 106, 113, 201
bethanechol chloride	74
BETIMOL.....	72, 98, 106, 201
BETOPTIC-S.....	77, 106, 201
BEVESPI AEROSPHERE.....	68, 76, 328
bexarotene	48, 321, 345
BEXSERO.....	62
BEYFORTUS.....	40
bicalutamide	48
BIGFOOT UNITY PROGRAM	173
BIJUVA.....	242, 257
BIKTARVY.....	34, 35, 36
BILTRICIDE.....	24
bimatoprost	210
BIMZELX.....	337, 345
BINAXNOW COVID-19 AG HOME TEST.....	183
bis subcit-metronid-tetracyc	25, 27, 46, 212, 214
bisacodyl ec	214
bismuth/metronidaz/tetracyc lin	25, 27, 46, 212, 214
bisoprolol fumarate	77, 98, 104, 106, 113
bisoprolol-hydrochlorothiazide	98, 104, 193
blisovi 24 fe	233, 242, 257
blisovi fe 1.5/30	233, 242, 257
blisovi fe 1/20	234, 242, 257
BONSITY.....	254, 281
BOOSTRIX.....	61, 62
bosentan	118, 312, 319
BOSULIF.....	48
bp 10-1	322, 339
BRAFTOVI.....	48
BREATHE COMFORT CHAMBER/ADULT.....	173
BREATHE COMFORT CHAMBER/CHILD.....	173
BRENZAVVY.....	266
BREO ELLIPTA 76, 203, 224, 309	
BREXAFEMME.....	24
BREZTRI AEROSPHERE.....	68, 76, 224
briellyn	234, 242, 257
brimonidine tartrate	196, 321, 322, 345
brinzolamide	202
BRIVIACT.....	126
bromocriptine mesylate	145
bromphen-pseudoeph-dm	19, 21, 66, 308
BRONCHITOL.....	316
BRONCHITOL TOLERANCE TEST.....	316
BROVANA.....	76, 318
BRUKINSA.....	49
budesonide	224, 309, 314, 315, 332
bumetanide	92, 112, 188
BUMEX.....	92, 112, 188
buprenorphine	157
buprenorphine hcl	157
buprenorphine hcl-naloxone hcl	155, 157
bupropion hcl	130
bupropion hcl er (smoking det)	65, 130
bupropion hcl er (sr)	130
bupropion hcl er (xl)	130
buspirone hcl	136, 149
butalbital-acetaminophen	123, 139, 150
butalbital-apap-caff-cod	123, 139, 150, 152, 159
butalbital-apap-caffeine	123, 139, 150, 159
BUTALBITAL-APAP-CAFFEINE.....	123, 139, 150, 159

butalbital-asa-caff-codeine	139, 152, 159, 162	CARESENS CONTROL SOLUTION A/B.....	174	chlordiazepoxide-clidinium	68, 141
butalbital-aspirin-caffeine	139, 159, 162	CARESENS LANCETS 30G... 174		chlorhexidine gluconate	22, 200, 201, 328, 341
butorphanol tartrate	134, 157	CARESTART COVID-19		chloroquine phosphate	25
BYLVAY.....	216, 218	HOME TEST.....	183	chlorpromazine hcl	158
BYLVAY (PELLETS).....	216, 218	CARETOUCH CONTROL SOL		chlorthalidone	93, 118, 194
cabergoline	145	LEVEL 2.....	174	chlorzoxazone	71
CABLIVI.....	79, 92	CARETOUCH HYPODERMIC		CHOLBAM.....	216, 218
CABOMETYX.....	49	NEEDLE.....	174	cholestyramine	100
caffeine citrate	134, 159	CARETOUCH		cholestyramine light	100
CALCIFOL.....	190, 353, 355	LANCING/EJECTOR.....	174	CHORIONIC	
calcipotriene	330, 345	carglumic acid	185	GONADOTROPIN.....	251
calcitonin (salmon)	231, 282	carisoprodol	71	CHOSEN LANCETS 30G.....	174
CALCITRENE.....	330, 345	CARNITOR.....	299	CHOSEN LANCING DEVICE. 174	
calcitriol	345, 355	CARNITOR SF.....	300	CHOSEN SAFETY LANCETS	
calcium acetate	189, 190	CAROSPIR93, 112, 113, 117, 190		28G.....	174
calcium acetate (phos		carteolol hcl	201	CIBINQO.....	275, 288, 338, 345
binder)	189, 190	cartia xt .. 100, 101, 102, 108, 118		ciclodan	336
CALQUENCE.....	49	carvedilol		ciclopirox	336
camila	234, 257	 72, 75, 94, 98, 104, 107, 113		ciclopirox olamine	336
CAMINO PRO		CAVERJECT.....	110, 118	cilostazol	90, 116
COMPLETE/GLYTACTIN.....	186	CAVERJECT IMPULSE.. 110, 118		CILOXAN.....	197
camrese	234, 243, 257	CAYA.....	304	CIMDUO.....	36
camrese lo	234, 243, 257	CAYSTON.....	40	cimetidine	20, 220
CAMZYOS.....	103	cefaclor	21	cimetidine hcl	20, 220
candesartan cilexetil	94, 95	cefaclor er	21	CIMZIA (2 SYRINGE)	
candesartan cilexetil-hctz		cefadroxil	21	 218, 271, 277, 288, 293	
.....	95, 193	cefdinir	22	CIMZIA-STARTER	
capecitabine	49	cefixime	22	 218, 271, 277, 288, 293	
CAPLYTA.....	137	cefpodoxime proxetil	22	cinacalcet hcl	231
CAPRELSA.....	49	cefprozil	22	CIPRO.....	28, 44
captopril	96	cefuroxime axetil	22	CIPRO HC.....	197, 203
captopril-		celecoxib	144	ciprofloxacin hcl	28, 44, 197
hydrochlorothiazide	96, 193	CELONTIN.....	165	ciprofloxacin-	
CAPVAXIVE.....	62	cephalexin	21	dexamethasone	197, 203
carbamazepine	126, 131	CEQUR SIMPLICITY 2U.....	174	italopram hydrobromide	164
carbamazepine er	126, 131	CERDELGA.....	195, 300	CITRANATAL MEDLEY	
CARBATROL.....	126, 131	CERVIDIL.....	305	 88, 300, 350, 353	
carbidopa	144	CETRAXAL.....	197	citroma	214
carbidopa-levodopa	144	CETROTIDE.....	230	claravis	339, 345
carbidopa-levodopa er	144	cevimeline hcl	74	clarithromycin	28, 42, 43, 214
carbidopa-levodopa-		charlotte 24 fe	234, 243, 257	clarithromycin er .. 28, 42, 43, 214	
entacapone	142, 144	chateal eq	234, 243, 257	CLEARDETECT COVID-19	
carbinoxamine maleate .. 19, 312		CHEMET.....	16, 223, 279	AG HOME.....	183
CARBZAH.....	19, 312	CHEMSTRIP BG LOG BOOK. 174		clearlax	214
CARDURA.....	73, 94, 98	CHEMSTRIP K.....	184	clemastine fumarate	19, 313
CARDURA XL.....	73, 94, 98	CHEMSTRIP UGK.....	184	CLENPIQ.....	214
CAREPOINT POLY HUB		CHENODAL.....	216	CLEOCIN.....	39, 322
NEEDLE.....	173, 174	chlordiazepoxide hcl	141	CLEOCIN-T.....	39, 323
CAREPOINT SAFETY 1ST		chlordiazepoxide-		CLEVER CHOICE COMFORT	
NEEDLE.....	174	amitriptyline	141, 166	EZ.....	174
				CLIMARA PRO.....	243, 257

<i>clindacin</i>	39, 323	COMBIVENT RESPIMAT	COVID-19 AT HOME
<i>clindacin etz</i>	39, 323	.....	ANTIGEN TEST.....
<i>clindacin-p</i>	39, 323	COMETRIQ.....	183
<i>clindamycin hcl</i>	39, 323	COMFORT EZ PRO PEN	COVID-19 AT-HOME TEST....
<i>clindamycin palmitate hcl</i>		NEEDLES.....	183
.....	39, 323	COMFORT TOUCH TWIST	CRENESSITY.....
<i>clindamycin phos (once-</i>		LANCET 30G.....	84, 255
<i>daily)</i>	39, 323	COMPLERA.....	195, 217
<i>clindamycin phos (twice-</i>		COMPLEX ESSENTIAL MSD	CRESEMB.....
<i>daily)</i>	39, 323	.....	29
<i>clindamycin phos-benzoyl</i>		CONDOMS.....	CREXONT.....
<i>perox</i>	39, 323, 341	CONDYLOX.....	144
<i>clindamycin phosphate</i> ..	39, 323	constulose	257
CLINDESSE.....	39, 323	185	cromolyn sodium ..
CLINITEST RAPID COVID-19		CONTOUR CONTROL.....	197, 207, 314
TEST.....	183	CONTOUR NEXT CONTROL.....	CROTAN.....
CLINOIN.....	100, 323, 331, 345	CONTOUR NEXT EZ.....	344
CLINPRO 5000.....	169, 283	CONTOUR NEXT GEN	cryselle-28
<i>clobazam</i>	139, 141	MONITOR.....	234, 243, 257
<i>clobetasol propionate</i>	332	CONTOUR NEXT MONITOR.....	CTEXLI.....
<i>clobetasol propionate e</i>	332	CONTOUR NEXT ONE.....	216
<i>clocortolone pivalate</i>	332	CONTOUR NEXT TEST.....	CUVPOSA.....
CLOMID.....	241	CONTOUR PLUS BLUE.....	68, 328
<i>clomiphene citrate</i>	241	CONTOUR PLUS TEST.....	cyanocobalamin
<i>clomipramine hcl</i>	166	CONTRAVE.....	90, 353
<i>clonazepam</i>	139, 140, 141	COPASIL.....	CYANOCOBALAMIN.....
<i>clonidine</i>	67, 104, 111	COPIKTRA.....	90, 353
<i>clonidine hcl</i>	67, 104, 110	CORDRAN.....	cyclobenzaprine hcl
<i>clonidine hcl er</i>	67, 110	CORIFACT.....	71
<i>clopidogrel bisulfate</i>	90	CORLANOR.....	CYCLOGYL.....
<i>clorazepate dipotassium</i>		CORTANE-B	209
.....	140, 141	.....	CYCLOMYDRIL.....
<i>clotrimazole</i>	328	.....	209, 210
<i>clotrimazole-betamethasone</i>		CORTEF.....	cyclopentolate hcl
.....	329, 332	.....	209
<i>clozapine</i>	137	CORTENEMA.....	cyclophosphamide ..
CLOZARIL.....	137	.....	49, 273, 298
COAGADEX.....	83	CORTIFOAM.....	CYCLOPHOSPHAMIDE
<i>coal tar</i>	341	.....	49, 273, 298
COARTEM.....	25	CORTISPORIN-TC.....	cycloserine
COBENFY.....	136, 349	.....	28
COBENFY STARTER PACK		CORTROPHIN.....	CYCLOSET.....
.....	136, 349	.....	229
<i>codeine sulfate</i>	152, 308	CORTROPHIN GEL.....	cyclosporine
<i>colchicine</i>	280	CORTROSYN.....	.....
<i>colchicine-probenecid</i> ..	194, 280	COSENTYX (300 MG DOSE)	200, 270, 288, 293, 298
<i>colesevelam hcl</i>	100, 229	.....	cyclosporine modified
COLESTID.....	100	.....	.....
<i>colestipol hcl</i>	100	COSENTYX 150 MG/ML	200, 270, 288, 293, 298
<i>colistimethate sodium (cba)</i> ..	44	.....	cyproheptadine hcl
COLY-MYCIN M.....	44	COSENTYX SENSOREADY	19, 313
COMBIGAN.....	196, 201, 322	(300 MG).....	cyred eq
COMBIPATCH.....	243, 257	.....	234, 243, 257
		COSENTYX SENSOREADY	CYSTADANE.....
		PEN.....	300
		COSENTYX UNOREADY	CYSTADROPS.....
		.....	207, 209
		COSOPT.....	CYSTAGON.....
		.....	300
		cosyntropin	CYSTARAN.....
		182	207, 209
		COTELIC.....	CYTOTEC.....
		49	221
		COVARYX.....	cytra k crystals
		228, 243	185
		COVARYX HS.....	dabigatran etexilate
		228, 243	mesylate
			80
			dalfampridine er
			300, 304
			danazol
			228
			DANTRIUM.....
			72
			dantrolene sodium
			72
			dapsone
			25, 26, 27, 323, 346
			DAPTACEL.....
			61, 62
			DARAPRIM.....
			25
			darifenacin hydrobromide er
			349
			darunavir
			38
			dasatinib
			49
			dasetta 1/35 (28)
			234, 243, 257
			dasetta 7/7/7
			234, 243, 257
			DAURISMO.....
			49
			DAYBUE.....
			143
			daysee
			234, 243, 257

DAYVIGO.....	136, 158	DEXCOM G6 RECEIVER.....	175	dimethyl fumarate starter pack	272, 293
DEBACTEROL.....	208, 341	DEXCOM G6 SENSOR.....	175	DIPENTUM.....	213
deblitane	234, 257	DEXCOM G6 TRANSMITTER	175	diphenhydramine hcl	
deferasirox	223	DEXCOM G7 RECEIVER.....	175	.....	19, 70, 126, 136, 308, 313
deferasirox granules	223	DEXCOM G7 SENSOR.....	175	diphenoxylate-atropine ..	68, 212
deferiprone	223	dexmethylphenidate hcl	159	DIPROLENE.....	225, 333
DELESTROGEN.....	243, 282	dexmethylphenidate hcl er ...	159	dipyridamole	90, 116, 119, 182
DELSTRIGO.....	35, 36	dextroamphetamine sulfate ..	122	disopyramide phosphate	105
delyla	234, 243, 257	dextroamphetamine sulfate er	122	disulfiram	16, 279
demeclocycline hcl	46	DIABECIN HR.....	326, 341	DIURIL.....	93, 118, 193
DEMSEER.....	184, 300	DIABETES MONITOR DIGIT		divalproex sodium	
DENGVAIXA.....	63	ADD-ON.....	175, 300	.....	127, 132, 134, 145
DENTA 5000 PLUS	168, 169, 283	DIABETES MONITOR DIGIT		divalproex sodium er	
SENSITIVE.....	169, 283	SOLN.....	175, 300	.....	127, 131, 134, 145
DENTAGEL.....	168, 169, 283	DIACOMIT.....	127, 145	DIVIGEL.....	243, 282
DEPAKOTE....	126, 131, 134, 145	DIASTIX REAGENT.....	184	dofetilide	108
DEPAKOTE ER		DIATRUST COVID-19 HOME		DOJOLVI.....	186
.....	126, 131, 134, 145	TEST.....	183	dolishale	234, 243, 258
DEPAKOTE SPRINKLES		diazepam	140, 141	donepezil hcl	74
.....	126, 131, 134	diazepam intensol	140, 141	DOPTLET.....	81
DEPEN TITRATABS.	16, 223, 288	diazoxide	231	DORZOLAMIDE HCL.....	202
DEPO-ESTRADIOL.....	243, 282	dichlorphenamide	92, 283	dorzolamide hcl	202
DEPO-PROVERA.....	234, 257	diclofenac potassium	151	dorzolamide hcl-timolol mal	
DEPO-SUBQ PROVERA	104	diclofenac sodium		.....	201, 202
.....	234, 257	.....	151, 160, 167, 208, 342	dotti	243, 282
DEPO-TESTOSTERONE	228, 230	diclofenac sodium er	151	DOUBLE PM.....	198, 203
DERMA-SMOOTH/FS BODY		diclofenac-misoprostol	151, 221	DOVATO.....	34, 36
.....	203, 332	dicloxacin sodium	43	doxazosin mesylate	73, 94, 98
DERMA-SMOOTH/FS		DICOPANOL FUSEPAQ		doxepin hcl	166, 326
SCALP.....	203, 332	.....	19, 70, 126, 136, 308, 313	doxercalciferol	355
DERMOTIC.....	203, 332	dicyclomine hcl	68	doxycycline hyclate ..	25, 46, 323
DESCOVY.....	36, 41	diethylpropion hcl	121	doxycycline monohydrate	
desipramine hcl	166	diethylpropion hcl er	121	.....	25, 26, 46, 323
desmopressin ace spray		DIFICID.....	42, 43	DRISDOL.....	355
refrig	84, 255	diflorasone diacetate	333	DRIZALMA SPRINKLE.....	163
desmopressin acetate	84, 255	diflunisal	151, 160	dronabinol	212, 218
DESMOPRESSIN ACETATE		difluprednate	203	DROPLET MICRON.....	175
.....	84, 255	digoxin	97, 104	DROPSAFE ACTI-LANCE	
desmopressin acetate pf	84, 255	dihydroergotamine mesylate		23G.....	175
desmopressin acetate spray		.....	73, 134	DROPSAFE SAFETY	
.....	84, 255	DILANTIN.....	106, 146	SYRINGE/NEEDLE.....	175
desogestrel-ethinyl estradiol		DILANTIN INFATABS.....	106, 146	DROPSAFE SICURA.....	175
.....	234, 243, 258	DILANTIN-125.....	106, 146	drosipren-eth estrad-	
desonide	332, 333	diltiazem hcl ..	101, 102, 108, 119	levomefol	234, 243, 258, 353
DESOWEN.....	333	diltiazem hcl er		drosiprenone-ethinyl	
desoximetasone	333	.....	100, 101, 102, 108, 119	estradiol	234, 244, 258
desvenlafaxine succinate er	163	diltiazem hcl er beads		DROXIA.....	49
dexamethasone	203, 225	.....	100, 101, 102, 108, 119	droxidopa	67
dexamethasone intensol		diltiazem hcl er coated		DRYSOL.....	328
.....	203, 225	beads	100, 101, 102, 108, 119	DUAKLIR PRESSAIR.	68, 76, 306
dexamethasone sodium		dilt-xr	101, 102, 108, 119	DUAL COMPLEX FORMULA 1	
phosphate	203	dimethyl fumarate	272, 293	KIT.....	71, 342, 346

DUAVEE.....	241, 244	ELIQUIS.....	80	ENDARI.....	300, 346
DUETACT.....	268	ELIQUIS DVT/PE STARTER		endocet	123, 150, 152
duloxetine hcl	145, 163	PACK.....	80	ENDOMETRIN.....	258
DUOPA.....	144	ELITE-OB.....	88, 351, 353	ENFLONSIA.....	40
DUPIXENT.....	313, 337, 346	elixophyllin		ENGERIX-B.....	63
DUREX EXTRA SENSITIVE		.....	111, 159, 188, 320, 350	enilloring	235, 244, 258
THIN.....	304	ELLA.....	234, 258	ENLITE GLUCOSE SENSOR..	176
DUREX TROPICAL.....	304	ELLUME COVID-19 HOME		ENOVARX-AMITRIPTYLINE..	166
dutasteride	278, 279	TEST.....	183	ENOVARX-BACLOFEN.....	72
DUVYZAT.....	300	ELMIRON.....	300	ENOVARX-	
DYCLOPRO.....	326	ELOCTATE.....	84	CYCLOBENZAPRINE HCL.....	71
E.E.S. GRANULES.....	31	eltrombopag olamine	81	ENOVARX-IBUPROFEN.....	343
EAA SUPPLEMENT.....	186	eluryng	234, 244, 258	ENOVARX-LIDOCAINE HCL..	326
EASIVENT.....	175	EMBECTA AUTOSHIELD		ENOVARX-NAPROXEN.....	343
EASY COMFORT SHARPS		DUO.....	176	ENOVARX-TRAMADOL.....	346
CONTAINER.....	175	EMBECTA INS SYR U/F 1/2		enoxaparin sodium	86, 87
EASY TOUCH HEALTHPRO		UNIT.....	176	enpresse-28	235, 244, 258
HIGH/LOW.....	175	EMBECTA INSULIN SYR		enskyce	235, 244, 258
EASYGEL.....	168, 169, 283	ULTRAFINE.....	176	ENSPRYNG.....	275, 293
EASYMAX 15 LEVEL 2-3		EMBECTA INSULIN SYRINGE		ENSTILAR.....	330, 333, 346
CONTROL.....	176	.....	176	ENSURE ORIGINAL.....	186
EASYMAX CONTROL.....	176	EMBECTA INSULIN SYRINGE		ENSURE PLUS.....	186
EASYMAX CONTROL		U-100.....	176	entacapone	142
NORMAL/HIGH.....	176	EMBECTA INSULIN SYRINGE		entecavir	41
EBGLYSS.....	337	U-500.....	176	ENTRESTO.....	94, 95, 117
EC-NAPROSYN		EMBECTA PEN NEEDLE		ENTYVIO PEN.....	211, 218, 271
.....	135, 151, 161, 280	NANO.....	176	enulose	185
ec-naproxen ...135, 151, 161, 280		EMBECTA PEN NEEDLE		EPANED.....	96, 97
econazole nitrate	329	NANO 2 GEN.....	176	EPCLUSA.....	32, 33
econtra one-step ...230, 234, 258		EMBECTA PEN NEEDLE		EPIDIOLEX.....	127
EC-RX DHEA.....	300	ULTRAFINE.....	176	EPIFOAM.....	327, 333
EC-RX ESTRADIOL.....	244, 282	EMBRACE PEN NEEDLES...176		epinastine hcl	21, 197
EC-RX PROGESTERONE.....	258	EMEND.....	221	epinephrine	67, 306
EC-RX TESTOSTERONE.....	228	EMGALITY.....	142	EPINEPHRINE.....	67, 306
EDEX.....	111, 119	EMPAVELI.....	286	epinephrine hcl (nasal)	
EDURANT.....	35	EMSAM.....	148	.....	67, 210, 306
EDURANT PED.....	35	emtricitabine	37	EPIPEN 2-PAK.....	67, 306
EEMT.....	229, 244	emtricitabine-tenofovir df ..37, 41		EPIVIR.....	37
EEMT HS.....	229, 244	emtricitab-rilpivir-tenofov df		eplerenone	
efavirenz	35	.....	35, 37, 41	.....	93, 112, 113, 117, 190
efavirenz-emtricitab-tenofo		EMTRIVA.....	37	EQUETRO.....	127, 132
df	35, 36	EMVERM.....	24	ergocalciferol	356
efavirenz-lamivudine-		emzahh	235, 258	ERGOMAR.....	74, 135
tenofovir	35, 36	enalapril maleate	96	ergotamine-caffeine 74, 135, 159	
EFFER-K.....	190	enalapril-		ERIVEDGE.....	49
effer-k	190	hydrochlorothiazide	97, 193	ERLEADA.....	49, 50
EGATEN.....	24	ENBRACE HR.. 88, 300, 351, 353		erlotinib hcl	50
EGRIFTA SV.....	267	ENBREL.....	277, 288, 293	ERMEZA.....	268
EGRIFTA WR.....	267	ENBREL MINI.....	277, 288, 293	errin	235, 258
ELESTRIN.....	244, 282	ENBREL SURECLICK		ery	31, 198, 324
eletriptan hydrobromide	163	.....	277, 288, 293	ERYGEL.....	31, 198, 324
ELIMITE.....	344	ENCALA.....	186	ERYPED 400.....	31
elimest	234, 244, 258	ENCARE.....	304	erythromycin	31, 198, 324

erythromycin base	31	FANATREX FUSEPAQ ...	123, 127	FLEXICHAMBER ADULT	
erythromycin ethylsuccinate ..	31	FASENRA PEN	313	MASK/SMALL	176
escitalopram oxalate	164	FASTEP COVID-19 ANTIGEN		FLEXICHAMBER CHILD	
eslicarbazepine acetate	127, 147	TEST	183	MASK/LARGE	176
esomeprazole magnesium ...	222	FBL KIT	72, 327, 343, 346	FLEXICHAMBER CHILD	
est estrogens-methyltest		FC2 FEMALE CONDOM	304	MASK/SMALL	176
.....	229, 244	febuxostat	280	FLOLIPID	112
est estrogens-methyltest ds		FEIBA	84	FLORIVA	168, 169, 284, 356
.....	229, 244	feirza 1.5/30	235, 245, 258	FLOTREX	168, 169, 284, 351
est estrogens-methyltest hs		feirza 1/20	235, 245, 258	FLOWFLEX COVID-19 AG	
.....	229, 244	felbamate	127	HOME TEST	184
estarylla	235, 244, 258	FELBATOL	127	FLUAD	63
estazolam	141	felodipine er	109, 110	FLUARIX	63
estradiol	244, 282	FEM PH	342, 346	FLUCELVAX	63
estradiol valerate	244, 282	FEMCAP	304	fluconazole	29
estradiol-norethindrone acet		FEMLYV	235, 245, 258	flucytosine	44
.....	245, 258	FEMRING	245, 282	fludrocortisone acetate	225
estratest f.s.	229, 245	fenofibrate	111	FLULAVAL	63
ESTRATEST H.S.	229, 245	fenofibrate micronized	111	FLUMIST	63
ESTRING	245, 282	fenofibric acid	111	flunisolid	204, 225, 309, 314
ESTROGEL	245, 282	fentanyl	152	fluocinolone acetonide	204, 333
eszopiclone	136, 149	FERRIPROX	223	fluocinolone acetonide body	
ethacrynic acid	92, 112, 188	FETZIMA	163	.....	204, 333
ethambutol hcl	28	FETZIMA TITRATION	163	fluocinolone acetonide scalp	
ethosuximide	165	fidaxomicin	42, 43	.....	204, 333
ethynodiol diac-eth estradiol		FILSPARI	117, 291, 300, 312	fluocinonide	333, 334
.....	235, 245, 258	FILSUVEZ	346	fluocinonide emulsified base	
etodolac	151, 161	FINACEA	324, 346	.....	333
etodolac er	151, 161	finasteride	278, 279, 331	FLUORIDEX	169, 284
etonogestrel-ethinyl		finbolimod hcl	276, 293	FLUORIDEX DAILY	
estradiol	235, 245, 258	FINTEPLA	127	RENEWAL	168, 169, 284
etoposide	50	finzala	235, 245, 258	FLUORIDEX ENHANCED	
etravirine	36	FIORICET	123, 139, 150, 159	WHITENING	169, 284
EUCRISA	326, 343	FIRDAPSE	74, 300	FLUORIMAX 5000	169, 284
EVAMIST	245, 282	FIRMAGON	50, 230	FLUORIMAX 5000 SENSITIVE	
everolimus	50, 273, 298	FIRMAGON (240 MG DOSE)		.....	170, 284
EVOTAZ	38, 300	.....	50, 230	fluorometholone	204
EVRYSDI	300	FIRST-LANSOPRAZOLE	222	fluorouracil	50, 321, 346
EXELDERM	329	FIRST-METRONIDAZOLE		fluoxetine hcl	164, 165
exemestane	50, 230	.....	22, 27, 214	fluphenazine hcl	158
EXENATIDE	252	FIRST-MOUTHWASH BLM		flurandrenolide	334
EXODERM	18, 326, 339	....	19, 20, 209, 210, 213, 214, 327	flurazepam hcl	141
EYSUVIS	203	FIRST-OMEPRAZOLE	222	flurbiprofen	151, 161, 208
EZALLOR SPRINKLE	112	FIRST-PANTOPRAZOLE	222	flurbiprofen sodium	161, 208
ezetimibe	105	FIRST-PROGESTERONE		fluticasone propionate	
ezetimibe-simvastatin ...	105, 112	VGS	259	.....	204, 225, 309, 314, 334
FABHALTA	270, 286	FIRVANQ	31	fluticasone-salmeterol	
falmina	235, 245, 258	FLAREX	204	.....	76, 204, 225, 309
famciclovir	41	flavoxate hcl	349	FLUTICASONE-	
famotidine	20, 220	flecainide acetate	106	SALMETEROL ..	76, 204, 225, 309
FANAPT	137	FLEQSUVY	72	fluvastatin sodium	112
FANAPT TITRATION PACK A	137	FLEXICHAMBER	177	fluvastatin sodium er	112
FANAPT TITRATION PACK C	138			fluvoxamine maleate	165

fluvoxamine maleate er	165	ft laxative	215	glyburide	268
FLUZONE.....	63	ft magnesium citrate	215	glyburide micronized	268
FLUZONE HIGH-DOSE.....	63	ft naloxone hcl	16, 156	glyburide-metformin	232, 268
FML FORTE.....	204	ft nicotine	65, 70	glycolax	215
FML LIQUIFILM.....	204	ft nicotine mini	65, 70	glycopyrrolate	68, 328
FOCALIN.....	159	FUROSCIX.....	92, 112, 188	glydo	327
FOLATEXCEL...88, 190, 351, 353		furosemide	92, 112, 188	GLYTACTIN BETTERMILK 15186	
folic acid	353	FUZEON.....	34	GLYTACTIN BETTERMILK	
FOLLISTIM AQ.....	251	fyavolv	245, 259	DE-LITE.....	186
fondaparinux sodium	79, 88	FYCOMPA.....	127	GLYTACTIN BUILD 10PE.....	186
FORA TEST N' GO ADVANCE		FYREMADEL.....	230	GLYTACTIN BUILD 20/20.....	186
.....	177	gabapentin	123, 127, 145, 146	GLYTACTIN BUILD 20/20	
FORA TEST N'GO ADV-		GALAFOLD.....	194, 300	PKU.....	186
VOICE-6 CON.....	183	galantamine hydrobromide	74	GLYTACTIN BURST.....	186
FORANE.....	147	galantamine hydrobromide		GLYTACTIN COMPLETE	
formaldehyde	185	er	74	10PE.....	186
formoterol fumarate	76, 318	galbriela	235, 245, 259	GLYTACTIN RESTORE 10....	186
FOSAMAX.....	283	gallfrey	259	GLYTACTIN RESTORE 5.....	187
FOSAMAX PLUS D.....	283, 356	GALZIN.....	190	GLYTACTIN RESTORE LITE	
fosamprenavir calcium	38	ganirelix acetate	230	10.....	187
fosfomycin tromethamine	46	GARDASIL 9.....	63	GLYTACTIN RESTORE LITE	
fosinopril sodium	96, 97	gatifloxacin	198	10PE.....	187
fosinopril sodium-hctz ... 97, 193		GATTEX.....	217, 218	GLYTACTIN RTD 10.....	187
FOSRENOL.....	189, 279	gavilax	215	GLYTACTIN RTD 15.....	187
FOTIVDA.....	50	gavilyte-c	215	GLYTACTIN RTD LITE 15.....	187
FRAGMIN.....	87	gavilyte-g	215	GLYTACTIN SWIRL 15.....	187
FRAICHE 5000 DENTAL		gavilyte-n with flavor pack ... 215		GLYTACTIN SWIRL 15PE.....	187
.....	168, 170, 284	GAVRETO.....	50	GLYXAMBI.....	241, 266
FREESTYLE LIBRE 14 DAY		gefitinib	50	GOLYTELY.....	215
READER.....	177	GELFILM.....	84	GOMEKLI.....	51
FREESTYLE LIBRE 14 DAY		gemfibrozil	111	GONAL-F.....	251
SENSOR.....	177	gemmily	235, 245, 259	GONAL-F RFF.....	252
FREESTYLE LIBRE 2 PLUS		generlac	185	GONAL-F RFF REDIRECT.....	252
SENSOR.....	177	gengraf ... 200, 270, 288, 294, 298		goodsense aspirin low dose	
FREESTYLE LIBRE 2		gentamicin sulfate .. 23, 198, 324		.....	90, 91, 135, 162
READER.....	177	gentle laxative	215	goodsense nicotine	65, 70
FREESTYLE LIBRE 2		GENVOYA.....	35, 37	GORDOFILM.....	329, 339
SENSOR.....	177	GILENYA.....	276, 294	granisetron hcl	211
FREESTYLE LIBRE 3 PLUS		GILOTRIF.....	50	GRASTEK.....	60
SENSOR.....	177	glatiramer acetate	269, 294	griseofulvin microsize	25
FREESTYLE LIBRE 3		glatopa	269, 270, 294	griseofulvin ultramicrosize	25
READER.....	177	GLEOSTINE.....	50	guaifenesin-codeine	308, 312
FREESTYLE LIBRE 3		glimepiride	268	guanfacine hcl	104, 111, 143
SENSOR.....	177	glipizide	268	guanfacine hcl er	143
FREESTYLE LIBRE READER	177	glipizide er	268	GUARDIAN 4 GLUCOSE	
FROTEK.....	343	glipizide-metformin hcl	232, 268	SENSOR.....	177
frovatriptan succinate	163	GLOPERBA.....	280	GUARDIAN 4 TRANSMITTER	177
FRUZAQLA.....	50	glucagon emergency kit		GUARDIAN LINK 3	
ft aspirin	90, 91, 135, 162	.....	16, 251, 279	TRANSMITTER.....	177
ft aspirin low dose		GLUCAGON EMERGENCY		GUARDIAN REAL-TIME	
.....	90, 91, 135, 162	KIT.....	16, 251, 279	CHARGER.....	177
ft clearlax	215	GLUCOTROL XL.....	268	GUARDIAN REAL-TIME	
ft folic acid	353	glutaraldehyde	185	REPLACE PED.....	177

GUARDIAN REAL-TIME TEST PLUG.....	177	HUMALOG U-100 JUNIOR KWIKPEN.....	265	<i>hydrocortisone-iodoquinol</i>	22, 328, 335, 342
GUARDIAN SENSOR 3.....	177	HUMATE-P.....	84	<i>hydrocort-pramoxine (perianal)</i>	205, 226, 327, 335
GVOKE HYPOPEN 1-PACK	16, 251, 279	HUMATIN.....	22, 23	<i>hydromet</i>	68, 308
GVOKE HYPOPEN 2-PACK	16, 251, 279	HUMIRA (1 PEN)	219, 277, 289, 294	<i>hydromorphone hcl</i>	153
GVOKE KIT.....	16, 251, 279	HUMIRA (2 PEN)	219, 277, 278, 289, 294	<i>hydromorphone hcl er</i>	153
GVOKE PFS.....	16, 251, 279	HUMIRA (2 SYRINGE)	219, 278, 289, 294	<i>hydroxychloroquine sulfate</i>	26, 271, 289, 295
GYNAZOLE-1.....	329	HUMIRA-CD/UC/HS STARTER.....	219, 278, 289, 294	<i>hydroxyurea</i>	51
<i>habitrol</i>	65, 70	HUMIRA-PSORIASIS/UEIT STARTER.....	219, 278, 289, 295	<i>hydroxyzine hcl</i>	20, 136
HAEGARDA.....	286	HUMULIN 70/30 KWIKPEN	253, 266	<i>hydroxyzine pamoate</i>	20, 136
<i>hailey 1.5/30</i>	235, 245, 259	HUMULIN 70/30 VIAL.....	253, 266	HYFTOR.....	276, 298, 337, 347
<i>hailey 24 fe</i>	235, 245, 259	HUMULIN N KWIKPEN.....	253	HYMPAVZI.....	84
<i>hailey fe 1.5/30</i>	235, 245, 259	HUMULIN N VIAL.....	254	<i>hyoscyamine sulfate</i>	17, 69, 307
<i>hailey fe 1/20</i>	235, 245, 259	HUMULIN R U-500 KWIKPEN.....	266	<i>hyoscyamine sulfate er</i>	17, 69, 307
<i>halcinonide</i>	334	HUMULIN R U-500 VIAL.....	266	<i>hyoscyamine sulfate sl</i>	17, 69, 307
HALCION.....	141	HUMULIN R VIAL.....	266	<i>hyosyne</i>	17, 69, 307
<i>halobetasol propionate</i>	334	HYCANTIN.....	51	HYPERSAL.....	314
<i>haloette</i>	235, 245, 259	<i>hydralazine hcl</i>	111	<i>ibandronate sodium</i>	283
<i>haloperidol</i>	142	HYDREA.....	51	IBRANCE.....	51
<i>haloperidol lactate</i>	142	HYDRO 40.....	93, 189, 209, 339	<i>ibuprofen</i>	135, 151, 161
HALUCORT.....	347	<i>hydrochlorothiazide</i>	93, 118, 193	<i>icatibant acetate</i>	92, 283, 286
HARVONI.....	32, 33	<i>hydrocod poli-chlorphe poli er</i>	20, 21, 308	<i>iclevia</i>	235, 245, 259
HAVRIX.....	63	<i>hydrocodone bitartrate er</i>	152, 153	ICLUSIG.....	51
<i>heather</i>	235, 259	<i>hydrocodone bit-homatrop mbr</i>	68, 308	IDELVION.....	84
HEMANGEOL	72, 98, 104, 107, 113, 135	<i>hydrocodone-</i> <i>acetaminophen</i>	123, 150, 153	IDHIFA.....	51
<i>hematinic/folic acid</i>	88, 353	<i>hydrocodone-ibuprofen</i>	151, 153, 161	IHEALTH CONTROL SOLUTION.....	178
HEMLIBRA.....	84	<i>hydrocortisone</i>	204, 205, 226, 334	IHEALTH COVID-19 RAPID TEST.....	184
HEMMOREX-HC....	204, 225, 334	<i>hydrocortisone (perianal)</i>	204, 225, 334	IHEALTH LANCING DEVICE.....	178
HEMOFIL M.....	84	<i>hydrocortisone ace-</i> <i>pramoxine</i>	204, 225, 327, 334	<i>imatinib mesylate</i>	51
<i>heparin na (pork) lock flsh pf.</i>	87	<i>hydrocortisone acetate</i>	204, 225, 334	IMBRUVICA.....	51, 52
<i>heparin sod (pork) lock flush.</i>	87	<i>hydrocortisone butyrate</i>	204, 225, 334	IMCIVREE.....	125, 223
<i>heparin sodium (porcine)</i>	87	<i>hydrocortisone valerate</i>	205, 226, 334, 335	<i>imipramine hcl</i>	166
<i>heparin sodium (porcine) pf..</i>	87	<i>hydrocortisone valerate</i>	205, 226, 334, 335	<i>imipramine pamoate</i>	166
HEPLISAV-B.....	63	<i>hydrocortisone-acetic acid</i>	205, 208, 226, 335	<i>imiquimod</i>	321, 347
HEPZATO W/50MM CATHETER.....	51			IMKELDI.....	52
HEPZATO W/62MM CATHETER.....	51			IMPAVIDO.....	27, 40
<i>her style</i>	230, 235, 259			IMVEXXY MAINTENANCE PACK.....	245, 246
HETLIOZ.....	136, 148			IMVEXXY STARTER PACK... ..	246
HETLIOZ LQ.....	136, 148			INBRIJA.....	145
HIBERIX.....	63			<i>incassia</i>	235, 259
HIPREX.....	47			INCRELEX.....	267
HUMALOG.....	265			<i>indapamide</i>	93, 118, 194
HUMALOG KWIKPEN.....	265			INDICAID COVID-19 RAPID TEST.....	184
HUMALOG MIX 50/50 KWIKPEN.....	265			INDOCIN.....	151, 161, 280, 281
HUMALOG MIX 75/25 KWIKPEN.....	265			<i>indomethacin</i>	151, 161, 281
HUMALOG MIX 75/25 VIAL....	265				

indomethacin er 151, 161, 281	IRESSA..... 52	KALYDECO..... 311
INFANRIX..... 61, 63	ISENTRESS..... 35	KAPSPARGO SPRINKLE
INGREZZA..... 167	ISENTRESS HD..... 35	 77, 99, 104, 107, 113
INLYTA..... 52	isibloom 235, 246, 259	kariva 236, 246, 259
INOVA..... 336, 342	isoflurane 147	kelnor 1/35 236, 246, 260
INOVA 4/1 ACNE CONTROL	isoniazid 28	KEPPRA..... 127
THERAPY..... 336, 339, 342	isosorb dinitrate-hydralazine	KEPPRA XR..... 127
INOVA 8/2 ACNE CONTROL	 111, 113, 115	KERENDIA..... 112
THERAPY..... 336, 340, 342	isosorbide dinitrate 113, 115	KESIMPTA..... 295
INPEN 100-BLUE-LILLY-	isosorbide mononitrate 113, 115	ketoconazole 29, 329
HUMALOG..... 178	isosorbide mononitrate er	ketodan 30, 329
INPEN 100-BLUE-NOVOLOG-	 113, 115	KETO-DIASTIX..... 184
FIASP..... 178	isotretinoin 340, 347	KETONE CARE..... 185
INPEN 100-GREY-LILLY-	isradipine 109, 110	ketorolac tromethamine
HUMALOG..... 178	ISTALOL..... 72, 98, 107, 201	 151, 161, 208
INPEN 100-GREY-	ISTURISA..... 226, 301	KETORUB..... 343
NOVOLOG-FIASP..... 178	ITOVEBI..... 52	KETOSTIX..... 184
INPEN 100-PINK-LILLY-	itraconazole 29	KEVZARA..... 274, 289
HUMALOG..... 178	ivabradine hcl 103, 104, 119	KINERET..... 274, 289, 295
INPEN 100-PINK-NOVOLOG-	ivermectin 24	KIRSTY..... 265
FIASP..... 178	IWILFIN..... 52	KISQALI (200 MG DOSE)..... 52
INQOVI..... 52	jaimiess 235, 246, 259	KISQALI (400 MG DOSE)..... 52
INREBIC..... 52	JAKAFI..... 52, 338	KISQALI (600 MG DOSE)..... 52
INSPIREASE RESERVOIR	jantoven 79	KLARON..... 324
BAGS..... 178	JARDIANCE..... 266	klayesta 43, 343
INSULIN LISPRO..... 265	jasmiel 235, 246, 259	KLISYRI (250 MG)..... 321, 347
INSULIN LISPRO (1 UNIT	JAYPIRCA..... 52	KLISYRI (350 MG)..... 321, 347
DIAL)..... 265	jencycla 235, 259	klor-con 191
INSULIN LISPRO JUNIOR	JENTADUETO..... 232, 241	klor-con 10 190
KWIKPEN..... 265	JENTADUETO XR..... 232, 241	klor-con m10 190
INSULIN LISPRO PROT &	jinteli 246, 259	klor-con m15 190
LISPRO..... 265	JIVI..... 84	klor-con m20 190
INSULIN PEN NEEDLES 178, 180	JOENJA..... 295	klor-con/ef 191
INSULIN SYRINGES..... 178, 179	jolessa 236, 246, 259	KLOXXADO..... 17, 156
INSUPEN32G EXTR3ME..... 179	JORNAY PM..... 159	KOATE..... 85
INTELENCE..... 36	JOURNAVX..... 123	KOATE-DVI..... 85
INTELISWAB COVID-19	joyeaux 236, 246, 259	KOGENATE FS..... 85
RAPID TEST..... 184	JUBLIA..... 329	KOSELUGO..... 52, 53
INTRAROSA..... 226	juleber 236, 246, 259	KOURZEQ..... 335
introvale 235, 246, 259	JULUCA..... 35, 36	KOVALTRY..... 85
INVELTYS..... 205	junel 1.5/30 236, 246, 259	K-PHOS..... 191
INZIRQO..... 93, 193	junel 1/20 236, 246, 259	K-PHOS NO 2..... 185
iodine strong	junel fe 1.5/30 236, 246, 259	K-PHOS-NEUTRAL..... 191
..... 17, 25, 231, 312, 328	junel fe 1/20 236, 246, 259	K-PRIME..... 191
iodine tincture 328, 342	junel fe 24 236, 246, 259	KRAZATI..... 53
IOPIDINE..... 196, 208	JUST RIGHT 5000..... 170, 284	KRINTAFEL..... 26
IPOL..... 64	JUXTAPID..... 97, 113	KRISTALOSE..... 185
ipratropium bromide 69, 307	JYLAMVO. 52, 271, 289, 295, 298	kurvelo 236, 246, 260
ipratropium-albuterol 69, 76, 307	K.B.G.L IN TERODERM	KYZATREX..... 229, 230
IQIRVO..... 216, 219	 72, 151, 327, 343, 347	labetalol hcl
irbesartan 94, 95	kaitlib fe 236, 246, 259	 72, 75, 94, 99, 104, 107, 114
irbesartan-	KALETRA..... 38	lacosamide 127, 147
hydrochlorothiazide 95, 193	kalliga 236, 246, 259	lactulose 186

lactulose encephalopathy	185	levobunolol hcl	201	LIVMARLI	216, 219
LAGEVRIO	41	levocarnitine	301	LIVTENCITY	29
LAMICTAL	128, 132	levocarnitine sf	301	LO LOESTRIN FE ...	237, 247, 260
LAMICTAL ODT	127, 128, 132	levocetirizine		LODOCO	79, 301
LAMICTAL STARTER	128, 132	dihydrochloride	21	lofexidine hcl	67
LAMICTAL XR	128, 132	levofloxacin .	28, 44, 45, 198, 324	lojaimiess	237, 247, 260
lamivudine	37	levonest	236, 246, 260	LOKELMA	189
lamivudine-zidovudine	37	levonorgest-eth est & eth est		LOMAIRA	121
lamotrigine	128, 132	.....	236, 246, 260	LOMOTIL	69, 212
lamotrigine er	128, 132	levonorgest-eth estrad 91-		LONSURF	53
lamotrigine starter kit-blue		day	236, 247, 260	LOPID	111
.....	128, 132	levonorgest-eth estradiol-		lopinavir-ritonavir	38
lamotrigine starter kit-green		iron	236, 247, 260	LOPRESSOR	
.....	128, 132	levonorgestrel	230, 236, 260	.....	77, 99, 104, 107, 114
lamotrigine starter kit-		levonorgestrel-ethinyl estrad		lorazepam	140, 141
orange	128, 132	.....	236, 247, 260	lorazepam intensol	140, 141
LAMPIT	27	levonorg-eth estrad triphasic		LORBRENA	53
LANCETS	179	.....	236, 247, 260	loryna	237, 247, 260
LANCETS 28G THIN	179	levora 0.15/30 (28) .	236, 247, 260	losartan potassium	94, 95
LANCETS SUPER THIN	179	levorphanol tartrate	153	losartan potassium-hctz .	95, 193
LANOXIN	97, 104	levo-t	268	LOTEMAX	205
lansoprazole	222	levothyroxine sodium	269	LOTEMAX SM	205
lanthanum carbonate	189, 279	levoxyl	269	LOTENSIN	96, 97
LANTUS SOLOSTAR	254	LEVSIN	17, 69, 307	LOTENSIN HCT	97, 193
LANTUS U-100 VIAL	254	LEVSIN/SL	17, 69, 307	loteprednol etabonate	205
lapatinib ditosylate	53	LEVULAN KERASTICK ..	321, 347	lovastatin	112
larin 1.5/30	236, 246, 260	l-glutamine	301, 347	low-ogestrel	237, 247, 260
larin 1/20	236, 246, 260	lidocaine	327	loxapine succinate	136, 144
larin 24 fe	236, 246, 260	lidocaine hcl	209, 327	lo-zumandimine	237, 247, 260
larin fe 1.5/30	236, 246, 260	lidocaine hcl		lubiprostone	211, 219
larin fe 1/20	236, 246, 260	urethral/mucosal	327	LUCEMYRA	67
LASIX	92, 112, 188	lidocaine viscous hcl	209	LUGOLS STRONG IODINE	
LATANOPROST	210	lidocaine-prilocaine	327	.....	328, 342
latanoprost	210	LIDOPIN	327	LUMAKRAS	53, 54
LAZCLUZE	53	LIDTOPIC MAX	327	LUMIGAN	210
LEDIPASVIR-SOFOSBUVIR		LIKMEZ	22, 27, 40, 214, 324	LUMRYZ	143, 167, 281
.....	32, 33	linezolid	43	LUMRYZ STARTER PACK	
leena	236, 246, 260	LINZESS	211, 219	.....	168, 281
leflunomide	275, 289, 295, 298	liothyronine sodium	269	LUPKYNIS	276, 298
lenalidomide	53, 295	liraglutide	125, 252	lurasidone hcl	138
LENVIMA	53	lisdexamfetamine dimesylate		luter	237, 247, 260
lessina	236, 246, 260	.....	122	lyleq	237, 260
letrozole	53, 230	lisinopril	96, 97	lyllana	247, 283
LETS	67, 278	lisinopril-		LYNPARZA	54
leucovorin calcium .	18, 279, 353	hydrochlorothiazide	97, 193	LYRICA	128, 145, 146
LEUKERAN	53	L-ISOLEUCINE	187	LYSODREN	54
LEUKINE	81	LITFULO	338, 347	LYTGOBI (12 MG DAILY	
leuprolide acetate	53, 252	lithium	133	DOSE)	54
levalbuterol hcl	76, 318	lithium carbonate	133	LYTGOBI (16 MG DAILY	
LEVALBUTEROL HFA	76, 318	lithium carbonate er	132	DOSE)	54
LEVBID	17, 69, 307	LITHOBID	133	LYTGOBI (20 MG DAILY	
levetiracetam	128	LITHOSTAT	186	DOSE)	54
levetiracetam er	128	LIVDELZI	216	LYUMJEV KWIKPEN	265

LYUMJEV VIAL.....	265	metformin hcl er	232	microgestin 1/20	237, 247, 261
lyza	237, 260	methadone hcl	153	microgestin fe 1.5/30	
MACROBID.....	47	methadone hcl intensol	153	.....	237, 247, 261
MACRODANTIN.....	47	METHADOSE.....	153	microgestin fe 1/20	237, 247, 261
magnesium citrate	215	methadose	153	MICROLET NEXT LANCING	
MALARONE.....	26	METHADOSE SUGAR-FREE.....	154	DEVICE.....	179
malathion	344	methamphetamine hcl	122	midazolam hcl	141
MALTOCARB.....	187	methazolamide	92, 103, 202	MIDAZOLAM+SYRSPEND SF	
maraviroc	34	methenamine hippurate	47	.....	141
marlissa	237, 247, 260	methenamine mandelate	47	midodrine hcl	67
MARPLAN.....	148	METHERGINE.....	305	MIEBO.....	200, 208
MATULANE.....	54	methimazole	232	MIFEPREX.....	305
matzim la	101, 102, 108, 119	METHITEST.....	229	mifepristone	229, 305
MAVENCLAD...54, 270, 295, 298		methocarbamol	36, 71	MIGERGOT.....	74, 135, 160
MAVYRET.....	33, 34	methotrexate sodium		miglitol	228
MAXIDEX.....	205	.....	54, 271, 289, 290, 295, 298	miglustat	195, 301
MAXITROL.....	198, 205	methotrexate sodium (pf)		mili	237, 247, 261
maxi-tuss ac	308, 312	.....	54, 271, 289, 295, 298	mimvey	247, 261
MAYZENT.....	276, 295	methoxsalen rapid	343	mineral oil heavy	215
MAYZENT STARTER PACK		methscopolamine bromide	69	minocycline hcl	26, 46, 198, 324
.....	276, 295	methsuximide	165	minocycline hcl er	
me/naphos/mb/hyo1	47, 69, 301	methyl salicylate	329	.....	26, 46, 198, 324, 347
meclofenamate sodium	151, 161	methyldopa	67, 104, 111	minoxidil	111, 331
MEDERMA SPF 30.....	347	methylergonovine maleate	305	minzoya	237, 247, 261
MEDROL.....	226	METHYLIN.....	159	MIPLYFFA.....	194
medroxyprogesterone		methyphenidate hcl	160	mirabegron er	350
acetate	237, 260, 261	methyphenidate hcl er	160	mirtazapine	131, 165
mefenamic acid	151, 161	methyphenidate hcl er (cd)	159	MIRVASO.....	197, 322, 347
mefloquine hcl	26	methyphenidate hcl er (la)		misoprostol	221
megestrol acetate	54, 261	.....	159, 160	MITIGARE.....	281
MEKINIST.....	54	methyphenidate hcl er		MITOSOL.....	198
MEKTOVI.....	54	(osm)	160	mm aspirin	90, 91, 135, 162
meleya	237, 261	methylnprednisolone	226	mm clearlax	215
MELOXICAM.....	151, 161	methyln testosterone	229	M-M-R II.....	64
meloxicam	152, 161	metoclopramide hcl	221	M-NATAL PLUS.....	88, 351, 353
memantine hcl	143	metolazone	93, 118, 194	MOBILE LANCETS 30G.....	179
memantine hcl er	143	METOPIRONE.....	184	modafinil	168
MENEST.....	247, 283	metoprolol succinate er		MODD1 SUPPLY KIT.....	179
MENOPUR.....	252	.....	77, 99, 104, 105, 107, 114	MODERNA COVID-19 VAC	
MENOSTAR.....	247, 283	metoprolol tartrate		6M-11Y.....	64
MENQUADFI.....	64	.....	77, 99, 105, 107, 114	moexipril hcl	96, 97
MENVEO.....	64	metoprolol-		molindone hcl	136, 144
meperidine hcl	153	hydrochlorothiazide	99, 105, 193	mometasone furoate	
meprobamate	136, 149	METROCREAM.....	22, 40, 324	.....	205, 226, 309, 314, 335
mercaptapurine	54, 273, 298	METROLOTION.....	22, 40, 324	mono-lynyah	237, 247, 261
merzee	237, 247, 261	metronidazole		MONSELS FERRIC	
mesalamine	213	.....	22, 23, 27, 41, 214, 324	SUBSULFATE.....	85
mesalamine-cleanser	213	metyrosine	184, 301	montelukast sodium	313
mesna	304	mexiletine hcl	106	morphine sulfate	154
MESNEX.....	304	MIACALCIN.....	231, 283	morphine sulfate	
MESTINON.....	74	mibelas 24 fe	237, 247, 261	(concentrate)	154
metaxalone	71	miconazole 3	329	morphine sulfate er	154
metformin hcl	232	microgestin 1.5/30	237, 247, 261	morphine sulfate er beads ...	154

MOTPOLY XR.....	128, 147	nebivolol hcl	72, 99, 105, 107	nicotine step 2	66, 71
MOUNJARO.....	252	NEBUPENT.....	27	nicotine step 3	66, 71
MOVIPREP.....	215, 355	NEBUSAL.....	314	NICOTROL.....	66, 71
moxifloxacin hcl 28, 45, 198, 324		necon 0.5/35 (28) ... 237, 248, 261		NICOTROL NS.....	66, 71
moxifloxacin hcl (2x day) 45, 198		nefazodone hcl	165	nifedipine	109, 110, 119
MOZOBIL.....	81	NEFFY.....	67	nifedipine er	109, 110, 119
MUCOSITISRX.....	208	NEMLUVIO.....	337	nifedipine er osmotic release	
MULPLETA.....	81	NEOCATE SYNEO JUNIOR...187		.....	109, 110, 119
MULTAQ.....	108	neomycin sulfate 23, 198, 324		nikki	237, 248, 261
multivitamin w/fluoride		neomycin-bacitracin zn-		nilotinib hcl	55
.....	168, 170, 284, 351	polymyx	198	nimodipine	109, 110, 119
multivitamin/fluoride		neomycin-polymyxin-		NIMODIPINE.....	109, 110, 119
.....	168, 170, 284, 351, 353	dexameth	198, 205	NINLARO.....	55
multi-vitamin/fluoride		neomycin-polymyxin-		nisoldipine er	109, 110
.....	168, 170, 284, 351	gramicidin	198	nitazoxanide	26, 27
multi-vitamin/fluoride/iron		neomycin-polymyxin-hc		NITRO-BID.....	114, 115
.....	88, 284, 351	.....	199, 206	NITRO-DUR.....	114, 115
mupirocin	324	NEONATAL COMPLETE		nitrofurantoin	47
mupirocin calcium	324	.....	88, 351, 354	nitrofurantoin macrocrystal ...47	
my choice	230, 237, 261	NEONATAL PLUS....	88, 351, 354	nitrofurantoin monohydrate	
my way	230, 237, 261	NEO-POLYCIN.....	199	macrocrystals	47
MYALEPT.....	254	NEO-POLYCIN HC		nitroglycerin ..	114, 115, 330, 347
mycophenolate mofetil ..270, 298		.....	30, 199, 206, 325	NITROSTAT.....	114, 115
mycophenolate sodium	298	NEOTUSS PLUS..	20, 21, 67, 308	NITRO-TIME.....	114, 115
mycophenolic acid	299	NEO-VITAL RX..88, 191, 351, 354		NIVA THYROID.....	269
MYCOZYL AL.....	349	NERLYNX.....	55	NIVESTYM.....	81, 82
MYFEMBREE.....	230, 248, 261	NESTABS.....	88, 351, 354	nora-be	238, 261
MYHIBBIN.....	299	NESTABS ONE 88, 301, 351, 354		NORDIPEN 5 INJECTION	
MYLERAN.....	54	neuac	39, 325, 342	DEVICE.....	179
MYSOLINE.....	139	NEULASTA.....	81	NORDITROPIN FLEXPPO	
MYTESI.....	212	NEUPRO.....	149	.....	255, 267
MYXREDLIN.....	191, 266	NEURAPTINE.....	123, 146	norelgestromin-eth estradiol	
na sulfate-k sulfate-mg sulf. 215		NEURONTIN.....	123, 129, 146	.....	238, 248, 261
nabumetone	152, 161	NEURORUB.....	123, 146	norethin ace-eth estrad-fe	
nadolol		NEVANAC.....	208	.....	238, 248, 261, 262
.....	72, 77, 94, 99, 105, 107, 114	nevirapine	36	norethindrone	238, 262
naloxone hcl		nevirapine er	36	norethindrone acetate	262
.....	17, 18, 156, 279, 280	new day	230, 237, 261	norethindrone acet-ethinyl	
naltrexone hcl		NEXIUM.....	222	est	238, 248, 262
.....	16, 18, 65, 156, 279, 280	NEXLETOL.....	93, 98	norethindrone-eth estradiol	
naproxen	135, 152, 161, 281	NEXLIZET.....	93, 98, 105	.....	248, 262
naproxen dr ... 135, 152, 161, 281		NEXTSTELLIS.....	237, 248, 261	norethindron-ethinyl estrad-	
naproxen sodium		NGENLA.....	255	fe	238, 248, 262
.....	135, 152, 161, 281	niacin er		norethin-eth estradiol-fe	
naratriptan hcl	163	(antihyperlipidemic)	98, 354	.....	238, 248, 262
NARCAN.....	17, 156	nicardipine hcl	109, 110, 119	norgestimate-eth estradiol	
NARDIL.....	148	NICORETTE.....	66, 70, 71	.....	238, 248, 262
NASCOBAL.....	90, 353	NICORETTE MINI.....	66, 70	norgestimate-ethinyl	
NATACYN.....	200	nicotine	66, 71	estradiol triphasic ..	238, 248, 262
NATAL PNV.....	88, 351, 353	nicotine mini	66, 71	NORLIQVA.....	109, 110, 119
NATAZIA.....	237, 248, 261	nicotine polacrilex	66, 71	norlyroc	238, 262
nateglinide	254	nicotine polacrilex mini	66, 71	NORPACE.....	105
NAYZILAM.....	140, 141	nicotine step 1	66, 71	NORPACE CR.....	105

NORPRAMIN.....	166	olanzapine	133, 138, 212	opium	154, 212
nortrel 0.5/35 (28) ..	238, 248, 262	olanzapine-fluoxetine hcl		OPSUMIT.....	119, 312, 319
nortrel 1/35 (21)	238, 248, 262	.....	133, 138, 165, 212	option 2	230, 238, 262
nortrel 1/35 (28)	238, 248, 262	olmesartan medoxomil	94, 95	OPTIONS GYNOL II	
nortrel 7/7/7	238, 248, 262	olmesartan medoxomil-hctz		CONTRACEPTIVE.....	304
nortriptyline hcl	166	.....	95, 193	OPVEE.....	156
NORVIR.....	38	olopatadine hcl	20, 197	OPZELURA.....	55, 338, 347
NOURIANZ.....	121, 143	OLUMIANT.....	275, 290	ORACIT.....	185
NOVAREL.....	252	OMECLAMOX-PAK		ORAL CITRATE.....	185
NOVOEIGHT.....	85	.....	24, 42, 43, 222	ORALAIR.....	60
NOVOFINE PEN NEEDLE.....	179	omega-3-acid ethyl esters		ORALAIR ADULT STARTER	
NOVOFINE PLUS PEN		.....	98, 115	PACK.....	60
NEEDLE.....	179	omeprazole	222	ORALAIR CHILDRENS	
NOVOLIN R FLEXPEN.....	266	OMNIFLEX DIAPHRAGM.....	304	STARTER PACK.....	60
NOVOLIN R FLEXPEN		OMNIPOD 5 DEXG7G6		ORALONE.....	335
RELION.....	266	INTRO GEN 5.....	179	ORAPRED ODT.....	206, 226
NOVOPEN ECHO.....	179	OMNIPOD 5 DEXG7G6 PODS		ORAVIG.....	329
NOVOSEVEN RT.....	85	GEN 5.....	179	ORENCIA.....	271, 290, 296
NOXAFIL.....	30	OMNIPOD 5 LIBRE2 G6		ORENCIA CLICKJECT	
np thyroid	269	INTRO G5.....	179	.....	271, 290, 296
NUBEQA.....	55	OMNIPOD 5 LIBRE2 PLUS G6		ORENITRAM.....	120, 316, 319
NUCALA.....	308	PODS.....	179	ORENITRAM MONTH 1	
NUCORT.....	206, 226, 335	OMNITROPE.....	255, 256, 267	.....	119, 316, 319
NUCYNTA.....	154	OMVOH.....	211, 219	ORENITRAM MONTH 2	
NUCYNTA ER.....	154	OMVOH (300 MG DOSE).....	211	.....	120, 316, 319
NUEDEXTA.....	143	ON/GO COVID-19 ANTIGEN		ORENITRAM MONTH 3	
NULEV.....	17, 69, 307	TEST.....	184	.....	120, 316, 319
NUPLAZID.....	138	ON/GO ONE COVID-19		ORFADIN.....	195, 301
NURTEC.....	142	HOME TEST.....	184	ORGOVYX.....	55, 231
NUWIQ.....	85	ondansetron hcl	211	ORIAHNN.....	231, 249, 262
NUZYRA.....	23	ondansetron odt	212	ORILISSA.....	231
nyamyc	44, 343	ONE VITE WOMENS PLUS		ORKAMBI.....	310, 311
nylia 1/35	238, 248, 262	.....	88, 351, 354	ORLISTAT.....	220
nylia 7/7/7	238, 248, 262	ONETOUCH DELICA PLUS		orphenadrine citrate er	
NYMALIZE.....	109, 110, 119	LANCING.....	179	.....	72, 78, 126
nystatin	44, 343, 344	ONETOUCH DELICA SAFETY		orquidea	238, 262
nystatin-triamcinolone		LANCING.....	179	ORSERDU.....	55
.....	44, 335, 344	ONETOUCH ULTRA.....	179, 183	OSCIMIN.....	17, 69, 307
nystop	44, 344	ONETOUCH ULTRA 2.....	179	oseltamivir phosphate	40
OBIZUR.....	85	ONETOUCH ULTRA BLUE		OSPHENA.....	241
OICALIVA.....	216, 219	TEST.....	183	OTEZLA.....	276, 290, 296, 347
ocella	238, 249, 262	ONETOUCH ULTRA TEST....	183	OVACE PLUS.....	325
octreotide acetate	219, 267	ONETOUCH VERIO.....	180, 183	OVACE PLUS WASH.....	325
OCUFLOX.....	45, 199	ONETOUCH VERIO FLEX		OVACE WASH.....	325
ODACTRA.....	60	SYSTEM.....	180	OVIDE.....	344
ODEFSEY.....	36, 37, 41	ONETOUCH VERIO		OVIDREL.....	252
ODOMZO.....	55	REFLECT.....	180	oxaprozin	152, 161
OFEV.....	307	ONFI.....	140, 141	oxazepam	141
ofloxacin	45, 199	ONUREG.....	55	oxcarbazepine	129, 147
OGSIVEO.....	55	ONYDA XR.....	67	OXERVATE.....	200, 208
OHTUVAYRE.....	306	opcicon one-step ..	230, 238, 262	oxiconazole nitrate	329
OJEMDA.....	55	OPFOLDA.....	195, 301	oxybutynin chloride	350
OJJAARA.....	55	OPILL.....	238, 262	oxybutynin chloride er	350

oxycodone hcl	154, 155	pentazocine-naloxone hcl		pimozide	136, 144
oxycodone-acetaminophen		.....	156, 157	pimtrea	239, 249, 263
.....	124, 150, 155	pentoxifylline er	82	pindolol	73, 99, 105, 107, 114
oxymorphone hcl	155	PEPTICATE.....	187	pioglitazone hcl	268
oxymorphone hcl er	155	perampanel	129	pioglitazone hcl-glimepiride	268
OZEMPIC.....	253	PERFECT POINT SAFETY		pioglitazone hcl-metformin	
OZOBAX DS.....	72	LANCETS.....	180	hcl	232, 268
PACERONE.....	108	PERFECT POINT SAFETY		PIP GLUCOSE CONTROL	
PALFORZIA.....	61	NEEDLE.....	180	SOLUTION.....	180
PALFORZIA (1 MG DAILY		PERFOROMIST.....	76, 318	PIQRAY.....	56
DOSE).....	60	PERIDEX..	23, 200, 201, 328, 342	pirfenidone	307, 308, 316, 317
PALFORZIA INITIAL DOSE 1-		perindopril erbumine	96, 97	piroxicam	152, 161
3YRS.....	61	periogard ..	23, 200, 201, 328, 342	PKU EASY MICROTABS.....	187
PALFORZIA INITIAL DOSE 4-		permethrin	344	PKU EASY MICROTABS	
17YRS.....	61	perphenazine	158	PLUS.....	187
paliperidone er	138	perphenazine-amitriptyline		PKU EASY SHAKE & GO.....	187
PALYNZIQ.....	195	.....	158, 166	PKU GOLIKE PLUS 16+.....	188
PANCREAZE.....	195, 217	PERTZYE.....	195, 217	PKU GOLIKE PLUS 4-16.....	188
PANRETIN.....	321, 348	phenazopyridine hcl	327	PKU START.....	188
pantoprazole sodium	222	phendimetrazine tartrate	121	PLAN B ONE-STEP	231, 239, 263
PARI VORTEX ADULT MASK	180	phendimetrazine tartrate er ..	121	PLEGRIDY.....	296
PARI VORTEX PEDIATRIC		phenelzine sulfate	148	PLEGRIDY STARTER PACK..	296
MASK.....	180	phenobarbital	139	PLENVU.....	215, 355
paricalcitol	356	phenoxybenzamine hcl ..	74, 118	plerixafor	82
PARNATE.....	148	phentermine hcl	121	PNEUMOVAX 23.....	64
paroxetine hcl	165	phentermine-topiramate er ..	124	pnv 27-ca/fe/fa	88, 351, 354
paroxetine hcl er	165	PHENYLADE ESSENTIAL		PODOCON-25.....	340, 348
PAXLOVID (150/100).....	29, 30	DRINK MIX.....	187	podofilox	340, 348
PAXLOVID (300/100 &		PHENYLADE GMP MIX		POLYCIN.....	30, 199, 325
150/100).....	29, 31	DHA/FIBER.....	187	polyethylene glycol 3350	215
PAXLOVID (300/100).....	29, 31	PHENYLADE GMP MIX-IN.....	187	polymyxin b-trimethoprim	
pazopanib hcl	55	PHENYLADE GMP ULTRA...	187	.....	44, 199, 325
PEDIAPRED.....	206, 226	PHENYLADE60 DRINK MIX...	187	POLY-VI-FLOR/IRON	
PEDIARIX.....	62, 64	phenylephrine hcl	209, 210	.....	89, 284, 351
PEDVAX HIB.....	64	phenytek	106, 146	POMALYST.....	56, 296
peg 3350	215	phenytoin	106, 147	portia-28	239, 249, 263
peg 3350-kcl-na bicarb-nacl ..	215	phenytoin infatabs	106, 147	posaconazole	30
peg-3350/electrolytes	215	phenytoin sodium extended		potassium chloride	191
peg-		.....	106, 147	potassium chloride crys er ..	191
3350/electrolytes/ascorbat		PHEXXI.....	304	potassium chloride er	191
.....	215, 355	philith	238, 249, 262	potassium citrate er	185
PEGASYS.....	38, 55, 56, 273, 296	PHOSPHA 250 NEUTRAL.....	191	potassium citrate-citric acid	185
peg-kcl-nacl-nasulf-na asc-c		PHOSPHOLINE IODIDE.....	209	potassium iodide	
.....	215, 355	phosphorous	191	(expectorant)	312
PEG-PREP.....	215	phospho-trin 250 neutral	191	PRADAXA.....	80
PEMAZYRE.....	56	PHOXILLUM B22K4/0.....	191	pramipexole dihydrochloride	
PEN NEEDLE/5-BEVEL TIP ...	180	PHOXILLUM BK4/2.5.....	191	.....	149
PENBRAYA.....	64	phytonadione	17, 280, 356	PRAMOSONE.....	327, 335
penicillamine	17, 223, 290	PIFELTRO.....	36	PRAMOTIC.....	200, 209
penicillin v potassium	40	pilocarpine hcl	74, 209	prasugrel hcl	90
PENTACEL.....	62, 64	PILOT COVID-19 AT-HOME		pravastatin sodium	112
pentamidine isethionate	27	TEST.....	184	praziquantel	24
		pimecrolimus	299, 337, 348	prazosin hcl	73, 94, 99

PRED MILD	206, 227	PRIFTIN	28, 45	pseudoephedrine-	
prednisolone	206, 227	primaquine phosphate	26	bromphen-dm	20, 21, 67, 309
prednisolone acetate	206, 227	primidone	139	PULMOSAL	314
prednisolone sodium		PRIORIX	64	PULMOZYME	196, 314
phosphate	206, 227	PRISMASOL B22GK 4/0	192	PURE COMFORT SAFETY	
prednisone	227	PRISMASOL BGK 0/2.5	192	PEN NEEDLE	180
prednisone intensol	227	PRISMASOL BGK 2/0	192	PURIXAN	56, 273, 299
pregabalin	129, 145, 146	PRISMASOL BGK 2/3.5	192	PYLERA	25, 27, 46, 212, 214
PREGNYL	252	PRISMASOL BGK 4/0/1.2	192	pyrazinamide	28
PREKUNIL	188	PRISMASOL BGK 4/2.5	192	PYRIDIUM	327
PREMARIN	249, 283	PRISMASOL BK 0/0/1.2	192	pyridostigmine bromide	74
PREMESISRX 191, 301, 351, 354		probenecid	194, 281	pyridostigmine bromide er	74
premium lidocaine	327	PROCENTRA	122	PYRIDOSTIGMINE BROMIDE	
PREMPHASE	249, 263	prochlorperazine	158, 213	ER	74
PREMPRO	249, 263	prochlorperazine maleate		pyrimethamine	26
prenatal	89, 351, 354	.....	158, 213	PYROGALLIC ACID 305, 340, 348	
prenatal plus vitamin/mineral		PROCTOFOAM HC		PYRUKYND	79
.....	89, 351, 354	.....	206, 227, 327, 335	PYRUKYND TAPER PACK	79
PRENATE	192, 352, 354	procto-med hc	206, 227, 335	QBRELIS	97
PRENATE DHA		PROCTOSOL HC ...	206, 227, 335	QFITLIA	85
.....	89, 191, 301, 352, 354	PROCTOZONE-HC 206, 227, 335		QINLOCK	56
PRENATE ELITE	89, 352, 354	PROCYSBI	302	QSYMIA	124
PRENATE ENHANCE		PROFILNINE	85	QUADRACEL	62, 64
.....	89, 191, 301, 352, 354	progesterone	263	QUESTRAN	100
PRENATE ESSENTIAL		PROGESTERONE		QUESTRAN LIGHT	100
.....	89, 192, 301, 352, 354	MICRONIZED	263	quetiapine fumarate	133, 138
PRENATE MINI		PROGLYCEM	231	quetiapine fumarate er	133, 138
.....	89, 192, 301, 352, 354	PROGRAF	270, 299, 337	QUFLORA PEDIATRIC	
PRENATE PIXIE		PROMACTA	82	.....	168, 169, 170, 285, 352
.....	89, 192, 301, 352, 354	promethazine hcl		QUICK TOUCH INSULIN PEN	
PRENATE RESTORE		....	19, 20, 136, 137, 212, 217, 313	NEEDLE	180
.....	89, 192, 301, 352, 354	promethazine-codeine		QUICKVUE AT-HOME	
PREPIDIL	305	.....	20, 21, 309	COVID-19 TEST	184
PRETOMANID	28	promethazine-dm	20, 21, 309	quinapril hcl	96, 97
prevalite	100	promethazine-phenylephrine		quinapril-	
PREVIDENT	168, 170, 285	.....	20, 21, 67	hydrochlorothiazide	97, 193
PREVIDENT 5000 BOOSTER		PROMETHEGAN		quinidine gluconate er	26, 105
PLUS	170, 284	.....	20, 21, 137, 212, 217, 313	quinidine sulfate	26, 106
PREVIDENT 5000 DRY		PRONAL	329, 340	quinine sulfate	26
MOUTH	168, 170, 284	propafenone hcl	106	QULIPTA	142
PREVIDENT 5000 ENAMEL		propafenone hcl er	106	QVAR REDHALER 227, 310, 315	
PROTECT	170, 284	proparacaine hcl	209	rabeprazole sodium	222
PREVIDENT 5000 KIDS. 170, 284		propranolol hcl		RADICAVA ORS	121, 143
PREVIDENT 5000 ORTHO		.....	73, 99, 105, 107, 114, 135	RADICAVA ORS STARTER	
DEFENSE	170, 284	propranolol hcl er		KIT	121, 143
PREVIDENT 5000 PLUS		.....	73, 99, 105, 107, 114, 135	RADIOGARDASE	18, 189, 280
.....	168, 170, 285	propylthiouracil	232	RAGWITEK	61
PREVIDENT 5000 SENSITIVE		PROQUAD	64	RALDESY	165
.....	170, 285	PRO-STAT/FIBER	188	raloxifene hcl	241, 283
PREVNAR 20	64	protriptyline hcl	166	ramelteon	137, 148
PREVYMIS	29	PROVERA	263	ramipril	96, 97
PREZCOBIX	38, 301	prucalopride succinate	220	ranolazine er	103
PREZISTA	38	PRURADIK	344	rasagiline mesylate	148, 149

RASUVO.....	272, 290, 291	rivastigmine tartrate	74	sertraline hcl	165
RAVICTI.....	186	rivelsa	239, 249, 263	setlakin	239, 249, 263
RAYA SURE PEN NEEDLE...	180	RIVFLOZA.....	302	sevelamer carbonate	
RAYASAL.....	340	RIVIVE.....	18, 156	.....	18, 189, 280
react	231, 239, 263	RIXUBIS.....	86	sevoflurane	147
REAL FOOD BLENDS.....	188	rizatriptan benzoate	164	sf	169, 170, 285
reclipsen	239, 249, 263	ROCALTROL.....	356	sf 5000 plus	169, 170, 285
RECOMBINATE.....	86	ROCKLATAN.....	210	SFROWASA.....	213
RECOMBIVAX HB.....	64	roflumilast	315, 338, 339, 343	sharobel	239, 263
RECOTHROM.....	86	ROMVIMZA.....	56	SHARPS COLLECTOR.....	180
RECOTHROM SPRAY KIT.....	86	ropinirole hcl	149	SHARPS CONTAINER.....	180
RECTIV.....	114, 330, 348	rosuvastatin calcium	112	SHINGRIX.....	65
REFRESH AA 15 PKU.....	188	rosyrah	239, 249, 263	SIGNIFOR.....	267
REGLAN.....	221	ROTARIX.....	64	sildenafil citrate	
RELENZA DISKHALER.....	40	ROTATEQ.....	64	.....	116, 315, 319, 350
RELISTOR.....	156, 211, 220	ROWASA.....	213	silodosin	75
RELNATE DHA.89, 302, 352, 354		roweepra	129	SILVADENE.....	328, 342
RENTHYROID.....	269	ROZLYTREK.....	56, 57	silver nitrate	200
repaglinide	254	RUBRACA.....	57	silver sulfadiazine	328, 342
REPATHA.....	115	RUCONEST.....	286, 287	simliya	239, 249, 263
REPATHA PUSHTRONEX		rufinamide	129, 147	simpesse	239, 249, 263
SYSTEM.....	115	RUKOBIA.....	34	SIMPONI.....	220, 278, 291, 297
REPATHA SURECLICK.....	115	RYBELSUS.....	253	simvastatin	112
RESTASIS.....	200, 207, 270	RYDAPT.....	57	SINEMET.....	145
RESTORIL.....	142	sacubitril-valsartan ...	94, 95, 117	SINGULAIR.....	313
RETACRIT.....	78, 82	SAFETY PEN NEEDLES.....	180	sirolimus	276, 299, 337, 338
RETEVMO.....	56	SALAGEN.....	74, 209	SIRTURO.....	29
RETROVIR.....	37	SALICATE.....	340	SIVEXTRO.....	43
REVLIMID.....	56, 297	salicylic acid	340	SKYCLARYS.....	302
REVUFORJ.....	56	salsalate	162	SKYRIZI.....	220, 338, 348
REXTOVY.....	18, 156	SALVAX DUO PLUS.....	330, 340	SKYRIZI PEN.....	338, 348
REXULTI.....	138	SAMSCA.....	194	SKYTROFA.....	256
REYATAZ.....	38	SANTYL.....	196, 330, 348	SLYND.....	231, 239, 263
REYVOW.....	163, 164	sapropterin dihydrochloride		smooth lax	216
REZDIFFRA.....	269	.....	195, 302	sod citrate-citric acid	185
REZLIDHIA.....	56	SAVAYSA.....	80	sod fluoride-potassium	
REZUROCK.....	302	SAVELLA.....	145, 163	nitrate	170, 285
RHOFADE.....	210, 322, 348	SAVELLA TITRATION PACK		sodium chloride	314
RHOPRESSA.....	210	.....	145, 163	sodium fluoride	169, 171, 285
ribavirin	41, 42	saxagliptin hcl	241	sodium fluoride 5000 enamel	
RIDAURA.....	222, 272, 291, 297	saxagliptin-metformin er		.....	170, 285
rifabutin	28, 45	.....	232, 241	sodium fluoride 5000 plus	
rifampin	28, 45	SAXENDA.....	125, 253	.....	169, 170, 285
RIFAMPIN+SYRSPEND SF29, 45		SCALACORT DK.....	335, 340	sodium fluoride 5000 ppm	
riluzole	121, 143	SCARCIN.....	348	.....	169, 171, 285
rimantadine hcl	22	SCEMBLIX.....	57	sodium fluoride 5000	
RINVOQ.....	275, 291	scopolamine	69, 212, 220	sensitive	171, 285
RINVOQ LQ.....	275	SELECT-OB.....	89, 352, 354	SODIUM OXYBATE.....	143, 168, 281
risedronate sodium	283	selegiline hcl	148, 149	sodium phenylbutyrate	186
risperidone	133, 138	selenium sulfide	328, 342	sodium polystyrene	
ritonavir	38	SELZENTRY.....	34	sulfonate	18, 189, 280
rivaroxaban	80	SEREVENT DISKUS.....	76, 318	sodium sulfacetamide	325
rivastigmine	74	SEROSTIM.....	256, 267	sodium sulfacetamide wash	325

SOFOSBUVIR-VELPATASVIR 32, 34	SUBOXONE.....156, 157	SYMPROIC.....211, 220
SOHONOS.....302	subvenite 129, 133	SYMTUZA.....37, 38, 302
solifenacin succinate 350	subvenite starter kit-blue 129, 133	SYNAPRYN FUSEPAQ..... 155
SOLIQUEA..... 253, 254	subvenite starter kit-green 129, 133	SYNAREL..... 252
SOLOSEC.....27	subvenite starter kit-orange 129, 133	SYNDROS..... 213, 220
SOMAVERT.....267	SUCRAID.....196	SYNJARDY.....232, 266
SOOLANTRA.....344	sucralfate 221, 222	SYNJARDY XR.....232, 233, 266
sorafenib tosylate 57	SUFLAVE.....216	TABLOID.....57
sotalol hcl 73, 99, 105, 107, 108, 114	SULAR..... 110	TABRADOL FUSEPAQ..... 71
sotalol hcl (af) 73, 99, 105, 107, 108, 114	SULCONAZOLE NITRATE.....329	TABRECTA.....57
SOTYKTU..... 339, 348	sulfacetamide sodium .. 199, 325	TACLONEX.....330, 335, 348
SOTYLIZE 73, 99, 105, 107, 108, 114	sulfacetamide sodium (acne) 325	tacrolimus 270, 299, 338, 348
SOVALDI..... 32	sulfacetamide sodium (cleans)..... 325	tadalafil 116, 315
SPEEDY SWAB COVID-19	sulfacetamide sodium-sulfur 325, 340	tadalafil (pah) 116, 315, 319
ANTIGEN.....184	sulfacetamide sod-sulfur wash 325, 340	TADLIQ..... 116, 315, 319
SPEVIGO.....338	sulfacetamide-prednisolone 199, 206	TAFINLAR.....57
SPIKEVAX..... 65	sulfacetamide-sulfur in urea 325, 340	tafluprost (pf) 210
spinosad 344	sulfadiazine 45	TAGRISSE..... 57
SPIRIVA HANDIHALER....69, 307	sulfamethoxazole- trimethoprim 27, 45, 47	take action 231, 239, 263
SPIRIVA RESPIMAT..... 69, 307	sulfamez wash 325, 340	TAKHZYRO..... 92, 287, 299
spironolactone 93, 112, 113, 117, 190	SULFAMYLON.....325, 342	TALZENNA..... 57
spironolactone-hctz 93, 113, 117, 190, 193	sulfasalazine 45, 213, 272, 291, 297	tamoxifen citrate 57, 241
SPORANOX.....30	sulfatrim pediatric 27, 46, 47	tamsulosin hcl 75
SPRAVATO (56 MG DOSE) 131, 149	sulfurated lime 344	TANLOR..... 71
SPRAVATO (84 MG DOSE) 131, 149	sulindac 152, 162	TAPERDEX 12-DAY..... 206, 227
sprintec 28 239, 249, 263	sumatriptan 164	TAPERDEX 6-DAY..... 206, 227
SPRIX..... 152, 162, 208	sumatriptan succinate 164	TAPERDEX 7-DAY..... 206, 227
SPS (SODIUM POLYSTYRENE SULF) 18, 189, 280	sumatriptan succinate refill subcutaneous solution cartridge 164	tarina 24 fe 239, 249, 263
sronyx 239, 249, 263	SUMAXIN.....325, 340	tarina fe 1/20 eq 239, 249, 263
ssd 328, 342	sunitinib malate 57	TARPEYO.....228
SSKI.....312	SUNLENCA..... 28, 34	tasimelteon 137, 148
sss 10-5 325, 340	SUNOSI..... 168	tavaborole 343
SSS 10-5.....325, 340	SUPREP BOWEL PREP KIT..216	TAVALISSE..... 79
ST JOSEPH LOW DOSE 91, 135, 162	SUTAB..... 216	TAVNEOS.....270, 286, 287
STENDRA.....116	syeda 239, 249, 263	taysofy 239, 249, 263
STEQEYMA..... 274	SYMBICORT..... 77, 227	tazarotene 340, 348
STIOLTO RESPIMAT..... 69, 76	SYMBYAX.....133, 138, 165, 213	TAZORAC.....340, 341, 348
STIVARGA.....57	SYMDEKO..... 310, 311	TAZVERIK..... 57
STRENSIQ.....196	SYMFI..... 36, 37	TECHLITE LANCETS 26G..... 180
STRIBILD..... 35, 37, 302	SYMPAZAN..... 140, 142	TECHLITE PLUS PEN NEEDLES..... 180
STRIVERDI RESPIMAT... 77, 318		TEGLUTIK..... 121, 143
STROMECTOL..... 24		TEGRETOL.....129, 133
		TEGRETOL-XR..... 129, 133
		TEKTRUNA.....117
		telmisartan 95
		telmisartan-hctz 95, 194
		temazepam 142
		TEMBEXA.....42
		temozolomide 57
		TENCON.....124, 139, 150
		TENIVAC..... 62
		tenofovir disoproxil fumarate 37

TEPMETKO.....	57	TIROSINT-SOL.....	269	<i>triamcinolone acetonide</i>	228, 336
<i>terazosin hcl</i>	73, 94, 99	TISSEEL.....	330, 348	<i>triamterene</i>	93, 117, 190
<i>terbinafine hcl</i>	22	TIVICAY.....	35	<i>triamterene-hctz</i>	190, 194
<i>terbutaline sulfate</i>	77, 318	TIVICAY PD.....	35	<i>triazolam</i>	142
<i>terconazole</i>	329	<i>tizanidine hcl</i>	71	TRICITRASOL.....	79
<i>teriflunomide</i>	270, 297	TOBI NEBULIZER.....	23, 199	<i>tricitrates</i>	185
TERIPARATIDE.....	254, 281	TOBI PODHALER.....	23, 199	<i>triderm</i>	228, 336
<i>terrell</i>	147	TOBRADEX.....	23, 199, 207	<i>trientine hcl</i>	223
TESTIM.....	229, 231	<i>tobramycin</i>	23, 199	<i>tri-estarylla</i>	239, 249, 263
<i>testosterone</i>	229, 231	<i>tobramycin-dexamethasone</i>	23, 199, 207	<i>trifluoperazine hcl</i>	158
<i>testosterone cypionate</i>	229, 231	.....	23, 199, 207	<i>trifluridine</i>	201
<i>testosterone enanthate</i>	229, 231	TOBREX.....	23, 199	<i>trihexyphenidyl hcl</i>	70, 126
<i>tetrabenazine</i>	167	TODAY SPONGE.....	304	TRIJARDY XR.....	233, 241, 266, 267
<i>tetracaine hcl</i>	209, 278	<i>tolcapone</i>	142	TRIKAFTA.....	310, 311, 312
<i>tetracycline hcl</i>	26, 46, 214, 326	<i>tolterodine tartrate</i>	350	<i>tri-legest fe</i>	239, 249, 263
TEXACORT.....	207, 228, 336	<i>tolvaptan</i>	194	TRILEPTAL.....	129, 130, 147
TEZSPIRE.....	313, 317	TOPAMAX.....	129, 135	<i>tri-lynyah</i>	239, 249, 264
THALOMID.....	58, 297	TOPAMAX SPRINKLE.....	129, 135	<i>tri-lo-estarylla</i>	239, 249, 264
THEO-24.....	111, 160, 188, 320, 350	TOPICORT.....	336	<i>tri-lo-marzia</i>	239, 249, 264
<i>theophylline</i>	111, 160, 188, 321, 350	<i>topiramate</i>	129, 136	<i>tri-lo-mili</i>	239, 249, 264
<i>theophylline er</i>	111, 160, 188, 321, 350	<i>toremifene citrate</i>	58, 241	<i>tri-lo-sprintec</i>	239, 250, 264
THIOLA.....	302	<i>torpenz</i>	58, 273	<i>trimethobenzamide hcl</i>	213
THIOLA EC.....	302	<i>torsemide</i>	92, 112, 189	<i>trimethoprim</i>	47
<i>thioridazine hcl</i>	158	TOUJEO MAX SOLOSTAR.....	254	<i>tri-mili</i>	239, 250, 264
<i>thiothixene</i>	166	TOUJEO SOLOSTAR.....	254	<i>trimipramine maleate</i>	166
THROMBIN-JMI.....	86	TPOXX.....	29	TRINATE.....	89, 352, 355
THROMBIN-JMI EPISTAXIS.....	86	TRACLEER.....	120, 312, 319	TRINTELLIX.....	165
THROMBOGEN.....	86	TRADJENTA.....	241	TRIPLE COMPLEX FORMULA	327, 343, 349
<i>thyroid</i>	269	<i>tramadol hcl</i>	155	3 KIT.....	199, 207, 208
<i>tiadylt er</i>	101, 102, 108, 120	<i>tramadol hcl (er biphasic)</i>	155	TRIPLE PMB.....	199, 207, 208
<i>tiagabine hcl</i>	129, 146	<i>tramadol hcl er</i>	155	TRIPLE PMK.....	199, 207, 208
TIAZAC... ..	101, 102, 103, 109, 120	<i>tramadol-acetaminophen</i>	124, 150, 155	<i>tri-sprintec</i>	239, 250, 264
TIBSOVO.....	58	<i>trandolapril</i>	96, 97	TRISTART DHA	89, 192, 302, 352, 355
<i>ticagrelor</i>	91	<i>trandolapril-verapamil hcl er</i>	97, 103	TRIUMEQ.....	35, 37
TIGLUTIK.....	121, 143	.....	97, 103	TRIUMEQ PD.....	35, 37
TIKOSYN.....	108	<i>tranexamic acid</i>	86	TRI-VI-FLORO	169, 171, 285, 352, 353, 355, 356
<i>tilia fe</i>	239, 249, 263	<i>tranylcypromine sulfate</i>	149	<i>tri-vite/fluoride</i>	169, 171, 285, 352, 353, 355, 356
<i>timolol hemihydrate</i>	73, 99, 107, 201	<i>travoprost (bak free)</i>	210	<i>tri-vylibra</i>	239, 250, 264
<i>timolol maleate</i>	73, 99, 105, 107, 114, 135, 201	<i>trazodone hcl</i>	165	<i>tri-vylibra lo</i>	239, 250, 264
<i>timolol maleate (once-daily)</i>	73, 99, 107, 201	TRELEGY ELLIPTA	70, 77, 207, 228, 310	<i>tropium chloride</i>	350
<i>timolol maleate ocudose</i>	73, 99, 107, 201	.....	70, 77, 207, 228, 310	TRUE COMFORT SAFETY	181
<i>timolol maleate pf</i>	73, 99, 107, 201	TREMFYA.....	272, 338, 349	PEN NEEDLE.....	304
.....	73, 99, 107, 201	TREMFYA CROHNS	272, 338, 349	TRUE COVER.....	355
TIMOPTIC OCUDOSE	73, 100, 108, 201	INDUCTION.....	272, 338	<i>true laxative</i>	216
<i>tinidazole</i>	28	TREMFYA ONE-PRESS	272, 338, 349	TRUE METRIX LEVEL 1.....	181
<i>tiopronin</i>	302	TREMFYA PEN.....	272, 338	TRUE METRIX LEVEL 2.....	181
		<i>tretinoin</i>	58, 331	TRUE METRIX LEVEL 3.....	181
		TRETEN.....	86	TRULICITY.....	253
		TREXALL.....	58, 272, 291, 297, 299		
		TREZIX.....	124, 150, 155, 160		

TRUMENBA.....	65	ursodiol	217	VERIFINE INSULIN PEN	
TRUQAP.....	58	URSODIOL+SYRSPEND SF..	217	NEEDLE.....	181
TRUVADA.....	37, 42	VAFSEO.....	82	VERIFINE INSULIN SYRINGE	
TRYNGOLZA.....	98, 228, 281	valacyclovir hcl	42	.....	181
TRYVIO.....	312	VALCHLOR.....	321, 349	VERIFINE PLUS PEN	
TUKYSA.....	58	valganciclovir hcl	42	NEEDLE.....	181
TURALIO.....	58	valproic acid ..	130, 133, 136, 146	VERIFINE SAFE LANCET	
turpentine	330	valsartan	95	MINI 21G.....	181
turqoz	240, 250, 264	VALSARTAN.....	95	VERIFINE SAFE LANCET	
TWIIST REFILL KIT.....	181	valsartan-		MINI 23G.....	181
TWIIST REFILL		hydrochlorothiazide	96, 194	VERIFINE SAFE LANCET	
KIT/INFUSION SET.....	181	VALTOCO 10 MG DOSE.....	140	MINI 28G.....	181
TWIIST STARTER KIT.....	181	VALTOCO 15 MG DOSE.....	140	VERIFINE SAFE LANCET	
TWINRIX.....	65	VALTOCO 20 MG DOSE.....	140	MINI 30G.....	181
TWIRLA.....	240, 250, 264	VALTOCO 5 MG DOSE.....	140	VERIFINE SHARPS	
TYBLUME.....	240, 250, 264	valtya 1/50	240, 250, 264	CONTAINER.....	181
TYBOST.....	302	VANCOCIN.....	31	VERISAFE SAFETY STERILE	
tydemy	240, 250, 264, 355	vancomycin hcl	31, 32	NEEDLE.....	181
TYENNE.....	275	VANCOMYCIN+SYRSPEND		VERKAZIA.....	200, 207, 270
TYMLOS.....	254, 281	SF.....	32	VERQUVO.....	105, 121
TYRVAYA.....	66, 208	VANDAZOLE.....	23, 41, 326	VERSAPENN (AG)	
TYVASO.....	120, 316, 320	VANFLYTA.....	58	ANHYDROUS.....	305
TYVASO DPI INSTITUTIONAL		VANRAFIA.....	291, 312	VERSAPENN (AL) ANHYD	
KIT.....	120, 316, 319	VAQTA.....	65	LIPID.....	306
TYVASO DPI MAINTENANCE		vardenafil hcl	116, 117	VERZENIO.....	59
KIT.....	120, 316, 320	varenicline tartrate	66, 71	vestura	240, 250, 264
TYVASO DPI TITRATION KIT		varenicline tartrate (starter)		VFEND.....	30
.....	120, 316, 320	.....	66, 71	VIBERZI.....	212, 220
TYVASO REFILL KIT		varenicline tartrate(continue)		vienna	240, 250, 264
.....	120, 316, 320	.....	66, 71	vigabatrin	130, 146
TYVASO STARTER KIT		VARIVAX.....	65	VIGADRONE.....	130, 146
.....	120, 316, 320	VAXELIS.....	62, 65	VIGAFYDE.....	146
UBRELVY.....	142	VAXNEUVANCE.....	65	VIJOICE.....	303
UCERIS.....	228	VCF VAGINAL		vilazodone hcl	165
UDENYCA.....	82	CONTRACEPTIVE.....	305	VILEVEV MB.....	47, 70, 124, 303
ULTANE.....	147	VECAMEYL.....	118	VIMPAT.....	130, 147
UNIFINE OTC PEN NEEDLES		velivet	240, 250, 264	VIOKACE.....	196, 217
.....	181	VELPHORO.....	189	viorele	240, 250, 264
UNIFINE PROTECT PEN		VELTASSA.....	190	VIRACEPT.....	38
NEEDLE.....	181	VENCLEXTA.....	58	VIREAD.....	37
UNISTRIP CONTROL.....	181	VENCLEXTA STARTING		VISTOGARD.....	19, 280
unithroid	269	PACK.....	59	VITAFOL FE+	
UPNEEQ.....	210	VENELEX.....	349	.....	89, 192, 303, 352, 355
UPTRAVI.....	320	venlafaxine hcl	163	VITAFOL-OB+DHA	
UPTRAVI TITRATION.....	320	venlafaxine hcl er	163	.....	89, 192, 303, 352, 355
urea	93, 189, 209, 341	VENTAVIS.....	120, 316, 320	VITAMIN C BRIGHTENING	
urea nail	93, 189, 209, 341	VEOZAH.....	143	SERUM.....	330
URELLE.....	47, 70, 124, 303	verapamil hcl		vitamin d (ergocalciferol)	356
UREMEZ-40.....	93, 189, 209, 341	.....	101, 102, 103, 109, 121	VITATHELY WITH GINGER	
uretron d/s	47, 70, 124, 303	verapamil hcl er		.....	89, 352, 355
UROCIT-K 10.....	185	.....	101, 102, 103, 109, 120	VITRAKVI.....	59
UROCIT-K 15.....	185	VEREGEN.....	341, 349	VIVAGUARD INO CONTROL	
UROGESIC-BLUE.....	47, 70, 303			SOLUTION.....	181, 182

VIVAGUARD LANCETS 30G . 182	WIDE-SEAL DIAPHRAGM 75 305	XROMI..... 60
VIVAGUARD LANCING	WIDE-SEAL DIAPHRAGM 80 305	XTAMPZA ER..... 155
DEVICE.....182	WIDE-SEAL DIAPHRAGM 85 305	XTANDI.....60
VIVAGUARD SAFETY	WIDE-SEAL DIAPHRAGM 90 305	xulane 240, 250, 264
LANCETS 28G.....182	WIDE-SEAL DIAPHRAGM 95 305	XURIDEN.....19, 303
VIVJOA..... 30	WILATE.....86	XYNTHA..... 86
VIZIMPRO.....59	WINREVAIR.....317	XYNTHA SOLOFUSE.....86
VOCABRIA..... 35	wixela inhub 77, 207, 228, 310	XYWAV..... 144
volnea 240, 250, 264	wymzya fe 240, 250, 264	YASMIN 28..... 240, 250, 264
VONJO.....59	XACIATO..... 39, 326	YAZ..... 240, 250, 264
VONVENDI..... 86	xarah fe 240, 250, 264	YESINTEK..... 275
VOQUEZNA.....221, 222	XARELTO..... 80	YEZTUGO.....34
VOQUEZNA DUAL PAK... 24, 221	XARELTO STARTER PACK.....80	YORVIPATH..... 254
VOQUEZNA TRIPLE PAK	XATMEP... 59, 272, 291, 297, 299	YUPELRI.....70, 307
..... 24, 42, 43, 221	XCOPRI..... 130, 148	yuvaferm 250, 283
VORANIGO.....59	XDEMVY..... 200	ZACARE..... 330, 342
voriconazole 30	XELJANZ..... 275, 291	ZACLIR CLEANSING..... 342
VORTEX VALVE CHAMBER-	XELJANZ XR..... 275, 291	zafemy 240, 250, 265
PEDI MASK..... 182	XELPROS..... 210	zafirlukast 313
VORTEX VALVED HOLDING	xelria fe 240, 250, 264	zaleplon 137, 149
CHAMBER..... 182	XELSTRYM.....122	ZANAFLEX..... 72
VOSEVI.....33, 34	XENICAL.....220	ZARONTIN.....166
VOWST..... 220, 303	XERMELO..... 212	ZARXIO.....82
VOXZOGO.....303	XIFAXAN.....45	ZAVZPRET..... 142
VOYDEYA.....286	XIIDRA..... 201, 207	ZEGALOGUE.....18, 251, 280
VP FC KIT.....71, 343, 349	XIRUN.....330, 341	ZEJULA.....60
VP GKL KIT..... 327, 343, 349	XOFLUZA (40 MG DOSE).. 29, 31	ZELAPAR.....148, 149
VRAYLAR..... 138	XOFLUZA (80 MG DOSE).. 29, 31	ZELBORAF..... 60
VTAMA.....326, 330, 349	XOLAIR.....273, 274, 317	ZEMPLAR..... 356
vyfemla 240, 250, 264	XOLEGEL COREPAK	zenatane 341, 349
VYKAT XR..... 124	 30, 329, 336	ZENPEP.....196, 217
VYLEESI..... 144, 223	XOLEGEL DUO/HEAD &	ZEPATIER..... 33, 34
vylibra 240, 250, 264	SHOULDERS.....30, 329, 342	ZEPBOUND..... 125, 253
VYNDAMAX.....103, 144, 303	XOLEGEL DUO/XOLEX	ZEPOSIA..... 297
VYNDAQEL..... 103, 303	 30, 329, 342	ZEPOSIA 7-DAY STARTER
WAINUA.....281	XOLREMDI..... 82	PACK..... 297
WAKIX..... 168	XOPENEX HFA..... 77, 318	ZEPOSIA STARTER KIT..... 297
warfarin sodium 80	XOSPATA..... 59	ZIAGEN.....38
WEGOVY..... 125, 253	XPHOZAH.....189, 190, 220	zidovudine 38
WELIREG..... 59	XPOVIO (100 MG ONCE	ZILBRYSQ..... 271, 286
wera 240, 250, 264	WEEKLY)..... 59	zileuton er 313
WESCAP-PN DHA	XPOVIO (40 MG ONCE	ZILXI..... 26, 46, 200, 326
..... 89, 192, 303, 352, 355	WEEKLY)..... 59	ZIMHI..... 18, 156, 280
WESNATAL DHA COMPLETE	XPOVIO (40 MG TWICE	ZIOPTAN..... 210
..... 89, 192, 303, 352, 355	WEEKLY)..... 59	ziprasidone hcl 134, 138
WESNATE DHA 89, 303, 353, 355	XPOVIO (60 MG ONCE	ZIRGAN..... 42, 201
wes-phos 250 neutral 192	WEEKLY)..... 59	ZITHROMAX.....42, 43
WESTGEL DHA	XPOVIO (60 MG TWICE	ZITHROMAX TRI-PAK.....42, 43
..... 89, 192, 303, 353, 355	WEEKLY)..... 59	ZITHROMAX Z-PAK..... 42, 43
wheat germ oil 356	XPOVIO (80 MG ONCE	ZOKINVY..... 195, 303, 304
WIDE-SEAL DIAPHRAGM 60 305	WEEKLY)..... 60	ZOLINZA.....60
WIDE-SEAL DIAPHRAGM 65 305	XPOVIO (80 MG TWICE	zolmitriptan 164
WIDE-SEAL DIAPHRAGM 70 305	WEEKLY)..... 60	zolpidem tartrate 137, 149

zolpidem tartrate er	137, 149
ZOMIG	164
ZONEGRAN	130, 148
ZONISADE	130, 148
zonisamide	130, 148
ZONTIVITY	91
ZORYVE	315, 339, 343, 349
zovia 1/35 (28)	240, 250, 265
ZTALMY	130, 146
ZTLIDO	278, 328
ZUBSOLV	156, 157, 158
zumandimine	240, 250, 265
ZURZUVAE	131
ZYDELIG	60
ZYFLO	313
ZYLET	200, 207
ZYVOX	43