



2026 Illinois Large Group 4-Tier Essential Prescription Drug List

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 All previous versions of this PDL are no longer in effect.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

The current PDL can also be accessed online at uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists. Scroll down to Illinois section. An example of a plan coverage document may be accessed online at [2025-IL-LrgGrp-SBC.pdf](#).

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

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

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

Updated 11/1/2025

Contents

Understand your medication options.....3

How do I use my PDL?5

What are tiers?6

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

Additional programs and details7

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

Requesting a prior authorization.....9

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

Prescription delivery options.....9

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

How do I get updated information about my pharmacy benefit? ...10

Nondiscrimination notice and access to communication services ...11

Prescription drug list.....15

Understand your medication options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do I use my PDL?

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

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

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

1. A drug is listed alphabetically by its brand and generic names or, if only the generic equivalent is covered under the plan, then just by its generic name, in the therapeutic category and class to which it belongs;
2. The generic name for a brand-name drug is included after the brand-name in parentheses and all lowercase bold and italicized letters;
3. If a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all bold and italicized lowercase letters; and
4. 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>)	4	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	

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

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

Drug Tier 1	Your lowest cost medications	SP	Specialty medication
Drug Tier 2	Your mid-range cost medications	CM	Orally administered anti-cancer medication
Drug Tier 3	Your mid-range cost medications	SMCS	Specialty medication cost share may apply
Drug Tier 4	Your highest cost medications	E	Excluded from coverage unless covered as part of health care reform preventive
PA	Prior authorization required	SM	Cost-share cap by state mandate applies when condition appropriate
QL	Quantity limit		
H	Part of health care reform		
H-N	Part of health care reform preventive with confirmation of age and/or condition appropriate preventive use		

What are tiers?

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

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

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

\$	Drug tier	Includes	Helpful tips
\$	Tier 1 Your lowest cost	Medications that provide the highest overall value. Mostly generic drugs. Some preferred brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
\$\$	Tier 2 and 3 Your mid-range cost	Medications that provide good overall value. A mix of brand-name and generic drugs.	Use Tier 2 or Tier 3 drugs instead of Tier 4 to help reduce your out-of-pocket costs.
\$\$\$	Tier 4 Your highest cost	Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Many Tier 4 drugs have lower-cost options in Tier 1, 2 or 3. Ask your provider if they could work for you.

Please note: If you have a high deductible plan, the tier cost levels may apply once you reach your deductible. Your cost-share will not exceed the lesser of the cost-sharing amount or the retail price of the medication without the drug coverage. Refer to your enrollment and plan materials on myuhc.com, or call the toll-free number on your member ID card for more information about your benefit plan. For information related to specialty medication cost share, please refer to the Specialty Medication Cost Share (SMCS) section below.

When does the PDL change?

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

- Medications may move to a lower tier or coverage may be added at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier, become non-formulary, or the dosage form covered may change, most often on Jan. 1, May 1, or Sept. 1.
- Medications may be subject to new or updated utilization management requirements at any time. This includes prior authorization or quantity limits. These changes most commonly occur upon FDA approval of a medication or its generic equivalent, or on scheduled update dates: Jan. 1, May 1, or Sept. 1.

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

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

Additional programs and details

Based on your benefit, the following may apply.

Patient Protection and Affordable Care Act (PPACA) zero cost-share preventive care medication when age and/or condition appropriate – This medication is part of a health care reform preventive benefit and may be available at no cost to you when used for appropriate preventive purposes. PPACA zero cost-share preventive care medications can be obtained, free of charge, at network pharmacies with a prescription from a prescribing provider. A prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products. PPACA zero cost-share preventive care medications are obtained at a network pharmacy with a prescription order or refill from a provider and are payable at 100% of the prescription drug charge (without application of any Copayment, Coinsurance, Deductible) as required by applicable law under any of the following:

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

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

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

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

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

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

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

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

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

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

Your right to request access to a non-formulary drug

This plan must cover all medically necessary Prescription Drug Products.

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

Urgent requests

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

External review

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

Expedited external review

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

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

Requesting a prior authorization

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization from us. Your prescribing provider can submit a request by phone to Optum Rx® or electronically by contacting us at [ProviderPA.com](https://www.providerpa.com). Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your prescribing provider may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested Prescription Drug Product meets plan criteria. You may determine whether a particular Prescription Drug Product is subject to prior authorization by going online at myuhc.com or by calling at the toll-free phone number on the back of your member ID card.

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

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

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

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

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

Prescription delivery options

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

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

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

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

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

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

How do I get updated information about my pharmacy benefit?

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

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

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

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

Sign in to myuhc.com for the following pharmacy information and tools:

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

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

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

Learn more

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

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

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

في احطه: انك ستحصل على مساعدة اللغة العربية (Arabic)، وسوف يترك خدم ابال لمساعدته اللغة العربية
تماما على ابال لمساعدته بلسان اخرى، مثل طاعة بالحروف العربية لصل ال لمساعدته اللغة العربية، و
طالع العربي فال مصود اصل.

দেখুন: আপক্ষ যক্ষ বাংলায় (Bengali-Bangala) কথা বটে : , তাহলে ক্র: মূর্' ভাষা সহায়তা
পক্ষষবা এবং বড় মুদ্রা ফ্রমতো অ: ' i: ' ফ্রম্মা টে যোগাযোগপ্ত্র আপ: ফ্রজ: ' ক্র: মূর্'
উপ ক্র। আপ: ফ্রস: সেরে ফ্রপক্ষচয়পর্ ফ্রকার্ডেফ্র ' i -ক্র: স্বফ্রেক কর:

ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Cambodian-Mon-Khmer)
សេវាជំនួយភាសាកម្ពុជា និងការទំនាក់ទំនងដកកម្ពុជាផ្គត់ផ្គង់ជូនជូនជូន
ដូចជាពុម្ពអក្សរជំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខដកកម្ពុជាផ្គត់ផ្គង់នៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

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

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

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlose 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), ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆພຣີ. ເຊັ່ນ: ກິນພິມຕວອັກສອນຂະໜາດໃຫຍ່. ໂທຫາເບີໂທພຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

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

بوحه: لکړه يې د اې واپسې (Persian-Farsi) صحېپ مېکندې حېماپ پلېکاډ کمکې دېلې و لېدېا طاب
پلېکاډ دې و اېلې هې ټېکړې هېلېدې حېا پېرر کې دې سېرېسېس مېا هېلېدې. دېلېس مېا پېه پلېکاډ مېدرج روي کارې
سېلېلې عېنوف ټېا رېه مېا سې مېکېدې.

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 ਸ਼ਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ
ਫ਼੍ਰਮੈਟਾਂ, 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.

موجود ہیں: اگر اب اردو (Urdu) ردا ے لہے مصیبت و ردا ے کی معاو ے خدمات اور بیکر واپس ے
مواطن اب، جس ے درجہ رب، اب کل ے مقب ے شہاد اب ے ممبر ے احی ے کارب رے سے کھول وری
ممبر 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 Illinois

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION	1
ANTIDOTE THERAPEUTICS	15
ANTIHISTAMINE DRUGS - Drugs for Allergy	17
ANTI-INFECTIVE AGENTS - Drugs for Infections	19
ANTINEOPLASTIC AGENTS - Drugs for Cancer	42
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM	53
AUTONOMIC DRUGS	59
AUTONOMIC DRUGS - Drugs for the Nervous System	60
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood	70
CARDIOVASCULAR DRUGS	82
CARDIOVASCULAR DRUGS - Drugs for the Heart	84
CENTRAL NERVOUS SYSTEM AGENTS	109
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System	109
DENTAL AGENTS	144
DENTAL AGENTS - Oral Care	145
DEVICES - Medical Supplies and Durable Medical Equipment	147
DIAGNOSTIC AGENTS	158
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants	159
ELECTROLYTIC, CALORIC, AND WATER BALANCE	159
ENZYMES	166
EYE, EAR, NOSE AND THROAT (EENT) PREPS.	168
GASTROINTESTINAL DRUGS	180
GASTROINTESTINAL DRUGS - Drugs for the Stomach	181
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron	190
HORMONES AND SYNTHETIC SUBSTITUTES	190
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones	190
IMMUNOMODULATORY AGENTS (90:00)	232
LOCAL ANESTHETICS - Drugs for Numbing	240
MISCELLANEOUS THERAPEUTIC AGENTS	240
NONHORMONAL CONTRACEPTIVES - Drugs for Women	262
OXYTOCICS - Drugs for Women	263
PHARMACEUTICAL AIDS	263
RESPIRATORY TRACT AGENTS - Drugs for the Lungs	263
SKIN AND MUCOUS MEMBRANE AGENTS	277
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin	277
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles	299
VITAMINS	300

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>)	3	
<i>ft naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
<i>glucagon emergency kit injection solution reconstituted 1 mg</i>	2	
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	2	QL (0.4 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	2	QL (0.4 ml per prescription.)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (<i>glucagon</i>)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	2	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
<i>iodine strong oral solution 5 %</i>	1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (<i>hyoscyamine sulfate</i>)	4	
LEVSIN ORAL TABLET 0.125 MG (<i>hyoscyamine sulfate</i>)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (<i>hyoscyamine sulfate</i>)	4	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
<i>penicillamine oral tablet 250 mg</i>	3	
<i>phytonadione oral tablet 5 mg</i>	3	QL (5 tablets per prescription.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
ANTIDOTES (91:04)		
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
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 acd</i>)	3	
FLUOROPYRIMIDINE ANTIDOTE		
VISTOGARD ORAL PACKET 10 GM (<i>uridine triacetate</i>)	3	QL (20 packets per prescription.)
ANTI HISTAMINE DRUGS - Drugs for Allergy		
ANTI HISTAMINE DRUGS - Drugs for Allergy		
<i>promethazine hcl oral tablet 25 mg</i>	1	
ETHANOLAMINE DERIVATIVES - Drugs for Allergy		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy		
<i>cypheptadine hcl oral syrup 2 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>cypheptadine hcl oral tablet 4 mg</i>	1	
FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>cypheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cypheptadine hcl oral tablet 4 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	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 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 15-6.25 mg/5ml, 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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 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 15-6.25 mg/5ml, 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	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	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
<i>epinastine hcl ophthalmic solution 0.05 %</i>	4	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>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	
HUMATIN ORAL CAPSULE 250 MG (<i>paromomycin sulfate</i>)	2	

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

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	4	QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicillin-clarithro-vonoprazan</i>)	4	QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
<i>albendazole oral tablet 200 mg</i>	3	QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (<i>praziquantel</i>)	4	
EGATEN ORAL TABLET 250 MG (<i>triclabendazole</i>)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (<i>mebendazole</i>)	4	QL (6 tablets per 3 days.)
<i>ivermectin oral tablet 3 mg</i>	1	PA; QL (20 tablets per 3 months.)
<i>ivermectin oral tablet 6 mg</i>	1	PA
<i>praziquantel oral tablet 600 mg</i>	2	
STROMECTOL ORAL TABLET 3 MG (<i>ivermectin</i>)	4	PA; QL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	1	
<i>griseofulvin microsize oral tablet 500 mg</i>	1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	1	
<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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTILEPROSY AGENTS - Antibiotics		
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
ANTIMALARIALS - Drugs for the Mouth and Throat		
ARAKODA ORAL TABLET 100 MG (<i>tafenoquine succinate</i>)	4	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	4	
<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>)	4	PA
<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>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>)	4	
<i>mefloquine hcl oral tablet 250 mg</i>	1	
<i>minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	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>	3	PA
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
<i>quinine sulfate oral capsule 324 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>tetracycline hcl oral capsule 250 mg, 500 mg</i>	3	
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>)	4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
IMPAVIDO ORAL CAPSULE 50 MG (<i>miltefosine</i>)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (<i>nifurtimox</i>)	4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (<i>nifurtimox</i>)	4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	4	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>nitazoxanide oral tablet 500 mg</i>	2	QL (6 tablets per prescription.)
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	2	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	4	PA; QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	4	PA; 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>)	4	
<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	4	
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	
SIRTURO ORAL TABLET 100 MG, 20 MG (<i>bedaquiline fumarate</i>)	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (<i>maribavir</i>)	4	PA; QL (4 tablets per day.)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (60 tablets per 365 days. 30 tablets per prescription.)
PREVYMIS ORAL PACKET 120 MG, 20 MG (<i>letermovir</i>)	3	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG (<i>letermovir</i>)	3	PA
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	
<i>ketoconazole external shampoo 2 %</i>	1	
<i>ketoconazole oral tablet 200 mg</i>	1	
<i>ketodan external foam 2 %</i>	3	
NOXAFIL ORAL PACKET 300 MG (<i>posaconazole</i>)	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML (<i>posaconazole</i>)	4	QL (20 ml per day.)
<i>posaconazole oral suspension 40 mg/ml</i>	2	QL (20 ml per day.)
<i>posaconazole oral tablet delayed release 100 mg</i>	2	
SPORANOX ORAL CAPSULE 100 MG (<i>itraconazole</i>)	4	QL (180 capsules per 365 days)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>voriconazole</i>)	4	QL (300 mL per prescription.)
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (<i>oteseconazole</i>)	3	PA; QL (18 capsules per 84 days.)
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	1	QL (300 mL per prescription.)
<i>voriconazole oral tablet 200 mg</i>	1	QL (62 tablets per prescription.)
<i>voriconazole oral tablet 50 mg</i>	1	QL (124 tablets per prescription)
BACITRACIN ANTIBIOTICS - Antibiotics		
<i>bacitracin 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	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (<i>bacitracin-polymyx-neo-hc</i>)	3	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM (<i>bacitracin-polymyxin b</i>)	3	
CORONAVIRUS (COVID-19) - Drugs for Viral Infections		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	3	QL (60 tablets per 365 days. 30 tablets per prescription.)
ENDONUCLEASE INHIBITORS - Drugs for Viral Infections		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (<i>baloxavir marboxil</i>)	3	QL (1 tablet per month.)
ERYTHROMYCIN ANTIBIOTICS - Antibiotics		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>erythromycin ethylsuccinate</i>)	3	
<i>ery external pad 2 %</i>	1	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (<i>erythromycin ethylsuccinate</i>)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
VANOCIN ORAL CAPSULE 125 MG, 250 MG (<i>vancomycin hcl</i>)	4	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	1	
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	1	
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (2 packets per day and 84 packets per 720 days.)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (1 packet per day and 84 packets per 720 days.)
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (84 tablets per 720 days.)
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (1 pellet packet per day and 28 pellet packets per month.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (1 tablet per day and 28 tablets per month.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	3	PA; QL (1 tablet per day and 28 tablets per month.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
SOVALDI ORAL PACKET 150 MG, 200 MG (<i>sofosbuvir</i>)	4	PA; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	3	PA; QL (84 tablets per 720 days.)
HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	3	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	3	PA; QL (168 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	3	PA; QL (84 tablets per 720 days.)
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	3	PA; QL (84 tablets per 720 days (12 weeks).)
HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (2 packets per day and 84 packets per 720 days.)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (1 packet per day and 84 packets per 720 days.)
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (1 tablet per day.)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; QL (84 tablets per 720 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (1 pellet packet per day and 28 pellet packets per month.)
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; QL (1 tablet per day and 28 tablets per month.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	3	PA; QL (1 tablet per day and 28 tablets per month.)
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	3	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	3	PA; QL (168 tablets per 720 days.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	3	PA; QL (84 tablets per 720 days.)
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	3	PA; QL (84 tablets per 720 days (12 weeks).)
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	4	PA; QL (24 tablets per year.)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (<i>lenacapavir sodium</i>)	4	PA; QL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	4	PA; QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	4	QL (4 tablets per year.); SM
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
<i>maraviroc oral tablet 150 mg, 300 mg</i>	2	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	4	PA
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	2	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (<i>maraviroc</i>)	4	PA

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofo</i>)	4	QL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	2	QL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	4	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	2	SM
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	2	SM
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	2	QL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	4	QL (1 tablet per day.); SM
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	3	SM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	3	SM
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivud</i>)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
HIV NONNUCLEOSIDE REV.TRANScrip. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofo</i>)	4	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofo df</i>)	2	QL (1 tablet per day.)
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	2	SM
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (<i>rilpivirine hcl</i>)	2	SM
<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.)

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	2	QL (1 tablet per day.)
emtricitabine oral capsule 200 mg	2	SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofovir df oral tablet 200-25-300 mg	3	QL (1 tablet per day.); SM
EMTRIVA ORAL SOLUTION 10 MG/ML (emtricitabine)	2	SM
GENVOYA ORAL TABLET 150-150-200-10 MG (elviteg-cobic-emtricit-tenofaf)	4	QL (1 tablet per day.)
lamivudine oral solution 10 mg/ml	1	SM
lamivudine oral tablet 100 mg	1	
lamivudine oral tablet 150 mg, 300 mg	1	SM
lamivudine-zidovudine oral tablet 150-300 mg	1	SM
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitab-rilpivir-tenofovir af)	4	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (zidovudine)	4	SM
RETROVIR ORAL SYRUP 50 MG/5ML (zidovudine)	3	SM
STRIBILD ORAL TABLET 150-150-200-300 MG (elviteg-cobic-emtricit-tenofdf)	4	QL (1 tablet per day.); SM
SYMFI ORAL TABLET 600-300-300 MG (efavirenz-lamivudine-tenofovir)	2	QL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	2	H-N
TRIUMEQ ORAL TABLET 600-50-300 MG (abacavir-dolutegravir-lamivud)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (emtricitabine-tenofovir df)	4	QL (1 tablet per day.); SM
VIREAD ORAL POWDER 40 MG/GM (tenofovir disoproxil fumarate)	3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	2	
zidovudine oral capsule 100 mg	1	SM
zidovudine oral syrup 50 mg/5ml	1	SM
zidovudine oral tablet 300 mg	1	SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HIV 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	SM
<i>darunavir oral tablet 600 mg, 800 mg</i>	1	SM
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	2	
<i>fosamprenavir calcium oral tablet 700 mg</i>	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>)	4	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	2	
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	2	SM
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	2	SM
PREZISTA ORAL TABLET 150 MG, 75 MG (<i>darunavir</i>)	2	SM
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	2	SM
<i>ritonavir oral tablet 100 mg</i>	2	SM
VIRACEPT ORAL TABLET 250 MG, 625 MG (<i>nelfinavir mesylate</i>)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	3	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	3	
LINCOMYCIN ANTIBIOTICS - Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (<i>clindamycin hcl</i>)	4	
CLEOCIN ORAL CAPSULE 75 MG (<i>clindamycin hcl</i>)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (<i>clindamycin palmitate hcl</i>)	4	
CLEOCIN VAGINAL CREAM 2 % (<i>clindamycin phosphate</i>)	4	
<i>clindacin etz external swab 1 %</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>clindacin 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 (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.)
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
ENFLONSIA 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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>)	4	
METROCREAM EXTERNAL CREAM 0.75 % (<i>metronidazole</i>)	4	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	2	
VANDAZOLE VAGINAL GEL 0.75 % (<i>metronidazole</i>)	4	
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>	3	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (<i>entecavir</i>)	2	
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitabine/rilpivir-tenofovir</i>)	4	QL (1 tablet per day.); SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	4	QL (1 tablet per day.); H; SM
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1	QL (1 tablet per day.); SM
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	QL (1 tablet per day.); H; SM
<i>emtricitab-rilpivir-tenofovir df oral tablet 200-25-300 mg</i>	3	QL (1 tablet per day.); SM
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	2	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	2	
LAGEVRIO ORAL CAPSULE 200 MG (<i>molnupiravir</i>)	3	QL (80 capsules per 365 days. 40 capsules per prescription.)
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofovir af</i>)	4	QL (1 tablet per day.)
<i>ribavirin inhalation solution reconstituted 6 gm</i>	3	
<i>ribavirin oral capsule 200 mg</i>	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (<i>brincidofovir</i>)	4	
TEMBEXA ORAL TABLET 100 MG (<i>brincidofovir</i>)	4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (<i>emtricitabine-tenofovir df</i>)	4	QL (1 tablet per day.); SM
<i>valacyclovir hcl oral tablet 1 gm</i>	1	QL (31 tablets per prescription)
<i>valacyclovir hcl oral tablet 500 mg</i>	1	QL (62 tablets per prescription.)
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	1	
<i>valganciclovir hcl oral tablet 450 mg</i>	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (<i>ganciclovir</i>)	4	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	QL (136 mL per 10 days.)
<i>fidaxomicin oral tablet 200 mg</i>	4	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>azithromycin</i>)	4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	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>)	4	QL (136 mL per 10 days.)
<i>fidaxomicin oral tablet 200 mg</i>	4	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>azithromycin</i>)	4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	2	
<i>linezolid oral tablet 600 mg</i>	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (<i>linezolid</i>)	4	
PENICILLINASE-RESISTANT PENICILLINS - Antibiotics		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	1	
POLYENE ANTIFUNGALS - Drugs for Fungus		
<i>klayesta external powder 100000 unit/gm</i>	1	QL (120 grams per prescription.)
<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>)	4	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (<i>flucytosine</i>)	4	
ANCOBON ORAL CAPSULE 500 MG (<i>flucytosine</i>)	3	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
QUINOLONE ANTIBIOTICS - Antibiotics		
BAXDELA ORAL TABLET 450 MG (<i>delafloxacin meglumine</i>)	4	
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>)	4	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>levofloxacin ophthalmic solution 0.5 %, 1.5 %</i>	1	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<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>)	4	
<i>ofloxacin ophthalmic solution 0.3 %</i>	1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	
<i>ofloxacin otic solution 0.3 %</i>	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	
SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics		
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	4	
<i>sulfadiazine oral tablet 500 mg</i>	1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<i>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	3	
AVIDOXY ORAL TABLET 100 MG	4	
<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	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	3	
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (<i>sulfamethoxazole-trimethoprim</i>)	4	
BACTRIM ORAL TABLET 400-80 MG (<i>sulfamethoxazole-trimethoprim</i>)	4	
<i>fosfomycin tromethamine oral packet 3 gm</i>	3	
HIPREX ORAL TABLET 1 GM (<i>methenamine hippurate</i>)	4	
MACROBID ORAL CAPSULE 100 MG (<i>nitrofurantoin monohyd macro</i>)	4	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>nitrofurantoin macrocrystal</i>)	4	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>methenamine hippurate oral tablet 1 gm</i>	1	
<i>methenamine mandelate oral tablet 0.5 gm, 1 gm</i>	1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystals oral capsule 100 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
nitrofurantoin oral suspension 25 mg/5ml	3	
ORLYNVAH ORAL TABLET 500-500 MG (sulopenem etzadrox-probenecid)	4	QL (10 tablets per course of therapy.)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
trimethoprim oral tablet 100 mg	1	
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
uretron d/s oral tablet 81.6 mg	4	
UROGESIC-BLUE ORAL TABLET 81.6 MG (methen-hyosc-meth blue-na phos)	2	
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	3	QL (4 tablets per day.); CM
abirtega oral tablet 250 mg	3	QL (4 tablets per day.); CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (niraparib-abiraterone acetate)	4	PA; QL (2 tablets per day.); SP; CM; SMCS
ALECENSA ORAL CAPSULE 150 MG (alectinib hcl)	3	PA; QL (8 capsules per day.); CM
ALUNBRIG ORAL TABLET 180 MG, 90 MG (brigatinib)	3	PA; QL (1 tablet per day.); CM
ALUNBRIG ORAL TABLET 30 MG (brigatinib)	3	PA; QL (4 tablets per day.); CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (brigatinib)	3	PA; QL (30 packs per year.); CM
anastrozole oral tablet 1 mg	1	H-N
AUGTYRO ORAL CAPSULE 160 MG (repotrectinib)	3	PA; QL (60 capsules per month.); CM
AUGTYRO ORAL CAPSULE 40 MG (repotrectinib)	3	PA; QL (8 capsules per day.); CM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (<i>avutometinib-defactinib</i>)	4	PA; QL (66 capsules/tablets per month.); SP; CM; SMCS
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (<i>avapritinib</i>)	4	PA; QL (1 tablet per day.); CM
<i>bexarotene external gel 1 %</i>	4	QL (60 grams per prescription.)
<i>bexarotene oral capsule 75 mg</i>	3	CM
<i>bicalutamide oral tablet 50 mg</i>	1	CM
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	3	PA; QL (3 Capsules per day.); SP; CM; SMCS
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	3	PA; QL (1 Capsule per day.); SP; CM; SMCS
BRUKINSA ORAL CAPSULE 80 MG (<i>zanubrutinib</i>)	4	PA; CM
BRUKINSA ORAL TABLET 160 MG (<i>zanubrutinib</i>)	4	PA; QL (60 capsules per month.); CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
CALQUENCE ORAL TABLET 100 MG (<i>acalabrutinib maleate</i>)	3	PA; QL (2 tablets per day.); CM
<i>capecitabine oral tablet 150 mg, 500 mg</i>	2	CM
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	3	PA; QL (2 tablets per day.); SP; CM; SMCS
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	3	PA; QL (1 tablet per day.); SP; CM; SMCS
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
COMETRIQ ORAL KIT 20 MG (<i>cabozantinib s-malate</i>)	3	PA; QL (93 capsules per month.); SP; CM; SMCS
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (<i>cabozantinib s-malate</i>)	3	PA; QL (124 capsules per month.); SP; CM; SMCS
COMETRIQ ORAL KIT 80 & 20 MG (<i>cabozantinib s-malate</i>)	3	PA; QL (62 capsules per month.); SP; CM; SMCS
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (<i>duvelisib</i>)	4	PA; QL (2 capsules per day.); SP; CM; SMCS
COTELLIC ORAL TABLET 20 MG (<i>cobimetinib fumarate</i>)	4	PA; QL (63 tablets per 21 days); SP; CM; SMCS
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	3	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	3	CM
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg</i>	3	PA; QL (1 tablet per day.); CM
<i>dasatinib oral tablet 20 mg</i>	3	PA; QL (90 tablets per month.); CM
DAURISMO ORAL TABLET 100 MG, 25 MG (<i>glasdegib maleate</i>)	3	PA; QL (2 tablets per day.); SP; CM; SMCS
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	1	CM
ERIVEDGE ORAL CAPSULE 150 MG (<i>vismodegib</i>)	3	PA; QL (1 capsule per day.); SP; CM; SMCS
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	3	PA; QL (1 tablet per day.)
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	3	PA; QL (4 tablets per day.); CM
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	3	PA; QL (1 tablet per day.); SP; CM; SMCS
<i>erlotinib hcl oral tablet 25 mg</i>	3	PA; QL (2 tablets per day.); SP; CM; SMCS
<i>etoposide oral capsule 50 mg</i>	1	CM
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	3	PA; QL (2 tablets per day.); CM
<i>everolimus oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); CM

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HYCANTIN ORAL CAPSULE 1 MG (<i>topotecan hcl</i>)	3	PA; QL (305 capsules per 15 days.); CM
<i>hydroxyurea oral capsule 500 mg</i>	1	CM
ICLUSIG ORAL TABLET 15 MG, 45 MG (<i>ponatinib hcl</i>)	4	PA; QL (1 tablet per day.); SP; CM; SMCS
IDHIFA ORAL TABLET 100 MG, 50 MG (<i>enasidenib mesylate</i>)	3	PA; QL (1 tablet per day.); CM
<i>imatinib mesylate oral tablet 100 mg</i>	1	QL (6 tablets per day.); CM
<i>imatinib mesylate oral tablet 400 mg</i>	1	QL (1 tablet per day.); CM
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	3	PA; QL (4 capsules per day.); CM
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	3	PA; QL (1 capsule per day.); CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (<i>ibrutinib</i>)	3	PA; QL (7.2 ml per day.); CM
IMBRUVICA ORAL TABLET 420 MG (<i>ibrutinib</i>)	3	PA; QL (1 tablet per day.); CM
IMKELDI ORAL SOLUTION 80 MG/ML	4	PA; QL (280 ml (2 bottles) per month.); CM
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	4	PA; QL (6 tablets per day.); SP; CM; SMCS
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	4	PA; QL (124 tablets per 30 days.); SP; CM; SMCS
INQOVI ORAL TABLET 35-100 MG (<i>decitabine-cedazuridine</i>)	4	PA; QL (5 tablets per month.); SP; CM; SMCS
IRESSA ORAL TABLET 250 MG (<i>gefitinib</i>)	4	PA; QL (2 tablets per day.); CM
ITOVEBI ORAL TABLET 3 MG (<i>inavolisib</i>)	3	PA; QL (56 tablets per month.); CM
ITOVEBI ORAL TABLET 9 MG (<i>inavolisib</i>)	3	PA; QL (28 tablets per month.); CM
IWILFIN ORAL TABLET 192 MG (<i>eflornithine hcl</i>)	3	PA; QL (8 tablets per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	3	PA; QL (2 tablets per day.); CM
JAYPIRCA ORAL TABLET 100 MG (<i>pirtobrutinib</i>)	4	PA; QL (3 tablets per day.); CM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
JAYPIRCA ORAL TABLET 50 MG (<i>pirtobrutinib</i>)	4	PA; QL (1 tablet per day.); CM
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	3	PA; QL (21 tablets per month.); CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	3	PA; QL (42 tablets per 21 days.); CM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (<i>ribociclib succinate</i>)	3	PA; QL (63 tablets per 21 days.); CM
KOSELUGO ORAL CAPSULE 10 MG (<i>selumetinib sulfate</i>)	3	PA; QL (8 capsules per day.); CM
KOSELUGO ORAL CAPSULE 25 MG (<i>selumetinib sulfate</i>)	3	PA; QL (4 capsules per day.); CM
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (<i>selumetinib sulfate</i>)	3	PA
KRAZATI ORAL TABLET 200 MG (<i>adagrasib</i>)	4	PA; QL (6 tablets per day.); CM
<i>lapatinib ditosylate oral tablet 250 mg</i>	3	PA; QL (186 tablets per month.); CM
LAZCLUZE ORAL TABLET 240 MG (<i>lazertinib mesylate</i>)	4	PA; QL (30 tablets per month.); CM
LAZCLUZE ORAL TABLET 80 MG (<i>lazertinib mesylate</i>)	4	PA; QL (60 tablets per month.); CM
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg</i>	3	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
<i>lenalidomide oral capsule 20 mg, 25 mg</i>	3	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (<i>lenvatinib mesylate</i>)	3	PA; QL (2 capsules per day.); SP; CM; SMCS
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG (<i>lenvatinib mesylate</i>)	3	PA; QL (3 capsules per day.); SP; CM; SMCS
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (<i>lenvatinib mesylate</i>)	3	PA; QL (1 capsule per day.); SP; CM; SMCS
<i>letrozole oral tablet 2.5 mg</i>	1	H-N
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	3	CM
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>Iomustine oral capsule 10 mg, 100 mg, 40 mg</i>	3	CM
LORBRENA ORAL TABLET 100 MG (<i>lorlatinib</i>)	4	PA; QL (30 tablets per month.); CM
LORBRENA ORAL TABLET 25 MG (<i>lorlatinib</i>)	4	PA; QL (90 tablets per month.); CM
LUMAKRAS ORAL TABLET 120 MG (<i>sotorasib</i>)	4	PA; QL (240 tablets per month.); CM
LUMAKRAS ORAL TABLET 240 MG (<i>sotorasib</i>)	4	PA; QL (120 tablets per month.); CM
LUMAKRAS ORAL TABLET 320 MG (<i>sotorasib</i>)	4	PA; QL (3 tablets per day.); CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (<i>olaparib</i>)	3	PA; QL (4 tablets per day.); SP; CM; SMCS
LYSODREN ORAL TABLET 500 MG (<i>mitotane</i>)	3	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	4	PA; QL (84 tablets per month.); CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	4	PA; QL (112 tablets per month.); CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (<i>futibatinib</i>)	4	PA; QL (140 tablets per month.); CM
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	3	SP; CM; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	4	PA; QL (40 tablets per 720 days.); SP; 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>)	4	QL (17.4 ml per day.); CM
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	4	PA; QL (2 tablets per day.); CM
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	4	PA; QL (1 tablet per day.); CM
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	3	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
MYLERAN ORAL TABLET 2 MG (busulfan)	3	CM
NERLYNX ORAL TABLET 40 MG (neratinib maleate)	3	PA; QL (6 tablets per day.); CM
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	3	PA; QL (4 capsules per day.); SP; CM; SMCS
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (ixazomib citrate)	3	PA; QL (3 capsules per prescription.); SP; CM; SMCS
NUBEQA ORAL TABLET 300 MG (darolutamide)	3	PA; QL (4 tablets per day.); CM
ODOMZO ORAL CAPSULE 200 MG (sonidegib phosphate)	3	PA; QL (1 capsule per day.); CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (nirogacestat hydrobromide)	3	PA; CM
OGSIVEO ORAL TABLET 50 MG (nirogacestat hydrobromide)	3	PA; QL (6 tablets per day.); CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (tovorafenib)	4	PA; QL (96 ml per month.); CM
OJEMDA ORAL TABLET 100 MG (tovorafenib)	4	PA; QL (24 tablets per month.); CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (mometinib dihydrochloride)	4	PA; QL (1 tablet per day.); CM
ONUREG ORAL TABLET 200 MG, 300 MG (azacitidine)	3	PA; QL (14 tablets per 24 days.); CM
ORGOVYX ORAL TABLET 120 MG (relugolix)	4	PA; QL (1 tablet per day); CM
ORSERDU ORAL TABLET 86 MG (elacestrant hydrochloride)	3	PA; QL (3 tablets per day.); CM
pazopanib hcl oral tablet 400 mg	4	PA; SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	3	

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SCEMBLIX ORAL TABLET 100 MG (<i>asciminib hcl</i>)	4	PA; QL (120 tablets per month.); SP; CM; SMCS
SCEMBLIX ORAL TABLET 20 MG, 40 MG (<i>asciminib hcl</i>)	4	PA; QL (2 tablets per day.); SP; CM; SMCS
sorafenib tosylate oral tablet 200 mg	3	PA; QL (4 tablets per day.); SP; CM; SMCS
STIVARGA ORAL TABLET 40 MG (<i>regorafenib</i>)	3	PA; QL (84 tablets per 21 days.); SP; CM; SMCS
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	3	PA; QL (1 capsule per day.); SP; CM; SMCS
TABLOID ORAL TABLET 40 MG (<i>thioguanine</i>)	3	CM
TABRECTA ORAL TABLET 150 MG, 200 MG (<i>capmatinib hcl</i>)	4	PA; QL (4 tablets per day.); CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (<i>dabrafenib mesylate</i>)	4	PA; QL (4 capsules per day.); CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (<i>dabrafenib mesylate</i>)	4	QL (420 tablets per month.); CM
TAGRISSE ORAL TABLET 40 MG, 80 MG (<i>osimertinib mesylate</i>)	4	PA; QL (1 tablet per day.); CM
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
TAZVERIK ORAL TABLET 200 MG (<i>tazemetostat hbr</i>)	4	PA; QL (8 tablets per day.); SP; CM; SMCS
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	CM
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	3	PA; QL (28 capsules per prescription.); SP; CM; SMCS
TIBSOVO ORAL TABLET 250 MG (<i>ivosidenib</i>)	3	PA; QL (2 tablets per day.); SP; CM; SMCS
toremifene citrate oral tablet 60 mg	3	CM
torpenz oral tablet 10 mg, 7.5 mg	3	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	3	PA; QL (1 tablet per day.); CM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	3	QL (20 grams per prescription.)
tretinoin oral capsule 10 mg	3	QL (279 capsules per prescription.); CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
TRUQAP ORAL TABLET 200 MG (capivasertib)	3	PA; QL (64 tablets per month.)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (capivasertib)	3	PA; QL (64 tablets every month.); CM
TUKYSA ORAL TABLET 150 MG (tucatinib)	3	PA; QL (4 tablets per day.); CM
TUKYSA ORAL TABLET 50 MG (tucatinib)	3	PA; QL (10 tablets per day.); CM
TURALIO ORAL CAPSULE 125 MG (pexidartinib hcl)	3	PA; QL (4 capsules per day.); SP; CM; SMCS
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (quizartinib dihydrochloride)	4	PA; QL (2 tablets per day.); SP; CM; SMCS
VENCLEXTA ORAL TABLET 10 MG (venetoclax)	3	PA; QL (14 tablets per month.); CM
VENCLEXTA ORAL TABLET 100 MG (venetoclax)	3	PA; QL (4 tablets per day.); CM
VENCLEXTA ORAL TABLET 50 MG (venetoclax)	3	PA; QL (1 tablet per day.); CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (venetoclax)	3	PA; QL (42 tablets per year.); CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (abemaciclib)	3	PA; QL (2 tablets per day.); CM
VITRAKVI ORAL CAPSULE 100 MG (larotrectinib sulfate)	3	PA; QL (2 capsules per day.); CM
VITRAKVI ORAL CAPSULE 25 MG (larotrectinib sulfate)	3	PA; QL (6 capsules per day.); CM
VITRAKVI ORAL SOLUTION 20 MG/ML (larotrectinib sulfate)	3	PA; QL (10 mL per day.); CM
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (dacomitinib)	4	PA; QL (1 tablet per day.); CM
VORANIGO ORAL TABLET 10 MG (vorasidenib)	3	PA; QL (62 tablets per month.); SP; CM; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VORANIGO ORAL TABLET 40 MG (<i>vorasidenib</i>)	3	PA; QL (31 tablets per month.); SP; CM; SMCS
WELIREG ORAL TABLET 40 MG (<i>belzutifan</i>)	4	PA; QL (3 tablets day.); SP; CM; SMCS
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	4	PA; CM
XOSPATA ORAL TABLET 40 MG (<i>gilteritinib fumarate</i>)	4	PA; QL (3 tablets per day.); CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (<i>selinexor</i>)	4	PA; QL (0.26 tablet per day.); CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (<i>selinexor</i>)	4	PA; QL (16 tablets per month.); CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (<i>selinexor</i>)	4	PA; QL (0.29 tablet per day.); CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (<i>selinexor</i>)	4	PA; QL (1 therapy pack per month.); CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (<i>selinexor</i>)	4	PA; QL (0.86 tablets per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (<i>selinexor</i>)	4	PA; QL (0.29 tablet per day.); CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (<i>selinexor</i>)	4	PA; QL (1.15 tablets per day.); CM
XTANDI ORAL CAPSULE 40 MG (<i>enzalutamide</i>)	3	PA; QL (4 capsules per day.); SP; CM; SMCS
ZELBORAF ORAL TABLET 240 MG (<i>vemurafenib</i>)	3	PA; QL (8 tablets per day.); SP; CM; SMCS
ZOLINZA ORAL CAPSULE 100 MG (<i>vorinostat</i>)	3	PA; QL (4 capsules per day.); CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (<i>idelalisib</i>)	4	PA; QL (60 tablets per month.); SP; CM; SMCS
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASSTK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (<i>timothy grass pollen allergen</i>)	4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (<i>dust mite mixed allergen ext</i>)	4	PA; QL (1 tablet per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	4	PA; QL (1 tablet per day.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (<i>grass mix pollens allergen ext</i>)	4	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	4	PA; QL (1 tablet per day.)
PALFORZIA (1 MG DAILY DOSE) ORAL 1 X 1 MG (<i>peanut powder-dnfp</i>)	4	PA
PALFORZIA INITIAL DOSE 1-3YRS ORAL 0.5 & 1 & 1.5 & 3 MG (<i>peanut powder-dnfp</i>)	4	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>)	4	PA; QL (13 capsules per year.)
PALFORZIA ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (13 capsules per year.)
PALFORZIA ORAL 2 X 1 MG & 10 MG, 3 X 1 MG (<i>peanut powder-dnfp</i>)	4	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>)	4	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>)	4	PA; QL (60 capsules per 13 days.)
PALFORZIA ORAL 20 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (15 capsules per 13 days.)
PALFORZIA ORAL 3 X 20 MG & 100 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (60 capsule per 13 days.)
PALFORZIA ORAL 6 X 1 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (90 capsules per 13 days.)
PALFORZIA ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (1 capsule per day.)
PALFORZIA ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	4	PA; QL (15 capsules per 13 days.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (<i>short ragweed pollen ext</i>)	4	PA; QL (1 tablet per day.)
TOXOIDS - Vaccines		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	3	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	2	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	3	H
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION (<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
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	3	H
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	3	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (<i>diphth-acell pertussis-tetanus</i>)	2	H
DENGVAIXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>dengue virus vaccine live tetr</i>)	3	H
ENGRIX-B INJECTION SUSPENSION 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	2	H
ENGRIX-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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (<i>hepatitis a vaccine</i>)	3	H
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (<i>hepatitis b vac recomb adj</i>)	3	H
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (<i>haemophilus b polysac conj vac</i>)	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (<i>diphth-acell pertussis-tetanus</i>)	3	H
IPOL INJECTION SUSPENSION (<i>poliovirus vaccine inactivated</i>)	2	H
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (<i>mening acy&w-135 tetanus conj</i>)	3	H
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	3	H
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	3	H
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2	H
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (<i>covid-19 mrna virus vaccine</i>)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3	H
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (<i>haemophilus b polysac conj vac</i>)	2	H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	3	H
PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	3	H
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>pneumococcal vac polyvalent</i>)	2	H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 20-val conj vacc</i>)	3	H
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	3	H
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	3	H
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	2	H
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	2	H
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	3	H
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	3	H
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</i>)	3	H
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	3	H
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b vac (recomb)</i>)	3	H
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (<i>hepatitis a-hep b recomb vac</i>)	3	H
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	2	H
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	2	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (<i>varenicline tartrate</i>)	1	H
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	1	H
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	1	H
<i>goodsense nicotine polacrilex mouth/throat gum 4 mg</i>	1	H
<i>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	1	H
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	1	H
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	1	H
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	1	H
<i>nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr</i>	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	1	H
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	1	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	1	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	1	H
AUTONOMIC DRUGS - Drugs for the Nervous System		
ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (<i>epinephrine</i>)	2	QL (2 pens per prescription.); SM
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	2	QL (2 injections per prescription.); SM
<i>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.); SM
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.); SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (<i>epinephrine</i>)	4	QL (2 nasal sprays (1 box) per copay.)
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs		
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	3	
lofexidine hcl oral tablet 0.18 mg	1	
LUCEMYRA ORAL TABLET 0.18 MG (lofexidine hcl)	1	
methyldopa oral tablet 250 mg, 500 mg	4	PA
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (phenylephrine-chlorphen-dm)	3	
ONYDA XR ORAL SUSPENSION EXTENDED RELEASE 0.1 MG/ML (clonidine hcl)	3	QL (120 mL per month.)
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (umeclidinium-vilanterol)	3	SM
atropine sulfate ophthalmic solution 1 %	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (ipratropium bromide hfa)	3	QL (0.87 grams per day.); SM
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (glycopyrrolate-formoterol)	2	QL (0.36 grams per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	QL (0.36 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (ipratropium-albuterol)	4	QL (0.28 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (glycopyrrolate)	4	
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	1	
dicyclomine hcl oral tablet 20 mg	1	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
glycopyrrolate oral solution 1 mg/5ml	3	
glycopyrrolate oral tablet 1 mg, 2 mg	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA; QL (120 mL per prescription and 360 ml per month.)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	1	PA; QL (120 mL per prescription and 360 ml per month.)
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (hyoscyamine sulfate)	4	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (hyoscyamine sulfate)	4	
LOMOTIL ORAL TABLET 2.5-0.025 MG (diphenoxylate-atropine)	4	
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)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
scopolamine transdermal patch 72 hour 1 mg/3days	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (<i>tiotropium bromide</i>)	2	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (<i>tiotropium bromide</i>)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>tiotropium bromide</i>)	2	SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	2	SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	4	
<i>uretron d/s oral tablet 81.6 mg</i>	4	
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>)	4	
YUPELRI INHALATION SOLUTION 175 MCG/3ML (<i>revefenacin</i>)	4	PA; QL (3 ml per day.); SM
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	
AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System		
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (<i>varenicline tartrate</i>)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (<i>varenicline tartrate</i>)	1	H
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	1	H
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	1	H
<i>goodsense nicotine polacrilex mouth/throat gum 4 mg</i>	1	H
<i>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (<i>nicotine polacrilex</i>)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (<i>nicotine polacrilex</i>)	1	H
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	1	H
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	1	H
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	1	H
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	1	H
<i>nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr</i>	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	1	H
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	1	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	1	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	1	H
CENTRALLY ACTING SKELETAL MUSCLE 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	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	1	
TANLOR ORAL TABLET 1000 MG (<i>methocarbamol</i>)	3	
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	
ZANAFLEX ORAL TABLET 4 MG (<i>tizanidine hcl</i>)	4	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (<i>dantrolene sodium</i>)	4	
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	1	
GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
<i>baclofen oral solution 10 mg/5ml</i>	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	
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (<i>baclofen</i>)	4	PA
OZOBAX DS ORAL SOLUTION 10 MG/5ML (<i>baclofen</i>)	4	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>)	4	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	4	QL (5 ml per prescription.)
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>propranolol hcl 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>)	4	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>)	4	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (<i>doxazosin mesylate</i>)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>cevimeline hcl oral capsule 30 mg</i>	1	
<i>donepezil hcl oral tablet 10 mg, 23 mg, 5 mg</i>	1	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	1	
FIRDAPSE ORAL TABLET 10 MG (<i>amifampridine phosphate</i>)	3	PA; QL (300 tablets per month.)
<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>)	4	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	1	
PYRIDOSTIGMINE BROMIDE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG	3	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	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>)	4	
SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	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.); SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per copay.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (1 inhaler per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (18 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (6.7 grams per prescription.); SM
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	2	QL (8.5 grams per prescription.); SM
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1	SM
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	3	PA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	3	SM
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	4	QL (2 nebules per day); SM
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	2	QL (0.36 grams per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (<i>fluticasone furoate-vilanterol</i>)	3	QL (2 blisters per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	3	QL (0.36 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	4	QL (0.28 grams per day.); SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	3	QL (90 ml per prescription.); SM
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	3	QL (30 vials per prescription); SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (salmeterol xinafoate)	2	QL (1 diskus (60 blisters) per month.); SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (tiotropium bromide-olodaterol)	2	SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (olodaterol hcl)	2	SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	QL (2 blisters per day.); SM
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (levalbuterol tartrate)	3	QL (15 grams per prescription.); SM
SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	3	
<i>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>)	4	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	4	
<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	
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>)	3	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	3	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	3	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	3	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	3	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (<i>darbepoetin alfa</i>)	3	QL (4 vials per month)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	3	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	3	QL (2 syringes per month)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (4 ml per 21 days.)
ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (<i>anticoagulant cit dext soln a</i>)	3	
ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML	3	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml</i>	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>)	3	PA; QL (1 vial per day and 58 vials per 120 days.); SP; SMCS
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	4	QL (1 tablet per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (<i>mitapivat sulfate</i>)	4	PA; QL (56 tablets per 28 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (<i>mitapivat sulfate</i>)	4	PA; QL (7 tablets per 365 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (<i>mitapivat sulfate</i>)	4	PA; QL (14 tablets per 365 days.); CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (<i>fostamatinib disodium</i>)	4	PA; QL (2 tablets per day.); SP; SMCS
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	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (<i>apixaban</i>)	2	
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (<i>apixaban</i>)	2	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (<i>apixaban</i>)	2	
ELIQUIS ORAL TABLET 2.5 MG (<i>apixaban</i>)	2	QL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG (<i>apixaban</i>)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (<i>apixaban</i>)	2	
<i>rivaroxaban oral suspension reconstituted 1 mg/ml</i>	2	QL (20 ml per day.)
<i>rivaroxaban oral tablet 2.5 mg</i>	2	QL (2 tablets 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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XARELTO ORAL TABLET 2.5 MG (<i>rivaroxaban</i>)	2	QL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG (<i>rivaroxaban</i>)	2	QL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	2	QL (51 tablets per year.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
<i>dabigatran etexilate mesylate oral capsule 110 mg</i>	2	QL (2 tablets per day.)
<i>dabigatran etexilate mesylate oral capsule 150 mg, 75 mg</i>	2	QL (62 capsules per 31 days.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (<i>eltrombopag choline</i>)	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (<i>darbepoetin alfa</i>)	3	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	3	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (<i>darbepoetin alfa</i>)	3	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (<i>darbepoetin alfa</i>)	3	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	3	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (<i>darbepoetin alfa</i>)	3	QL (4 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (<i>darbepoetin alfa</i>)	3	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	3	QL (2 syringes per month)
DOPTELET ORAL TABLET 20 MG (<i>avatrombopag maleate</i>)	4	PA; QL (60 tablets per month.)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (<i>avatrombopag maleate</i>)	4	PA
<i>eltrombopag olamine oral packet 12.5 mg, 25 mg</i>	1	PA; QL (6 packets per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (<i>sargramostim</i>)	3	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (<i>plerixafor</i>)	4	
MULPLETA ORAL TABLET 3 MG (<i>lusutrombopag</i>)	4	PA; QL (7 tablets per prescription.)
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim</i>)	3	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	3	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	3	
<i>plerixafor subcutaneous solution 24 mg/1.2ml</i>	3	
PROMACTA ORAL PACKET 12.5 MG, 25 MG (<i>eltrombopag olamine</i>)	4	PA; QL (6 packets per day.)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	3	QL (4 ml per 21 days.)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	3	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	3	
XOLREMDI ORAL CAPSULE 100 MG (<i>mavorixafor</i>)	3	PA; QL (120 capsules per month.); SP; SMCS
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	3	
HEMORRHEOLOGIC AGENTS - Drugs for Blood Flow		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>)	3	
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	4	
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact single chain</i>)	4	
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor-vwf</i>)	3	
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>coagulation factor ix</i>)	3	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>coagulation factor ix (rfixfc)</i>)	4	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT (<i>coagulation factor ix (rfixfc)</i>)	3	
ALTUVIIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact fc-vwf-xten-eh1l</i>)	4	
<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>)	3	
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (<i>coagulation factor x (human)</i>)	3	
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (<i>factor xiii concentrate human</i>)	3	
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (<i>crinecerfont</i>)	4	PA; QL (62 capsules per month.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 SOLUTION 50 MG/ML (<i>crinecerfont</i>)	4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	1	
<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	
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (<i>antiinhibitor coagulant cmplx</i>)	3	
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>)	3	PA; SP; SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	3	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (<i>antihemophilic factor-vwf</i>)	3	
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>marstacimab-hncq</i>)	3	PA; QL (4 mL (4 Auto-injectors) per month.)
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (<i>coagulation factor ix (rix-fp)</i>)	4	
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>ahf (bdd-rfviii peg-aucl)</i>)	4	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	3	
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (<i>antihemophilic factor</i>)	3	
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihem factor recomb (rfviii)</i>)	3	
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact bd truncated</i>)	3	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (<i>coagulation factor viia recomb</i>)	3	
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	3	
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	3	
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	4	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>factor ix complex</i>)	3	
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (<i>fitusiran sodium</i>)	4	PA; QL (0.2 mL (1 vial) per month.)
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>fitusiran sodium</i>)	4	PA; QL (0.5 mL (1 pen) per month.)
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (<i>antihem factor recomb (rfviii)</i>)	3	
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	3	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>)	4	SP; SMCS
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (<i>von willebrand factor (recomb)</i>)	3	
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (<i>antihemophilic factor-vwf</i>)	3	
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)
<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)
<i>heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sodium (porcine) +rfid injection solution 1000 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml</i>	1	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml, 5000 unit/ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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		
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
<i>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	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
NESTABS ORAL TABLET 32-1 MG (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (<i>prenatal multivit-min-fe-fa</i>)	3	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
<i>prenatal oral tablet 27-1 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (<i>prenatal-feaspgly-methylfol-fa</i>)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fechn-feasp-meth-fa-dha</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	4	
TRINATE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (<i>prenat-fe poly-methfol-fa-dha</i>)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (cyanocobalamin)	4	
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	
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>)	4	QL (1 tablet per day.)

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

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (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>	3	PA; QL (4 tablets per day.)
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
FACTOR XIa INHIBITORS		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (<i>garadacimab-gxii</i>)	3	PA; QL (1 auto-injector per month.)
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.072 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.072 ml per day.); SP; SMCS
LOOP DIURETICS (24:36)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
<i>ethacrynic acid oral tablet 25 mg</i>	4	
<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>)	4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
OSMOTIC DIURETICS (24:36)		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %</i>	1	
<i>urea external lotion 40 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
POTASSIUM-SPARING DIURETICS (24:36)		
<i>amiloride hcl oral tablet 5 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	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	
THIAZIDE-LIKE DIURETICS (24:36)		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ACL INHIBITORS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; QL (1 tablet per day.)
ALPHA-ADRENERGIC BLOCKING AGENTS (24:16) - Drugs for Varicose Veins		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (<i>doxazosin mesylate</i>)	4	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<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>)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST/NEPROLYS - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (<i>sacubitril-valsartan</i>)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	4	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	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>valsartan oral solution 4 mg/ml</i>	4	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	2	
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>)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	4	PA; QL (240 sprinkle capsules (pellets) per month)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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 solution 4 mg/ml</i>	4	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	2	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	
ANGIOTENSIN-CONVERT. ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	
<i>enalapril maleate oral solution 1 mg/ml</i>	3	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
EPANED ORAL SOLUTION 1 MG/ML (<i>enalapril maleate</i>)	4	PA
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (<i>benazepril hcl</i>)	4	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	2	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart		
<i>amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1	
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	
<i>enalapril maleate oral solution 1 mg/ml</i>	3	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
EPANED ORAL SOLUTION 1 MG/ML (<i>enalapril maleate</i>)	4	PA
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (<i>benazepril-hydrochlorothiazide</i>)	4	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (<i>benazepril hcl</i>)	4	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	2	
QBRELIS ORAL SOLUTION 1 MG/ML (<i>lisinopril</i>)	4	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	2	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	3	
LANOXIN ORAL TABLET 62.5 MCG (<i>digoxin</i>)	4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; QL (1 tablet per day.)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	3	
<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>)	4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
BETA-ADRENERGIC BLOCKING AGENTS (24:20) - Drugs for High Blood Pressure		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	4	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	4	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>)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>doxazosin mesylate</i>)	3	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	4	
<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>)	4	
<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>)	4	PA
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<i>timolol hemihydrate ophthalmic solution 0.5 %</i>	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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	4	
BILE ACID SEQUESTRANTS - Drugs for Cholesterol		
<i>cholestyramine light oral packet 4 gm</i>	1	
<i>cholestyramine light oral powder 4 gm/dose</i>	1	
<i>cholestyramine oral packet 4 gm</i>	1	
<i>cholestyramine oral powder 4 gm/dose</i>	1	
<i>colesevelam hcl oral packet 3.75 gm</i>	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>)	4	
<i>colestipol hcl oral granules 5 gm</i>	1	
<i>colestipol hcl oral packet 5 gm</i>	1	
<i>colestipol hcl oral tablet 1 gm</i>	1	
<i>prevalite oral packet 4 gm</i>	1	
<i>prevalite oral powder 4 gm/dose</i>	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (<i>cholestyramine light</i>)	4	
QUESTRAN ORAL PACKET 4 GM (<i>cholestyramine</i>)	4	
QUESTRAN ORAL POWDER 4 GM/DOSE (<i>cholestyramine</i>)	4	
CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>)	4	
<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	
<i>matzim la oral tablet extended release 24 hour 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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
<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	
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>)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (<i>acoramidis hcl</i>)	3	PA; QL (124 tablets per month.)
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>mavacamten</i>)	4	PA; QL (1 capsule per day.)
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	3	PA; QL (2 tablets per day.)
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	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>)	3	PA; QL (1 capsule per day.)
CARDIOTONIC AGENTS - Drugs for Angina		
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	3	PA; QL (2 tablets per day.)
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	3	PA; QL (2 tablets per day.)
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	3	
LANOXIN ORAL TABLET 62.5 MCG (<i>digoxin</i>)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ALPHA-AGONISTS - Drugs for Abnormal Heart Rhythms		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	4	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	3	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	4	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	4	PA
<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>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>propranolol hcl 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>)	4	PA
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
<i>ezetimibe oral tablet 10 mg</i>	2	
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	2	PA; QL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (<i>disopyramide phosphate</i>)	2	
NORPACE ORAL CAPSULE 100 MG, 150 MG (<i>disopyramide phosphate</i>)	4	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
CLASS IB ANTIARRHYTHMICS - Drugs for Angina		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (<i>phenytoin sodium extended</i>)	3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (<i>phenytoin</i>)	3	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	1	
<i>phenytek oral capsule 200 mg</i>	1	
<i>phenytek oral capsule 300 mg</i>	4	
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	4	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	1	
CLASS II ANTIARRHYTHMICS - Drugs for Angina		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	4	
<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>)	4	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	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	4	
<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>)	4	
<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	
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>propranolol hcl 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>)	4	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>)	4	
CLASS III ANTIARRHYTHMICS - Drugs for Angina		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	4	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	2	
PACERONE ORAL TABLET 100 MG (<i>amiodarone hcl</i>)	3	
PACERONE ORAL TABLET 200 MG (<i>amiodarone hcl</i>)	4	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	4	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (<i>dofetilide</i>)	4	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	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	
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>)	4	
<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		
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg</i>	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	4	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	1	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg</i>	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (<i>nimodipine</i>)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
<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>	4	PA
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	1	
DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
FIBRIC ACID DERIVATIVES - Drugs for Cholesterol		
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>gemfibrozil oral tablet 600 mg</i>	1	
LOPID ORAL TABLET 600 MG (<i>gemfibrozil</i>)	4	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (<i>atorvastatin calcium</i>)	4	PA
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1	H-N
<i>atorvastatin calcium oral tablet 40 mg, 80 mg</i>	1	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (<i>rosuvastatin calcium</i>)	3	PA
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	4	PA
<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-N
<i>simvastatin oral tablet 80 mg</i>	1	
LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
<i>ethacrynic acid oral tablet 25 mg</i>	4	
<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>)	4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
NITRATES AND NITRITES - Drugs for High Blood Pressure & Angina		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	4	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<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>)	4	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	4	
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	4	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>)	4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (<i>nitroglycerin</i>)	3	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	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>)	4	PA
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (<i>nitroglycerin</i>)	3	
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	2	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	2	QL (2 syringes per 28 days.)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	2	QL (2 ml per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
<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.)
<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>	4	PA; QL (186 ml per month.)
<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.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	4	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>tadalafil oral tablet 10 mg</i>	2	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	2	QL (1 tablet per day.)
<i>tadalafil tablet 20 mg oral</i>	2	QL (0.5 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	4	PA; QL (10 ml per day.)
<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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
<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>	4	PA; QL (186 ml per month.)
<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.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (<i>avanafil</i>)	4	PA; QL (3 tablets per month.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
<i>tadalafil oral tablet 10 mg</i>	2	QL (0.5 tablet per day.)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	2	QL (1 tablet per day.)
<i>tadalafil tablet 20 mg oral</i>	2	QL (0.5 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	4	PA; QL (10 ml per day.)
<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.)
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>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>triamterene oral capsule 100 mg, 50 mg</i>	3	
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (<i>sacubitril-valsartan</i>)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (<i>sacubitril-valsartan</i>)	4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	4	PA; QL (1 tablet per day.)
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
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, MISC (24:08) - Drugs for High Blood Pressure & Angina		
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	2	
VECAMEYL ORAL TABLET 2.5 MG (<i>mecamylamine hcl</i>)	4	PA
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); SP; SMCS
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	3	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	3	PA; QL (4 tablets per day.); SP; SMCS
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (<i>alprostadil (vasodilator)</i>)	3	QL (6 units per month.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (alprostadil (vasodilator))	3	QL (6 units per month.)
CORLANOR ORAL SOLUTION 5 MG/5ML (ivabradine hcl)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (ivabradine hcl)	3	PA; QL (2 tablets per day.)
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (alprostadil (vasodilator))	3	QL (6 units per month.)
ivabradine hcl oral tablet 5 mg, 7.5 mg	3	PA; QL (2 tablets per day.)
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (amlodipine besylate)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (nimodipine)	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	3	PA; QL (1 tablet per day.); SP; SMCS
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	4	PA; QL (6 tablets per day.)
<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>)	4	
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	3	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X 64MCG, 112 X 48MCG & 112 X 64MCG, 80 MCG (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	3	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
<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	
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	4	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (<i>edaravone</i>)	4	PA; QL (1 starter kit per year.)
<i>riluzole oral tablet 50 mg</i>	1	
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	4	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (<i>riluzole</i>)	4	PA
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System		
ADAMANTANES (CNS) - Drugs for Parkinson		
<i>amantadine hcl oral capsule 100 mg</i>	1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
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>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	3	QL (5 capsules per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	3	QL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	2	QL (10 capsules per day.)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	2	
lisdexamphetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	3	QL (2 capsules per day.)
lisdexamphetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	3	QL (1 capsule per day)
lisdexamphetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	3	QL (2 tablets per day.)
lisdexamphetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	3	QL (1 tablet per day.)
methamphetamine hcl oral tablet 5 mg	1	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (dextroamphetamine)	4	PA; QL (1 patch per day.)
ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg	3	QL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	4	QL (6 capsules per day.)
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>)	4	QL (30 tablets per 90 Days.)
<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
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	4	
<i>uretron d/s oral tablet 81.6 mg</i>	4	
VILEVEV MB ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	4	
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
<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.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	
<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	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	4	PA
<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>)	4	PA
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	4	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>)	4	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (<i>perampanel</i>)	4	PA

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	4	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	4	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	1	
<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	
<i>vigabatrin oral packet 500 mg</i>	3	PA; QL (6 packets per day.); SP; SMCS
<i>vigabatrin oral tablet 500 mg</i>	3	PA; QL (6 tablets per day.); SP; SMCS
VIGADRONE ORAL PACKET 500 MG (<i>vigabatrin</i>)	3	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (<i>vigabatrin</i>)	3	PA; QL (6 tablets per day.); SP; SMCS
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	4	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	4	PA
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	1	H
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	1	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	4	PA; QL (12 devices (4 kits) per month.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	3	PA; QL (28 capsules per year.)
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	3	PA; QL (14 capsules per year.)
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>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	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	4	PA
<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	
<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 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	

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

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>valproic acid oral solution 250 mg/5ml</i>	1	
<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>)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	4	PA
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<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	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 aspirin oral tablet chewable 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<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	
<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		
<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>)	4	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	2	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	4	PA; QL (1 capsule per day.)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
<i>ramelteon oral tablet 8 mg</i>	4	QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	4	PA; QL (1 capsule per day.)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	1	
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	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>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>)	4	PA; QL (1 capsule per day.)
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	1	
CLOZARIL ORAL TABLET 100 MG, 25 MG (<i>clozapine</i>)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (<i>pimavanserin tartrate</i>)	4	PA; QL (31 tablets per month.)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	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>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>)	4	QL (1 tablet per day.)
<i>risperidone oral solution 1 mg/ml</i>	1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<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>)	4	QL (1 capsule per day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	4	QL (1 capsule per day.)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	2	
BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures		
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (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	
<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>)	4	QL (6 capsules per day.)
<i>phenobarbital oral elixir 20 mg/5ml</i>	1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1	
TENCON ORAL TABLET 50-325 MG (<i>butalbital-acetaminophen</i>)	3	
BENZODIAZEPINES (ANTICONSULSANTS) - 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	
<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)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	4	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	4	PA
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (<i>diazepam</i>)	3	PA; QL (1 box (5 doses/box) per month.)
BENZODIAZEPINES (ANXIOLYTIC, SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	
<i>alprazolam intensol oral concentrate 1 mg/ml</i>	1	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>diazepam intensol oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	1	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	1	QL (1 box (2 doses/box) per prescription)
<i>estazolam oral tablet 1 mg, 2 mg</i>	1	
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	1	
HALCION ORAL TABLET 0.25 MG (<i>triazolam</i>)	4	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>midazolam hcl oral syrup 2 mg/ml</i>	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	3	PA; QL (1 box per prescription.)
ONFI ORAL SUSPENSION 2.5 MG/ML (<i>clobazam</i>)	4	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	4	PA
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (<i>temazepam</i>)	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	4	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>)	3	PA; QL (1 pen per month.)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (<i>galcanezumab-gnlm</i>)	3	PA; QL (0.04 ml per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>galcanezumab-gnlm</i>)	3	PA; QL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>galcanezumab-gnlm</i>)	3	PA; QL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (<i>rimegepant sulfate</i>)	3	PA; QL (0.27 tablets per day.)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (<i>atogepant</i>)	3	PA; QL (1 tablet per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG (<i>ubrogepant</i>)	3	PA; QL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (<i>zavegepant hcl</i>)	4	PA; 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	
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>)	4	PA; QL (1 tablet per day.)
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	4	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	4	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	4	QL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	4	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (<i>trofinetide</i>)	3	PA; QL (120 ml per day.)
<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>)	4	PA; QL (1 packet per day.)
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
NUEDEXTA ORAL CAPSULE 20-10 MG (dextromethorphan-quinidine)	2	PA; QL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (edaravone)	4	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (edaravone)	4	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	4	PA; QL (18 ml per day.); SP; SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (riluzole)	4	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (riluzole)	4	PA
VEOZAH ORAL TABLET 45 MG (fezolinetant)	4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (bremelanotide acetate)	4	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	3	PA; QL (1 capsule per day.)
XYWAV ORAL SOLUTION 500 MG/ML (ca, mg, k, and na oxybates)	4	PA; QL (18 mL per day.); SP; SMCS
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	2	
DIBENZOXAPINES - Drugs for Depression & Psychosis		
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	
DIHYDROINDOLONES - Drugs for Depression & Psychosis		
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	3	
DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis		
pimozide oral tablet 1 mg, 2 mg	2	
DOPAMINE PRECURSORS - Drugs for Parkinson		
carbidopa oral tablet 25 mg	1	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	1	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (<i>carbidopa-levodopa</i>)	4	PA
INBRIJA INHALATION CAPSULE 42 MG (<i>levodopa</i>)	3	PA; QL (10 tablets per day.)
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (<i>carbidopa-levodopa</i>)	4	
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson		
<i>bromocriptine mesylate oral capsule 5 mg</i>	1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	1	
<i>cabergoline oral tablet 0.5 mg</i>	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 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>)	4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	4	QL (1 pack per 365 days.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	4	PA

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	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	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
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	
<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>	3	PA; QL (6 packets per day.); SP; SMCS
<i>vigabatrin oral tablet 500 mg</i>	3	PA; QL (6 tablets per day.); SP; SMCS
VIGADRONE ORAL PACKET 500 MG (<i>vigabatrin</i>)	3	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (<i>vigabatrin</i>)	3	PA; QL (6 tablets per day.); SP; SMCS
VIGAFYDE ORAL SOLUTION 100 MG/ML (<i>vigabatrin</i>)	3	PA; QL (900 mL per month.); SP; SMCS
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	4	PA
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</i>	1	
<i>phenytek oral capsule 300 mg</i>	4	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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		
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	4	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>)	4	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
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	4	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
MELATONIN RECEPTOR AGONISTS - Drugs for Anxiety & Sleep Disorder		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	4	PA; QL (1 capsule per day.)
<i>ramelteon oral tablet 8 mg</i>	4	QL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	4	PA; QL (1 capsule per day.)
MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson		
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis		
NARDIL ORAL TABLET 15 MG (<i>phenelzine sulfate</i>)	4	
PARNATE ORAL TABLET 10 MG (<i>tranylcypromine sulfate</i>)	4	
<i>phenelzine sulfate oral tablet 15 mg</i>	1	
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	1	
NMDA ANTAGONISTS - Drugs for Depression & Psychosis		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	4	PA; QL (12 devices (4 kits) per month.)
NON-BENZODIAZEPINE ANXIOLYTICS - Drugs for Anxiety & Sleep Disorder		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	
NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	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		
<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	
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>bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg</i>	1	QL (6 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	
<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>)	4	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
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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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 RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	4	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin rectal suppository 50 mg</i>	3	PA
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	3	
<i>mefenamic acid oral capsule 250 mg</i>	3	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	4	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
<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>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>belladonna alkaloids-opium rectal suppository 16.2-60 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	
<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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	PA; QL (0.34 patches per day.)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	2	PA; QL (15 patches per 31 days.)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	3	PA; QL (2 capsules per day.)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	3	PA; QL (0 tablets per 100 days, diagnosis review required.)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	3	PA; QL (1 tablet per day.)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml	1	NTT
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	2	
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	2	NTT
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	3	PA; QL (2 tablets per day.)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg	3	PA; QL (1 tablet per day.)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	3	PA; QL (0 tablet per 100 days, diagnosis review required.)
hydromorphone hcl oral liquid 1 mg/ml	1	NTT
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	NTT
hydromorphone hcl rectal suppository 3 mg	1	NTT
meperidine hcl oral solution 50 mg/5ml	1	NTT
meperidine hcl oral tablet 50 mg	1	NTT
methadone hcl intensol oral concentrate 10 mg/ml	1	QL (6 ml per day.)
methadone hcl oral concentrate 10 mg/ml	1	QL (6 ml per day.)
methadone hcl oral solution 10 mg/5ml	1	PA; QL (11.3 ml per day.)

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (<i>tapentadol hcl</i>)	4	QL (6 tablets per day); NTT
<i>opium oral tincture 10 mg/ml (1%)</i>	1	
<i>oxycodone hcl oral capsule 5 mg</i>	1	NTT
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	1	NTT
<i>oxycodone hcl oral solution 5 mg/5ml</i>	1	NTT
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg</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
<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-acetaminophen oral tablet 37.5-325 mg</i>	1	QL (40 tablets per prescription.); NTT
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (<i>oxycodone</i>)	4	PA; QL (2 tablets per day.)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (<i>oxycodone</i>)	4	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, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	1	
<i>ft naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (<i>nalmefene hcl</i>)	1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	1	NTT
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	1	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	1	SM
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (<i>nalmefene hcl</i>)	1	
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (<i>buprenorphine hcl</i>)	3	PA; QL (2 Films per day.)
BELBUCA BUCCAL FILM 750 MCG (<i>buprenorphine hcl</i>)	3	PA; QL (2 films per day.)
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	1	
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr</i>	3	PA; QL (4 patches per 28 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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, 2-0.5 MG, 4-1 MG, 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	1	
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	4	QL (1 tablet per day.)
PHENOTHIAZINES - Drugs for Depression & Psychosis		
<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>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	4	QL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	4	QL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	4	QL (5 capsules per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
atomoxetine hcl oral capsule 40 mg	4	QL (2 capsules per day)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (serdexmethylphen-dexmethylphen)	3	QL (1 capsule per day.)
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg	3	QL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	2	QL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	2	QL (31 capsules per 31 days.)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
elixophyllin oral elixir 80 mg/15ml	3	
ergotamine-caffeine oral tablet 1-100 mg	3	
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	4	QL (6 capsules per day.)
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (methylphenidate hcl)	3	QL (1 capsule per day.)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg	2	QL (2 tablets per day.)
methylphenidate hcl er (cd) oral capsule extended release 60 mg	2	QL (31 capsules per 31 days.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	2	QL (5 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg	2	QL (5capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	2	QL (3 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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, 27 mg, 36 mg, 54 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 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	4	
<i>diclofenac sodium external gel 3 %</i>	2	PA; QL (100 grams per prescription.)
<i>diflunisal oral tablet 500 mg</i>	3	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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 RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	4	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<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	
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
<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	4	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
<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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>aspirin low dose oral tablet 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
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>)	4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (<i>duloxetine hcl</i>)	4	QL (1 capsule per day.)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	2	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	4	QL (1 pack per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	4	QL (10 tablets per copay.)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	3	QL (10 tablets per copay.)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	3	QL (10 tablets per copay.)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	1	QL (10 per prescription.)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	1	QL (10 tablets per copay.)
<i>rizatriptan benzoate oral tablet dispersible 10 mg</i>	1	QL (10 per prescription.)
<i>rizatriptan benzoate oral tablet dispersible 5 mg</i>	1	QL (10 tablets per copay.)
<i>sumatriptan nasal solution 20 mg/act, 5 mg/act</i>	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 subcutaneous solution 6 mg/0.5ml</i>	1	QL (2 kits per prescription)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	1	QL (2 kits per prescription)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	2	QL (10 tablets per copay.)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	3	QL (10 tablets per copay.)
ZOMIG NASAL SOLUTION 2.5 MG (<i>zolmitriptan</i>)	3	QL (6 units per prescription.)
ZOMIG NASAL SOLUTION 5 MG (<i>zolmitriptan</i>)	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	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	4	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>)	4	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	
<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>)	4	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>)	4	
<i>ethosuximide oral capsule 250 mg</i>	1	
<i>ethosuximide oral solution 250 mg/5ml</i>	1	
<i>methsuximide oral capsule 300 mg</i>	2	
ZARONTIN ORAL CAPSULE 250 MG (<i>ethosuximide</i>)	4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (<i>ethosuximide</i>)	4	
THIOXANTHENES - Drugs for Depression & Psychosis		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	3	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (<i>desipramine hcl</i>)	4	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	1	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	1	
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	4	
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (<i>deutetrabenazine</i>)	3	PA; QL (4 tablets per day.)
AUSTEDO ORAL TABLET 6 MG (<i>deutetrabenazine</i>)	3	PA; QL (2 tablets per day.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (<i>deutetrabenazine</i>)	3	PA; QL (30 tablets per month.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (<i>deutetrabenazine</i>)	3	PA; QL (30 Tablets per month.)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (<i>deutetrabenazine</i>)	3	PA

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (<i>valbenazine tosylate</i>)	3	PA; QL (1 capsule per day.)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	3	PA; QL (30 tablets per month.)
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	3	PA; QL (30 capsules per month.)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (<i>valbenazine tosylate</i>)	3	PA; QL (1 kit (28 tablets) per year.)
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	3	PA; SP; SMCS
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>)	4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	4	PA; QL (1 box (28 packets) per year.)
<i>modafinil oral tablet 100 mg, 200 mg</i>	2	QL (3 tablets per day.)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	4	PA; QL (18 ml per day.); SP; SMCS
SUNOSI ORAL TABLET 150 MG, 75 MG (<i>solriamfetol hcl</i>)	2	PA; QL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (<i>pitolisant hcl</i>)	4	PA; QL (2 tablets per day.)
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	4	
DENTAGEL DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	4	
EASYGEL DENTAL GEL 0.4 % (<i>stannous fluoride</i>)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (<i>sodium fluoride-vitamin d</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (<i>stannous fluoride</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FRAICHE 5000 DENTAL DENTAL GEL 1.1 %	4	
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 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	4	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	4	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 % (sodium fluoride)	4	
EASYGEL DENTAL GEL 0.4 % (stannous fluoride)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 %	4	
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)	4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>sf 5000 plus dental cream 1.1 %</i>	1	
<i>sf dental gel 1.1 %</i>	1	
<i>sod fluoride-potassium nitrate dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 enamel dental gel 1.1-5 %</i>	1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	1	
<i>sodium fluoride 5000 ppm dental paste 1.1 %</i>	1	
<i>sodium fluoride 5000 sensitive dental gel 1.1-5 %</i>	1	
<i>sodium fluoride dental cream 1.1 %</i>	1	
<i>sodium fluoride dental gel 1.1 %</i>	1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	1	H
<i>sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	1	H
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ADVOCATE SAFETY LANCETS 21G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 23G (<i>lancets</i>)	3	
ADVOCATE SAFETY LANCETS 28G (<i>lancets</i>)	3	
AEROCHAMBER HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
AEROCHAMBER2GO ANTI-STATIC DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
ALCOHOL PREP PADS SHEET 70 %	3	
AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	QL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
ASSURE CONTROL SOLUTION 2/3 IN VITRO LIQUID (<i>blood glucose calibration</i>)	2	
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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
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	SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BREATHE COMFORT CHAMBER/CHILD DEVICE	3	SM
CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 25G X 5/8"	2	
CAREPOINT POLY HUB NEEDLE 21G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 22G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 27G X 1/2"	2	
CAREPOINT SAFETY 1ST NEEDLE 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8"	2	
CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION (blood glucose calibration)	2	
CARESENS LANCETS 30G (lancets)	3	
CARESENS S CONTROL SOLN A/B IN VITRO LIQUID (blood glucose calibration)	3	
CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID (blood glucose calibration)	3	
CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" (needle (disp))	2	
CARETOUCH LANCING/EJECTOR (lancet devices)	3	QL (1 device per prescription.)
CEQUR SIMPLICITY 2U DEVICE (injection device for insulin)	3	
CHEMSTRIP BG LOG BOOK (blood glucose monitoring suppl)	1	
CHOSEN LANCETS 30G (lancets)	3	
CHOSEN LANCING DEVICE (lancet devices)	3	QL (1 device per prescription.)
CHOSEN SAFETY LANCETS 28G (lancets)	3	
CLEVER CHOICE COMFORT EZ (lancets)	3	
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
COMFORT TOUCH TWIST LANCET 30G (lancets)	3	
CONTOUR CONTROL IN VITRO LIQUID HIGH (blood glucose calibration)	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (blood glucose calibration)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 CONTROL IN VITRO SOLUTION LOW , NORMAL (<i>blood glucose calibration</i>)	2	
CONTOUR NEXT EZ KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
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 KIT (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR NEXT ONE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	SM
CONTOUR PLUS BLUE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	1	
CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	2	
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (3 sensors per month.); SM
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.); SM
DEXCOM G7 15 DAY SENSOR (<i>continuous glucose sensor</i>)	3	PA; SM
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (3 sensors per month.); SM
DIABETES MONITOR DIGIT ADD-ON KIT	3	
DIABETES MONITOR DIGIT SOLN KIT	3	
DROPLET MICRON 34G X 3.5 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
DROPSAFE ACTI-LANCE 23G (<i>lancets</i>)	3	
DROPSAFE 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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DROPSAFE SICURA 25G X 1" , 25G X 5/8" (needle (disp))	2	
EASIVENT (spacer/aero-holding chambers)	3	SM
EASY COMFORT SHARPS CONTAINER	3	
EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (blood glucose calibration)	3	
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (blood glucose calibration)	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL (blood glucose calibration)	3	
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (blood glucose calibration)	3	
EMBECTA AUTOSHIELD DUO 30G X 5 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML, 28G X 1/2" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (insulin syringe/needle u-500)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (insulin pen needle)	2	QL (10 pen needles per day.)
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
ENLITE GLUCOSE SENSOR (continuous glucose sensor)	3	PA; SM
FLEXICHAMBER ADULT MASK/SMALL (spacer/aero-hold chamber mask)	2	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 CHILD MASK/LARGE (<i>spacer/aero-hold chamber mask</i>)	2	SM
FLEXICHAMBER CHILD MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	2	SM
FLEXICHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	QL (1 device per prescription.)
FONDCIRCLE SINGLE USE LANCETS	3	
FORA TEST N' GO ADVANCE DEVICE (<i>blood glucose/ketone monitor</i>)	3	
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA; SM
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	3	PA; SM
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; SM
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 kit per 999 days.); SM
GUARDIAN 4 GLUCOSE SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per month.); SM
GUARDIAN 4 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 transmitter kit per year.); SM
GUARDIAN LINK 3 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 transmitter kit per 365 days.); SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GUARDIAN REAL-TIME CHARGER (<i>continuous glucose monitor sup</i>)	3	PA; SM
GUARDIAN REAL-TIME TEST PLUG (<i>continuous glucose monitor sup</i>)	3	PA; SM
GUARDIAN SENSOR 3 (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per 24 days.); SM
IHEALTH CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	
IHEALTH LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
INPEN 100-BLUE-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-PINK-LILLY-HUMALOG DEVICE (<i>injection device for insulin</i>)	3	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE (<i>injection device for insulin</i>)	3	
INSPIREASE RESERVOIR BAGS (<i>spacer/aero-hold chamber bags</i>)	2	SM
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
INSULIN PEN NEEDLES 29G X 4MM , 29G X 5MM , 30G X 5 MM , 30G X 8 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML (<i>insulin syringe-needle u-100</i>)	2	QL (10 syringes per day.)
INSULIN SYRINGES 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 29G X 5/16" 0.5 ML, 29G X 5/16" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 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.)
KT TAPE CGM PATCH (<i>continuous glucose monitor sup</i>)	3	PA; SM
LANCETS (<i>lancets</i>)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (<i>lancets</i>)	3	
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	3	QL (1 device per prescription.)
MOBILE LANCETS 30G	3	
NORDIPEN 5 INJECTION DEVICE (<i>injection device</i>)	3	
NOVOFINE PEN NEEDLE 32G X 6 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
NOVOPEN ECHO DEVICE (<i>injection device for insulin</i>)	3	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 180 days.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (10 pods per prescription.)
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DELICA SAFETY LANCING (<i>lancets</i>)	1	
ONETOUCH ULTRA IN VITRO LIQUID (<i>blood glucose calibration</i>)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (<i>blood glucose calibration</i>)	1	
PARI VORTEX ADULT MASK (<i>spacer/aero-hold chamber mask</i>)	2	SM
PARI VORTEX PEDIATRIC MASK (<i>spacer/aero-hold chamber mask</i>)	2	SM
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 31G X 8 MM (RX)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (OTC)	2	QL (10 pen needles per day.)
PEN NEEDLES 32G X 4 MM (RX)	2	QL (10 pen needles per day.)
PERFECT POINT SAFETY LANCETS (<i>lancets</i>)	3	
PERFECT POINT SAFETY NEEDLE 25G X 1" (<i>needle (disp)</i>)	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (<i>blood glucose calibration</i>)	3	
POLY HUB NEEDLE 23G X 1"	2	
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 33G X 8 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)
RAYA SURE PEN NEEDLE 29G X 12MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM	2	QL (10 pen needles per day.)
SAFETY PEN NEEDLES 30G X 5 MM , 30G X 8 MM	2	QL (10 pen needles per day.)
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 (<i>lancets</i>)	3	
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	2	QL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	2	QL (10 syringes per day.)
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	QL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G (lancets)	3	
VERIFINE SAFE LANCET MINI 23G (lancets)	3	
VERIFINE SAFE LANCET MINI 28G (lancets)	3	
VERIFINE SAFE LANCET MINI 30G (lancets)	3	
VERIFINE SHARPS CONTAINER (sharps container)	3	
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (needle (disp))	2	
VIVAGUARD INO CONTROL SOLUTION IN VITRO LIQUID (blood glucose calibration)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	SM
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	3	SM
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (<i>cosyntropin</i>)	4	
<i>cosyntropin injection solution reconstituted 0.25 mg</i>	1	
CARDIAC FUNCTION		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	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.)
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	
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>)	4	PA
<i>metirosine oral capsule 250 mg</i>	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 FUNCTION		
METOPIRONE ORAL CAPSULE 250 MG (<i>metyrapone</i>)	3	
SUGAR		
DIASTIX REAGENT IN VITRO STRIP (<i>glucose urine test-glucose ox</i>)	3	
URINE AND FECES CONTENTS		
CHEMSTRIP UGK IN VITRO STRIP (<i>urine glucose-ketones test</i>)	3	
KETO-DIASTIX IN VITRO STRIP (<i>urine glucose-ketones test</i>)	3	
KETONE CARE IN VITRO STRIP (<i>urine glucose-ketones test</i>)	2	
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
<i>formaldehyde external solution 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>)	4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (<i>potassium citrate</i>)	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AMMONIA DETOXICANTS		
<i>carglumic acid oral tablet soluble 200 mg</i>	3	PA; SP; SMCS
<i>constulose oral solution 10 gm/15ml</i>	1	
<i>enulose oral solution 10 gm/15ml</i>	1	
<i>generlac oral solution 10 gm/15ml</i>	1	
<i>glycerol phenylbutyrate oral liquid 1.1 gm/ml</i>	4	PA; QL (17.5 ml per day.)
KRISTALOSE ORAL PACKET 10 GM (<i>lactulose</i>)	4	
KRISTALOSE ORAL PACKET 20 GM (<i>lactulose</i>)	3	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	
<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	
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	1	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	4	PA
CALORIC AGENTS - Drugs for Nutrition		
DOJOLVI ORAL LIQUID 100 % (<i>triheptanoin</i>)	4	PA
CARBONIC ANHYDRASE INHIBITORS (40:28) - Drugs for Water Balance		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
DIURETICS, MISCELLANEOUS - Drugs for Water Balance		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
LOOP DIURETICS (40:28) - Drugs for Water Balance		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BUMEX ORAL TABLET 0.5 MG (<i>bumetanide</i>)	3	
<i>ethacrynic acid oral tablet 25 mg</i>	4	
<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>)	4	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
OSMOTIC DIURETICS (40:28) - Drugs for Water Balance		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>urea external cream 20 %, 40 %</i>	1	
<i>urea external lotion 40 %</i>	1	
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	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</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	
VELPHORO ORAL TABLET CHEWABLE 500 MG (<i>sucroferric oxyhydroxide</i>)	4	
XPHOZAH ORAL TABLET 20 MG, 30 MG (<i>tenapanor hcl (ckd)</i>)	4	PA; QL (2 tablets per day.)
POTASSIUM-REMOVING AGENTS		
LOKELMA ORAL PACKET 10 GM (<i>sodium zirconium cyclosilicate</i>)	3	PA; QL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM (<i>sodium zirconium cyclosilicate</i>)	3	PA; QL (3 packets per day.)
<i>sodium polystyrene sulfonate oral powder</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
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>)	4	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance		
<i>amiloride hcl oral tablet 5 mg</i>	1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (<i>spironolactone</i>)	4	PA; SM
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5ml</i>	3	PA; SM
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	SM
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 m15 oral tablet extended release 15 meq</i>	1	
<i>klor-con m20 oral tablet extended release 20 meq</i>	1	
<i>klor-con oral packet 20 meq</i>	1	
<i>klor-con oral tablet extended release 8 meq</i>	1	
K-PHOS ORAL TABLET 500 MG (<i>potassium phosphate monobasic</i>)	2	
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (<i>k phos mono-sod phos di & mono</i>)	2	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (<i>insulin regular(human) in nacl</i>)	3	SM
ONENATAL RX ORAL TABLET 1 MG (<i>prenatal multivit-min-fe-fa</i>)	3	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (<i>k phos mono-sod phos di & mono</i>)	2	
<i>phosphorous oral tablet 155-852-130 mg</i>	1	
<i>phospho-trin 250 neutral oral tablet 155-852-130 mg</i>	1	
PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION 22-4-1 MEQ-MMOL/L	3	
PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5-1 MEQ-MMOL/L	3	
POKONZA PACKET 15 MEQ ORAL (<i>potassium chloride</i>)	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, 20 meq, 8 meq</i>	1	
<i>potassium chloride er oral tablet extended release 15 meq</i>	2	
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<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	
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	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	3	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	2	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (<i>benazepril-hydrochlorothiazide</i>)	4	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	2	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
THIAZIDE-LIKE DIURETICS (40:28) - Drugs for Water Balance		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
URICOSURIC AGENTS		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
ORLYNVAH ORAL TABLET 500-500 MG (<i>sulopenem etzadrox-probenecid</i>)	4	QL (10 tablets per course of therapy.)
<i>probenecid oral tablet 500 mg</i>	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
<i>tolvaptan oral tablet 15 mg</i>	3	PA; SMCS
<i>tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg</i>	3	PA; QL (2 tablets per day.)
<i>tolvaptan tablet 30 mg oral</i>	3	PA; SMCS
<i>tolvaptan tablet 30 mg oral</i>	3	PA; QL (2 tablets per day.); SMCS
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	4	PA; QL (14 capsules per 21 days.)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (<i>arimoclomol citrate</i>)	4	PA; QL (90 capsules per month.)
<i>sapropterin dihydrochloride oral packet 100 mg</i>	3	PA; QL (16 packets per day.)
<i>sapropterin dihydrochloride oral packet 500 mg</i>	3	PA; QL (4 packets per day.)
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	3	PA; QL (16 tablets per day)
<i>zelvysia oral packet 100 mg</i>	3	PA; QL (16 packets per day.)
<i>zelvysia oral packet 500 mg</i>	3	PA; QL (4 packets per day.)
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	3	PA
<i>miglustat oral capsule 100 mg</i>	3	
OPFOLDA ORAL CAPSULE 65 MG (<i>miglustat (gaa deficiency)</i>)	3	PA; QL (8 capsules per 21 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	3	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	3	PA
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	3	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (<i>lonafarnib</i>)	3	PA; QL (1 tablet per day.)
ENZYMES		
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	2	
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	3	
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	2	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	4	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	3	PA; QL (5 ml per day.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	4	QL (90 grams per prescription.)
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML (<i>asfotase alfa</i>)	3	PA; QL (5.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (<i>asfotase alfa</i>)	3	PA; QL (8.4 ml per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (<i>asfotase alfa</i>)	3	PA; QL (12 ml tablets per month.); SP; SMCS
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (<i>asfotase alfa</i>)	3	PA; QL (9.6 ml (12 vials) per month.); SP; SMCS
SUCRAID ORAL SOLUTION 8500 UNIT/ML (<i>sacrosidase</i>)	3	PA; SP; SMCS
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	4	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
ALPHA-ADRENERGIC AGONISTS (52:40) - Drugs for the Eye		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (<i>brimonidine tartrate</i>)	2	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	4	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	
MIRVASO EXTERNAL GEL 0.33 % (<i>brimonidine tartrate</i>)	3	PA; QL (30 grams per prescription.)
ANTIALLERGIC AGENTS - Drugs for Allergy		
ALOCRIAL OPHTHALMIC 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	SM
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	4	QL (5 ml per prescription)
<i>olopatadine hcl nasal solution 0.6 %</i>	3	
ANTIBACTERIALS (52:04) - Drugs for Infections		
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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	
<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>	4	
<i>ciprofloxacin-hydrocortisone otic suspension 0.2-1 %</i>	1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (<i>neomycin-colist-hc-thonzonium</i>)	3	
<i>ery external pad 2 %</i>	1	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	1	H-N
<i>gatifloxacin ophthalmic solution 0.5 %</i>	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>)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (<i>neomycin-polymyxin-dexameth</i>)	4	
<i>minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
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)	4	
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	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	
tobramycin inhalation nebulization solution 300 mg/4ml	3	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
TOBREX OPHTHALMIC OINTMENT 0.3 % (tobramycin)	3	QL (3.5 grams per prescription.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (<i>loteprednol-tobramycin</i>)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (<i>natamycin</i>)	4	
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>)	4	
<i>periogard mouth/throat solution 0.12 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (<i>pramoxine-chloroxylonol</i>)	3	
<i>silver nitrate external solution 0.5 %</i>	1	
XDEMVIY OPHTHALMIC SOLUTION 0.25 % (<i>lotilaner</i>)	4	PA; QL (10 ml per 63 days.)
ANTI-INFLAMMATORY AGENTS (EENT) - Drugs for Inflammation		
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	4	PA; QL (3 ml per 23 days.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (<i>cenegermin-bkbj</i>)	4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	4	PA; QL (60 vials per prescription.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	4	PA; QL (60 vials per prescription.)
ANTIVIRALS (EENT) - Drugs for Infections		
<i>trifluridine ophthalmic solution 1 %</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZIRGAN OPHTHALMIC GEL 0.15 % (<i>ganciclovir</i>)	4	
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>)	4	
<i>perio gard mouth/throat solution 0.12 %</i>	1	
BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	4	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>)	4	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	4	
<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>)	4	
CARBONIC ANHYDRASE INHIBITORS (52:40) - Drugs for the Eye		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
brinzolamide ophthalmic suspension 1 %	2	QL (10 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (dorzolamide hcl-timolol mal)	4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	2	
methazolamide oral tablet 25 mg, 50 mg	1	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (fluticasone-salmeterol)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	QL (10.7 grams per prescription.); SM
ALA SCALP EXTERNAL LOTION 2 % (hydrocortisone)	4	
ALREX OPHTHALMIC SUSPENSION 0.2 % (loteprednol etabonate)	4	QL (5 ml per prescription)
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (fluticasone furoate)	2	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (fluticasone furoate)	2	QL (1 packet per day.); SM
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.); SM
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	4	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (hydrocortisone)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (hydrocortisone)	4	
CORTIFOAM EXTERNAL FOAM 10 % (hydrocortisone acetate)	2	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin-colist-hc-thonzonium)	3	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (fluocinolone acetonide)	4	QL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (fluocinolone acetonide)	4	
DERMOTIC OTIC OIL 0.01 % (fluocinolone acetonide)	4	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	3	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	3	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (loteprednol etabonate)	4	QL (8.3 mL per prescription)
FLAREX OPHTHALMIC SUSPENSION 0.1 % (fluorometholone acetate)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluocinolone acetonide body external oil 0.01 %	3	QL (118.28 ml per prescription.)
fluocinolone acetonide external cream 0.01 %, 0.025 %	3	QL (15 grams per prescription.)
fluocinolone acetonide external ointment 0.025 %	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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
fluocinolone acetonide external solution 0.01 %	1	QL (60 ml per prescription.)
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	3	
fluorometholone ophthalmic suspension 0.1 %	1	
fluticasone propionate nasal suspension 50 mcg/act	2	QL (16 grams (1 bottle) per prescription)
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.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (fluorometholone)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (fluorometholone)	4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	3	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	2	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2 %	4	
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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (neomycin-polymyxin-dexameth)	4	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	3	QL (34 grams (2 bottles) per copay.)
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
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)	4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (prednisolone acetate)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
<i>procto-med hc external cream 2.5 %</i>	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	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)	4	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (dexamethasone)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (hydrocortisone)	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	QL (2 blisters per day.); SM
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (loteprednol-tobramycin)	3	
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS OPHTHALMIC EMULSION 0.05 % (cyclosporine)	4	PA; QL (60 vials per prescription.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (cyclosporine)	4	PA; QL (4 vials per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	4	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	SM
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (<i>cysteamine hcl</i>)	4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	3	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	2	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	3	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	4	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>)	4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	4	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LURBIRO ORAL TABLET 100 MG (<i>flurbiprofen</i>)	3	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (<i>nepafenac</i>)	4	
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (<i>lidocaine hcl</i>)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (<i>proparacaine hcl</i>)	3	
ALTACAIN OPHTHALMIC SOLUTION 0.5 % (<i>tetracaine hcl</i>)	3	
<i>lidocaine hcl mouth/throat solution 4 %</i>	1	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (<i>pramoxine-chloroxylonol</i>)	3	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	1	
MACULAR DEGENERATION AGENTS		
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (<i>cysteamine hcl</i>)	4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	3	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (<i>echothiophate iodide</i>)	2	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (<i>pilocarpine hcl</i>)	4	
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>)	4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	3	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
OSMOTIC AGENTS - Drugs for the Eye		
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>urea external cream 20 %, 40 %</i>	1	
<i>urea external lotion 40 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
<i>bimatoprost ophthalmic solution 0.03 %</i>	2	QL (2.5 ml per prescription.)
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	2	QL (2.5 mL per copay.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per prescription.)
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	3	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 OPHTHALMIC EMULSION 0.005 % (<i>latanoprost</i>)	3	QL (2.5 ml per prescription.)
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (<i>tafluprost</i>)	3	QL (30 unit of use droppers per prescription.)
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (<i>netarsudil dimesylate</i>)	3	QL (2.5 ml per prescription.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per prescription.)
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
<i>altafrin ophthalmic solution 10 %, 2.5 %</i>	1	
CYCLOMYDRIL OPHTHALMIC 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	
GASTROINTESTINAL DRUGS		
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (56:44)		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (vedolizumab)	3	PA; QL (0.05 ml per day.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (mirikizumab-mrkz)	3	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (mirikizumab-mrkz)	3	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH SOLUTION AUTO-INJECTOR 200 MG/2ML SUBCUTANEOUS (mirikizumab-mrkz)	3	PA
OMVOH SOLUTION PREFILLED SYRINGE 200 MG/2ML SUBCUTANEOUS (mirikizumab-mrkz)	3	PA
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (mirikizumab-mrkz)	3	PA; QL (0.072 ml per day.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (mirikizumab-mrkz)	3	PA; QL (2 prefilled syringe per month.)
OPIOID ANTAGONISTS (56:18)		
alvimopan oral capsule 12 mg	3	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (methylnaltrexone bromide)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (methylnaltrexone bromide)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (methylnaltrexone bromide)	4	PA; QL (0.4 ml per day.)
SYMPROIC ORAL TABLET 0.2 MG (naldemedine tosylate)	2	PA; QL (1 tablet per day.)
GASTROINTESTINAL DRUGS - Drugs for the Stomach		
5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (netupitant-palonosetron)	4	QL (1 capsule per prescription.)
ANZEMET ORAL TABLET 50 MG (dolasetron mesylate)	4	QL (6 tablets per prescription.)
granisetron hcl oral tablet 1 mg	2	
ondansetron hcl oral solution 4 mg/5ml	1	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
<i>opium oral tincture 10 mg/ml (1%)</i>	1	
VIBERZI ORAL TABLET 100 MG, 75 MG (<i>eluxadoline</i>)	4	PA; QL (2 tablets per day.)
XERMELO ORAL TABLET 250 MG (<i>telotristat etiprate</i>)	4	PA; QL (3 tablets per day.)
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 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	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (<i>olanzapine-fluoxetine hcl</i>)	4	QL (1 capsule per day)
SYNDROS ORAL SOLUTION 5 MG/ML (<i>dronabinol</i>)	4	PA; QL (4 ml per day.)
ANTI-HISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTI-INFLAMMATORY AGENTS (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	
<i>balsalazide disodium oral capsule 750 mg</i>	1	
<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.)
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
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	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	4	
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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.)
<i>ft clearlax oral powder 17 gm/scoop</i>	E	H
<i>ft laxative oral tablet delayed release 5 mg</i>	E	H
<i>ft magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
<i>gavilax oral powder 17 gm/scoop</i>	E	H
<i>gavilyte-c oral solution reconstituted 240 gm</i>	1	H
<i>gavilyte-g oral solution reconstituted 236 gm</i>	1	QL (4000 mL per prescription.); H
<i>gavilyte-n with flavor pack oral solution reconstituted 420 gm</i>	1	QL (4000 ml per prescription.); H
<i>gentle laxative oral tablet delayed release 5 mg</i>	E	H
<i>glycolax oral powder 17 gm/scoop</i>	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	1	QL (4000 mL per prescription.); H
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
<i>mineral oil heavy oral oil</i>	1	
<i>mm clearlax oral powder 17 gm/scoop</i>	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	4	QL (1 kit per prescription.)
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml</i>	3	QL (354 ml per prescription.)
<i>peg 3350 oral powder 17 gm/scoop</i>	E	H
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	1	QL (4000 ml per prescription.); H
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	1	QL (4000 mL per prescription.); H
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	3	QL (1 kit per prescription.)
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	3	QL (1 kit per prescription.)
PEG-PREP ORAL KIT 5-210 MG-GM (<i>bisacodyl-peg-kcl-nabicar-nacl</i>)	4	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	3	QL (3 cartons per prescription.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
smooth lax oral powder 17 gm/scoop	E	H
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (peg 3350-kcl-nacl-nasulf-mgsul)	3	QL (2 doses (1 box) per prescription.)
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (na sulfate-k sulfate-mg sulf)	3	QL (354 ml per prescription.)
SUTAB ORAL TABLET 1479-225-188 MG (sodium sulfate-mag sulfate-kcl)	3	
true laxative oral powder 17 gm/scoop	E	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (cholic acid)	3	PA; QL (4 capsules per day.)
CTEXLI ORAL TABLET 250 MG (chenodiol (basds))	4	PA; QL (93 tablets per month.)
IQIRVO ORAL TABLET 80 MG (elafibranor)	4	PA; QL (31 tablets per month.)
LIVDELZI ORAL CAPSULE 10 MG (seladelpar lysine)	4	PA; QL (30 capsules per month.)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (maralixibat chloride)	4	PA; QL (60 tablets per month.)
LIVMARLI ORAL TABLET 30 MG (maralixibat chloride)	4	PA; QL (30 tablets per month.)
OALIVA ORAL TABLET 10 MG, 5 MG (obeticholic acid)	4	PA; QL (1 tablet per day.)
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
DIGESTANTS - Drugs for the Stomach		
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL (pancrelipase (lip-prot-amyl))	2	
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL (pancrelipase (lip-prot-amyl))	3	
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 6000-19000 UNIT (pancrelipase (lip-prot-amyl))	2	
GATTEX SUBCUTANEOUS KIT 5 MG (teduglutide (rdna))	3	PA; QL (1 vial per day.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	4	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	4	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	2	
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	3	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	3	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	3	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	3	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
<i>alvimopan oral capsule 12 mg</i>	3	
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	3	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (<i>cholic acid</i>)	3	PA; QL (4 capsules per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	1	
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (<i>vedolizumab</i>)	3	PA; QL (0.05 ml per day.)
GATTEX SUBCUTANEOUS KIT 5 MG (<i>teduglutide (rdna)</i>)	3	PA; QL (1 vial per day.); SP; SMCS
IQIRVO ORAL TABLET 80 MG (<i>elafibranor</i>)	4	PA; QL (31 tablets per month.)
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (<i>linaclotide</i>)	2	PA; QL (1 capsule per day.)
<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>)	4	PA; QL (1 tablet per day.)
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mirikizumab-mrkz</i>)	3	PA; QL (0.072 ml per day.)
<i>prucalopride succinate oral tablet 1 mg, 2 mg</i>	3	PA; QL (1 tablet per day.)
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	4	PA; QL (0.4 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (<i>risankizumab-rzaa</i>)	3	PA; QL (1.2 ml per 42 days.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (<i>risankizumab-rzaa</i>)	3	PA; QL (2.4 mL per 42 days.)
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	2	PA; QL (1 tablet per day.)
SYNDROS ORAL SOLUTION 5 MG/ML (<i>dronabinol</i>)	4	PA; QL (4 ml per day.)
VIBERZI ORAL TABLET 100 MG, 75 MG (<i>eluxadoline</i>)	4	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (<i>fecal microb spores, live-brpk</i>)	4	PA; QL (12 capsules per 365 days.)
XPHOZAH ORAL TABLET 30 MG (<i>tenapanor hcl (ckd)</i>)	4	PA; QL (2 tablets per day.)
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	3	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	4	QL (1 capsule 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>)	4	QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (<i>vonoprazan fumarate</i>)	4	PA; QL (1 tablet per day and 186 tablets per 365 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	4	PA; QL (1 tablet per day and 62 tablets per 365 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	4	QL (112 tablets per 180 days.)
PROKINETIC AGENTS - Drugs for the Stomach		
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
REGLAN ORAL TABLET 10 MG, 5 MG (<i>metoclopramide hcl</i>)	4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (<i>misoprostol</i>)	4	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	
<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>	4	PA; QL (1 packet per day.)
<i>esomeprazole magnesium oral packet 40 mg</i>	4	PA; QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (<i>lansoprazole</i>)	3	PA
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	3	PA; QL (1 tablet per day.)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 5 MG (<i>esomeprazole magnesium</i>)	4	PA; QL (1 packet per day.)
NEXIUM ORAL PACKET 40 MG (<i>esomeprazole magnesium</i>)	4	PA; QL (1 packet per day)
<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>)	4	PA; QL (1 tablet per day and 186 tablets per 365 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VOQUEZNA ORAL TABLET 20 MG (<i>vonoprazan fumarate</i>)	4	PA; QL (1 tablet per day and 62 tablets per 365 days.)
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>	3	PA
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	3	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	3	PA
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	3	PA
<i>deferiprone oral tablet 1000 mg</i>	4	PA
DEPEN TITRATABS ORAL TABLET 250 MG (<i>penicillamine</i>)	3	
<i>penicillamine oral tablet 250 mg</i>	3	
<i>trientine hcl oral capsule 500 mg</i>	4	PA
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (<i>bremelanotide acetate</i>)	4	PA; QL (4 autoinjector pens (1.2mls) per month.)
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (<i>fluticasone-salmeterol</i>)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	4	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	2	SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	2	QL (1 packet per day.); SM
<i>betamethasone dipropionate aug external cream 0.05 %</i>	1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	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	
<i>betamethasone valerate external lotion 0.1 %</i>	1	
<i>betamethasone valerate external ointment 0.1 %</i>	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (<i>fluticasone furoate-vilanterol</i>)	3	QL (2 blisters per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budesonide-glycopyrrol-formoterol</i>)	3	QL (0.36 grams per day.); SM
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	2	SM
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	2	QL (120 ml (2 boxes) per 30 days.); SM
<i>budesonide inhalation suspension 1 mg/2ml</i>	2	QL (60 ml (1 box) per 30 days.); SM
<i>budesonide oral capsule delayed release particles 3 mg</i>	2	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (<i>hydrocortisone</i>)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (<i>hydrocortisone</i>)	4	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	2	
<i>dexamethasone intensol oral concentrate 1 mg/ml</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	3	
DIPROLENE EXTERNAL OINTMENT 0.05 % (betamethasone dipropionate aug)	4	
fludrocortisone acetate oral tablet 0.1 mg	1	
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
fluticasone propionate nasal suspension 50 mcg/act	2	QL (16 grams (1 bottle) per prescription)
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.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	3	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	2	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2 %	4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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	
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (methylprednisolone)	4	
MEDROL ORAL TABLET 2 MG (methylprednisolone)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (methylprednisolone)	4	
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 (34 grams (2 bottles) per copay.)
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (prednisolone sodium phosphate)	4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (prednisolone acetate)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	3	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisone intensol oral concentrate 5 mg/ml	1	
prednisone oral solution 5 mg/5ml	1	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	2	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (beclomethasone diprop hfa)	2	QL (42.4 grams per month.); SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	SM
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)	4	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (dexamethasone)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (hydrocortisone)	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	QL (2 blisters per day.); SM
triamcinolone acetonide external aerosol solution 0.147 mg/gm	2	QL (63 grams per prescription.)
triamcinolone acetonide external cream 0.025 %, 0.1 %	1	
triamcinolone acetonide external cream 0.5 %	1	QL (15 grams per prescription.)
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
triderm external cream 0.5 %	1	QL (15 grams per prescription.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
<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.); SM
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 (<i>testosterone cypionate</i>)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (<i>testosterone cypionate</i>)	4	SM
EEMT HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	
EEMT ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	2	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	1	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	
KYZATREX ORAL CAPSULE 150 MG, 200 MG (<i>testosterone undecanoate</i>)	4	PA; QL (4 capsules per day.); SM
METHITEST ORAL TABLET 10 MG	2	SM
<i>methyltestosterone oral capsule 10 mg</i>	2	SM
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); SM
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	SM
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	2	PA; QL (150 grams (2 pumps) per month.); SM
<i>testosterone transdermal gel 1.62 %</i>	2	PA; QL (150 grams (2 pumps) per month.); SM
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	
<i>mifepristone oral tablet 300 mg</i>	4	PA; QL (4 tablets per day.); SP; SMCS
ANTIESTROGENS - Drugs for Women		
<i>anastrozole oral tablet 1 mg</i>	1	H-N
<i>exemestane oral tablet 25 mg</i>	2	H-N
<i>letrozole oral tablet 2.5 mg</i>	1	H-N
ANTIGONADTROPINS - Hormones		
<i>aftera oral tablet 1.5 mg</i>	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (<i>cetrorelix acetate</i>)	4	PA; QL (14 cartons per 21 days.)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (<i>testosterone cypionate</i>)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (<i>testosterone cypionate</i>)	4	SM
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (<i>degarelix acetate</i>)	4	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	4	
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>ganirelix acetate</i>)	3	QL (7 ml per 21 days.)
<i>ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous</i>	1	QL (7 ml per 21 days.)
<i>ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous</i>	4	QL (7 ml per 21 days.)
<i>her style oral tablet 1.5 mg</i>	1	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KYZATREX ORAL CAPSULE 150 MG, 200 MG (testosterone undecanoate)	4	PA; QL (4 capsules per day.); SM
levonorgestrel oral tablet 1.5 mg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix-estradiol-norethind)	2	PA; QL (1 tablet day.)
new day oral tablet 1.5 mg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
option 2 oral tablet 1.5 mg	1	H
ORGOVYX ORAL TABLET 120 MG (relugolix)	4	PA; QL (1 tablet per day); CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; QL (2 capsules per day.)
ORILISSA ORAL TABLET 150 MG (elagolix sodium)	2	PA; QL (1 tablet per day.)
ORILISSA ORAL TABLET 200 MG (elagolix sodium)	2	PA; QL (2 tablets per day.)
PLAN B ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	1	H
react oral tablet 1.5 mg	1	H
shewise oral tablet 1.5 mg	1	H
SLYND ORAL TABLET 4 MG (drospirenone)	4	H
take action oral tablet 1.5 mg	1	H
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (testosterone)	2	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone gel 20.25 mg/act (1.62%) transdermal	2	PA; QL (150 grams (2 pumps) per month.); SM
testosterone transdermal gel 1.62 %	2	PA; QL (150 grams (2 pumps) per month.); SM
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROGLYCEM ORAL SUSPENSION 50 MG/ML (<i>diazoxide</i>)	4	
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	
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	1	
BIGUANIDES - Drugs for Diabetes		
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, 850 mg</i>	1	
<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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	QL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	QL (2 tablets per day.)
CONTRACEPTIVES - Drugs for Women		
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aftera oral tablet 1.5 mg</i>	1	H
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	3	QL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estradiol</i>)	4	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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
<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>	4	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>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>)	4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (<i>medroxyprogesterone acetate</i>)	4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	1	QL (3.25 ml per year.); H; SM
<i>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>	4	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg</i>	1	H
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	1	QL (1 tablet per 21 days.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>emzahh oral tablet 0.35 mg</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>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 (<i>norethindrone acet-ethinyl est</i>)	4	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>galbriela oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	4	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>jencycla oral tablet 0.35 mg</i>	1	H
<i>jolessa oral tablet 0.15-0.03 mg</i>	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth 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</i>	4	H
<i>levonorgest-eth estrad 91-day oral tablet 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
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>	4	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>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; SM
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	QL (5 mL per 365 days.); H; SM
<i>meleya oral tablet 0.35 mg</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
<i>my choice oral tablet 1.5 mg</i>	1	H
<i>my way oral tablet 1.5 mg</i>	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>new day oral tablet 1.5 mg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	4	H
<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>	4	H
<i>norethin ace-eth estrad-fe 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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	1	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
norlyroc oral tablet 0.35 mg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
OPILL ORAL TABLET 0.075 MG (norgestrel)	1	H
option 2 oral tablet 1.5 mg	1	H
orquidea oral tablet 0.35 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
react oral tablet 1.5 mg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
setlakin oral tablet 0.15-0.03 mg	2	H
sharobel oral tablet 0.35 mg	1	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>shewise oral tablet 1.5 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	4	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>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>	4	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-lynyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	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>)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>valtya 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	2	QL (1 tablet per day.)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	QL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (<i>linagliptin-metformin hcl</i>)	2	QL (2 tablets per day.)
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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	2	QL (31 tablets per month.)
TRADJENTA ORAL TABLET 5 MG (<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	
clomiphene citrate oral tablet 50 mg	2	
DUAVEE ORAL TABLET 0.45-20 MG (<i>conj estrogens-bazedoxifene</i>)	4	QL (1 tablet per day.)
milophene oral tablet 50 mg	2	
OSPHENA ORAL TABLET 60 MG (<i>ospemifene</i>)	3	PA; QL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	2	H-N
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
toremifene citrate oral tablet 60 mg	3	CM
ESTROGENS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	2	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (<i>estradiol-norethindrone acet</i>)	4	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (<i>estradiol</i>)	3	QL (8 patches (1 box) per 28 days.); SM
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (<i>drospirenone-estradiol</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	3	QL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	4	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (<i>estradiol-progesterone</i>)	3	
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	1	H
<i>camrese lo oral tablet 0.1-0.02 & 0.01 mg</i>	4	H
<i>camrese oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>chateal eq oral tablet 0.15-30 mg-mcg</i>	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (<i>estradiol-levonorgestrel</i>)	3	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (<i>estradiol-norethindrone acet</i>)	3	QL (8 patches per 28 days.)
COVARYX HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COVARYX ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	2	
<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
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (<i>estradiol valerate</i>)	4	SM
<i>delyla oral tablet 0.1-20 mg-mcg</i>	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	3	SM
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	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 (<i>estradiol</i>)	3	SM
<i>dolishale oral tablet 90-20 mcg</i>	1	H
<i>dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	2	QL (8 patches (1 box) per 28 days.); SM
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg</i>	4	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg</i>	1	H
DUAVEE ORAL TABLET 0.45-20 MG (<i>conj estrogens-bazedoxifene</i>)	4	QL (1 tablet per day.)
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	
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (<i>estradiol</i>)	3	SM
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
est estrogens-methyltest hs oral tablet 0.625-1.25 mg	1	
est estrogens-methyltest oral tablet 1.25-2.5 mg	1	
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm	3	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	3	QL (50 grams (1 box) per month.); SM
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (8 patches (1 box) per 28 days.); SM
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 patches (1 carton) per 28 days.); SM
estradiol vaginal cream 0.01 %	4	
estradiol vaginal tablet 10 mcg	2	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
estradiol-norethindrone acet oral tablet 0.5-0.1 mg	2	
estradiol-norethindrone acet oral tablet 1-0.5 mg	1	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (est estrogens-methyltest)	3	
ESTRING VAGINAL RING 7.5 MCG/24HR (estradiol)	2	QL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (estradiol)	3	QL (50 grams (1 box) per month.); SM
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	4	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (estradiol)	2	SM
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	4	H
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	4	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>	4	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.)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (<i>estradiol</i>)	2	QL (0.29 insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (<i>estradiol</i>)	2	QL (18 inserts per year.)
<i>introvale oral tablet 0.15-0.03 mg</i>	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>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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth 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</i>	4	H
<i>levonorgest-eth estrad 91-day oral tablet 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-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
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>	4	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lutra oral tablet 0.1-20 mg-mcg</i>	1	H
<i>lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	2	QL (8 patches (1 box) per 28 days.); SM
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (<i>estradiol</i>)	3	QL (4 patches (1 carton) per 28 days.); SM
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
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>)	4	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>	4	H
<i>norethin ace-eth estrad-fe oral tablet 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>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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (<i>elagolix-estradiol-norethind</i>)	2	PA; QL (2 capsules per day.)
<i>philith oral tablet 0.4-35 mg-mcg</i>	1	H
<i>pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>portia-28 oral tablet 0.15-30 mg-mcg</i>	1	H
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (<i>estrogens conjugated</i>)	4	
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (<i>conj estrogen-medroxyprogest ace</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-medroxyprogest ace</i>)	4	
<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>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
<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>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>	4	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-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>)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>valtya 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 solution reconstituted 1 mg</i>	2	
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	2	QL (0.4 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	2	QL (0.4 ml per prescription.)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (<i>glucagon</i>)	2	
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	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (<i>follitropin beta</i>)	2	PA; QL (5.4 mL per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML, 900 UNT/1.08ML (<i>follitropin beta</i>)	2	PA; QL (8.64 mL per 21 days.)
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>follitropin alfa</i>)	4	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (<i>follitropin alfa</i>)	4	PA
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA; SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>menotropins</i>)	4	PA; QL (6 vials per day.)
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>chorionic gonadotropin</i>)	3	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>choriogonadotropin alfa</i>)	4	
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (<i>chorionic gonadotropin</i>)	3	
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	2	SM
INCRETIN MIMETICS - Drugs for Diabetes		
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	3	PA; QL (2.4 ml (one pen) per month.)
EXENATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	3	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>)	3	PA; QL (0.08 ml per day.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>semaglutide</i>)	3	PA; QL (1 Pen-injector per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (<i>semaglutide</i>)	3	PA; QL (3 ml per month.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	2	QL (18 ml per month.); SM
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (<i>dulaglutide</i>)	3	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	3	PA; QL (2 mL per month.)
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	2	QL (70 ml per prescription.); SM
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	2	QL (75 ml per prescription.); SM
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	2	QL (70 ml per prescription.); SM
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (<i>metreleptin</i>)	4	PA; QL (0.9 vial per day.); SP; SMCS
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	2	QL (75 ml per prescription.); SM
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	2	QL (70 ml per prescription.); SM
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	2	QL (18 ml per month.); SM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	3	QL (75 ml per prescription.); SM
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	3	QL (37.5 ml per prescription.); SM
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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	4	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	4	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	4	PA
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (<i>palopegteriparatide</i>)	4	PA; QL (2 pens (1.12 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (<i>palopegteriparatide</i>)	4	PA; QL (2 pens (1.96 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (<i>palopegteriparatide</i>)	4	PA; QL (2 pens (2.8 mL) per 28 days.)
PITUITARY - Hormones		
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (<i>crinecerfont</i>)	4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (<i>crinecerfont</i>)	4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	1	
<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>)	4	PA; QL (0.172 ml per day.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (<i>somatropin</i>)	3	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (<i>somatropin</i>)	3	PA; QL (9 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (<i>somatropin</i>)	3	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (<i>somatropin</i>)	3	PA; QL (13.5 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	3	PA; QL (27 mL per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	3	PA; QL (16 vials per month.)
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (<i>lonapegsomatropin-tcgd</i>)	4	PA
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>)	4	PA; QL (0.143 cartridge per day.)
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>)	4	
<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
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	4	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (<i>estradiol-progesterone</i>)	3	
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<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>	4	H
<i>camrese oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
<i>charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>chateal eq oral tablet 0.15-30 mg-mcg</i>	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (<i>estradiol-levonorgestrel</i>)	3	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (<i>estradiol-norethindrone acet</i>)	3	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (<i>progesterone</i>)	4	
<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>)	4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (<i>medroxyprogesterone acetate</i>)	4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	1	QL (3.25 ml per year.); H; SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>	4	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.03-0.451 mg</i>	1	H
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	1	QL (1 tablet per 21 days.); H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>emzahh oral tablet 0.35 mg</i>	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (<i>progesterone</i>)	2	
<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>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>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 (<i>norethindrone acet-ethinyl est</i>)	4	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>galbriela oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>gallifrey oral tablet 5 mg</i>	1	
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	4	H
<i>hailey 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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>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
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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</i>	4	H
<i>levonorgest-eth estrad 91-day oral tablet 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
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	1	H
<i>lojaimiess oral tablet 0.1-0.02 & 0.01 mg</i>	4	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>luizza 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>luizza 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>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; SM
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	QL (5 mL per 365 days.); H; SM
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	SM
<i>megestrol acetate oral suspension 40 mg/ml</i>	1	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	3	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
<i>meleya oral tablet 0.35 mg</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>minzoya oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>mono-linyah oral tablet 0.25-35 mg-mcg</i>	1	H
<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.)
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>)	4	H
<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>	4	H
<i>norethin ace-eth estrad-fe oral tablet 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>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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
norlyroc oral tablet 0.35 mg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
OPILL ORAL TABLET 0.075 MG (norgestrel)	1	H
option 2 oral tablet 1.5 mg	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; QL (2 capsules per day.)
orquidea oral tablet 0.35 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMPHASE ORAL TABLET 0.625-5 MG (conj estrogen-medroxyprogesterone)	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-medroxyprogesterone)	4	
progesterone intramuscular oil 50 mg/ml	1	SM
progesterone oral capsule 100 mg, 200 mg	2	SM
progesterone vaginal insert 100 mg	2	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (medroxyprogesterone acetate)	4	SM
react oral tablet 1.5 mg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>setlakin oral tablet 0.15-0.03 mg</i>	2	H
<i>sharobel oral tablet 0.35 mg</i>	1	H
<i>shewise oral tablet 1.5 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 & 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	4	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>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>	4	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (<i>norethin ace-eth estrad-fe</i>)	E	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	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>)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	1	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>valtya 1/35 oral tablet 1-35 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>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
RAPID-ACTING INSULINS - Drugs for Diabetes		
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml (25 pens) per prescription.); SM
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	2	QL (70 ml per prescription.); SM
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	2	QL (75 ml per prescription.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.); SM
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	2	QL (70 ml per prescription.); SM
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.); SM
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	QL (75 ml per prescription.); SM
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin lispro-aabc</i>)	2	QL (75 ml per prescription.); SM
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro-aabc</i>)	2	QL (70 ml per prescription.); SM
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	2	QL (70 ml per prescription.); SM
HUMULIN R SOLUTION 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	1	QL (70 ml per prescription.); SM
HUMULIN R SOLUTION 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	2	QL (70 ml per prescription.); SM
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	2	QL (75 mL per prescription.); SM
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (<i>insulin regular(human) in nacl</i>)	3	SM
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	2	QL (75 ml per prescription.); SM
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	2	QL (75 ml per prescription.); SM
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (<i>bexagliflozin</i>)	3	QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	QL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG (<i>empagliflozin</i>)	2	QL (30 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (empagliflozin-metformin hcl)	2	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (empagliflozin-metformin hcl)	2	QL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (empagliflozin-metformin hcl)	2	QL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (empagliflozin-linaglip-metform)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (empagliflozin-linaglip-metform)	2	QL (2 tablets per day.)
SOMATOSTATIN AGONISTS - Hormones		
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
SOMATOTROPIN AGONISTS - Hormones		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (mecasermin)	3	PA; QL (52 vials per month.); SP; SMCS
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (somatropin)	3	PA; QL (13.5 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (somatropin)	3	PA; QL (9 mL per month.)
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (somatropin)	3	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (somatropin)	3	PA; QL (13.5 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (somatropin)	3	PA; QL (27 mL per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (somatropin)	3	PA; QL (16 vials per month.)
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (pioglitazone hcl-glimepiride)	3	QL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
<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		
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	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	3	
<i>levo-t oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>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</i>	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>liomny oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
<i>np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	1	
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	3	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (<i>resmetirom</i>)	4	PA; QL (1 Tablet per day.)
<i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>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</i>	1	
IMMUNOMODULATORY AGENTS (90:00)		
AMINO ACID POLYMERS		
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	3	PA; QL (30 ml per month.)
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	4	PA; QL (30 ml per month.)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	3	PA; QL (12 ml per 21 days.)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	4	PA; QL (12 ml per 21 days.)
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	3	PA; QL (30 ml per month.)
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	3	PA; QL (12 ml per 21 days.)
ANTIMETABOLITES		
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	4	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>teriflunomide oral tablet 14 mg</i>	3	PA; QL (1 tablet per day.)
<i>teriflunomide oral tablet 7 mg</i>	3	PA; QL (31 tablets per month.)
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	4	
<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>engraft oral capsule 100 mg, 25 mg</i>	1	
<i>engraft oral solution 100 mg/ml</i>	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	4	PA
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	4	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>)	4	PA; QL (4 vials per day.)
COMPLEMENT INHIBITOR AGENTS (90:20)		
FABHALTA ORAL CAPSULE 200 MG (<i>iptacopan hcl</i>)	3	PA; QL (2 capsules per day.)
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (<i>zilucoplan sodium</i>)	4	PA; QL (0.416 ml per day.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (<i>ziluoplan sodium</i>)	4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (<i>ziluoplan sodium</i>)	4	PA; QL (0.81 ml per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (<i>vedolizumab</i>)	3	PA; QL (0.05 ml per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	4	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	4	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (<i>abatacept</i>)	4	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (<i>abatacept</i>)	4	PA; QL (0.1 ml per day.)
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	4	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
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.)
<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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PEN-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (2ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (2ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (4 ml (2 pens/1 box) per month.)
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>)	4	PA; CM
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	3	PA; QL (4 capsules per day.)
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; QL (56 capsules per year.); SP; SMCS
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; QL (2 capsules per day.); SP; SMCS
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SP; SMCS
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	3	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	3	PA; QL (4 ml per month.)
IMMUNOMODULATORY AGENTS (90:00)		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	3	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	3	CM
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	3	PA; QL (2 tablets per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>everolimus oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); CM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); CM
<i>mercaptopurine oral suspension 2000 mg/100ml</i>	3	CM
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	4	CM
<i>torpenz oral tablet 10 mg, 7.5 mg</i>	3	PA; QL (2 tablets per day.); CM
<i>torpenz oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); CM
INTERFERONS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	3	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	3	PA; QL (4 syringes (1 box) per month.)
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	3	PA; QL (14 vials per month.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	3	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	3	
INTERLEUKIN INHIBITOR AGENTS, MISC		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	3	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	3	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	3	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	3	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; QL (0.04 ml per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INTERLEUKIN-MEDIATED AGENTS, MISC		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (4 syringes (3.6 ml) per month.)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	3	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	4	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-stba</i>)	3	PA; QL (1 syringe every 3 months.)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	4	PA
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	4	PA
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-auub</i>)	3	PA; QL (1 single-dose vial every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-auub</i>)	3	PA; QL (1 syringe per 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-kfce</i>)	3	PA; QL (1 single-dose vial every 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-kfce</i>)	3	PA; QL (1 syringe every 3 months.)
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	3	PA; QL (1 tablet per day.); CM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (<i>baricitinib</i>)	4	PA; QL (1 tablet per day.)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (<i>upadacitinib</i>)	3	PA; QL (360 mL (2 bottles) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	3	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	3	PA; QL (84 tablets per 365 days.)
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	3	PA; QL (8 mL per day.)
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	3	PA; QL (2 tablets per day.)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	3	PA; QL (1 tablet per day.)
MONOCARBOXYLIC ACID AMIDE AGENTS		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	4	PA; QL (10 g per 23 days.)
<i>sirolimus oral solution 1 mg/ml</i>	3	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
NEONATAL FC RECEPTOR BLOCKERS		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (<i>efgartigimod alfa-hyalur-qvfc</i>)	4	PA; QL (1 syringe every 50 days.)
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	3	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	3	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	3	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	3	PA; QL (1 starter pack per year.)
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
<i> fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.)
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	4	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	4	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (<i>siponimod fumarate</i>)	4	PA; QL (1 tablet per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; QL (7 tablets per 365 days.)
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	3	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	3	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	3	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	3	PA
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (<i>tetracaine hcl</i>)	3	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	1	
ZTLIDO EXTERNAL PATCH 1.8 % (<i>lidocaine</i>)	3	PA; QL (3 patches per day.)
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
<i>dutasteride oral capsule 0.5 mg</i>	2	
<i>finasteride oral tablet 5 mg</i>	1	
5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	1	
<i>dutasteride oral capsule 0.5 mg</i>	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	
<i>glucagon emergency kit injection solution reconstituted 1 mg</i>	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	2	QL (0.4 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 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	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	SM
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	SM
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	1	SM
<i>naltrexone hcl oral tablet 50 mg</i>	1	
<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>)	3	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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	2	QL (1.2 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	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	3	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (<i>colchicine</i>)	4	PA
INDOCIN RECTAL SUPPOSITORY 50 MG (<i>indomethacin</i>)	4	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	2	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<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	
ORLYNVAH ORAL TABLET 500-500 MG (<i>sulopenem etzadrox-probenecid</i>)	4	QL (10 tablets per course of therapy.)
<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>)	4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (<i>sodium oxybate</i>)	4	PA; QL (1 box (28 packets) per year.)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	4	PA; QL (18 ml per day.); SP; SMCS
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>olezarsen sodium</i>)	4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (<i>eplontersen sodium</i>)	3	PA; QL (0.029 ml per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (<i>teriparatide</i>)	4	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	4	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	4	PA
BONE RESORPTION INHIBITORS - Drugs for Bone Loss		
<i>alendronate sodium oral solution 70 mg/75ml</i>	1	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	1	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (<i>estradiol</i>)	3	QL (8 patches (1 box) per 28 days.); SM
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	3	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	2	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (<i>estradiol valerate</i>)	4	SM
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	3	SM
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (<i>estradiol</i>)	3	SM
<i>dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	2	QL (8 patches (1 box) per 28 days.); SM
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (<i>estradiol</i>)	3	SM
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	SM
<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	SM
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	3	QL (50 grams (1 box) per month.); SM
<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.); SM
<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.); SM
<i>estradiol vaginal cream 0.01 %</i>	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 vaginal tablet 10 mcg</i>	2	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	1	SM
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.); SM
<i>estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg</i>	4	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (<i>estradiol</i>)	2	SM
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	4	QL (1 ring per 3 months.)
FOSAMAX ORAL TABLET 70 MG (<i>alendronate sodium</i>)	4	
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.); SM
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (<i>estradiol</i>)	3	QL (4 patches (1 carton) per 28 days.); SM
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>)	4	
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	3	
<i>raloxifene hcl oral tablet 60 mg</i>	2	H-N
<i>risedronate sodium oral tablet 150 mg</i>	4	QL (Benefit maximum quantity 1 per month.)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	4	
<i>risedronate sodium oral tablet 35 mg</i>	4	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>	3	PA; QL (0.6 ml per day.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (92:26)		
<i>dichlorphenamide oral tablet 50 mg</i>	3	PA; QL (4 tablets per day.)
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	4	
EASYGEL DENTAL GEL 0.4 % (<i>stannous fluoride</i>)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (<i>sodium fluoride-vitamin d</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (<i>stannous fluoride</i>)	3	
FLUORIDEX DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (<i>sod fluoride-potassium nitrate</i>)	3	
FRAICHE 5000 DENTAL DENTAL GEL 1.1 %	4	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>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	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (<i>sodium fluoride</i>)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.072 ml per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (4 syringes (3.6 ml) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	3	PA
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	3	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	3	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	3	PA
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	4	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine oral tablet 50 mg</i>	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	3	PA; QL (1 tablet per day.); CM
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	3	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	3	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	3	PA; QL (0.072 ml per day.)
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
DEPEN TITRATABS ORAL TABLET 250 MG (<i>penicillamine</i>)	3	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	4	PA; CM
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	4	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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, 2 MG, 4 MG (baricitinib)	4	PA; QL (1 tablet per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	4	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	4	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (abatacept)	4	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (abatacept)	4	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 30 MG (apremilast)	3	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	3	PA; QL (55 tablets (one starter pack) per year.)
penicillamine oral tablet 250 mg	3	
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (methotrexate (anti-rheumatic))	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (methotrexate (anti-rheumatic))	2	QL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (methotrexate (anti-rheumatic))	2	QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (methotrexate (anti-rheumatic))	2	QL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (methotrexate (anti-rheumatic))	2	QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (methotrexate (anti-rheumatic))	2	QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (methotrexate (anti-rheumatic))	2	QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (methotrexate (anti-rheumatic))	2	QL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (methotrexate (anti-rheumatic))	2	QL (0.6 ml (4 auto-injectors) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (upadacitinib)	3	PA; QL (1 tablet per day.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	3	PA; QL (84 tablets per 365 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	4	PA; CM
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	3	PA; QL (8 mL per day.)
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	3	PA; QL (2 tablets per day.)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	3	PA; QL (1 tablet per day.)
IGA NEPHROPATHY		
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	4	PA; QL (30 tablets per month.)
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (3.6 ml per 21 days.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	4	PA; QL (4 syringes (3.6 ml) per month.)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (<i>interferon gamma-1b</i>)	3	PA; QL (8.5 mls per month.); SP; SMCS
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	3	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	3	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	3	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (<i>adalimumab-atto</i>)	3	PA
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	3	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	3	PA; QL (4 syringes (1 box) per month.)
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	4	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine oral tablet 50 mg</i>	1	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	3	PA; QL (4 capsules per day.)
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	3	PA; QL (14 vials per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	3	PA; QL (1 kit per 21 days.)
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>cladribine (6 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (7 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (8 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (9 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; QL (56 capsules per year.); SP; SMCS
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; QL (2 capsules per day.); SP; SMCS
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SP; SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	3	PA; QL (0.15 ml per day.)
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; QL (1 capsule per day.)
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	3	PA; QL (30 ml per month.)
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	4	PA; QL (30 ml per month.)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	3	PA; QL (12 ml per 21 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	4	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	3	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	3	PA; QL (12 ml per 21 days.)
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JOENJA ORAL TABLET 70 MG (leniolisib phosphate)	3	PA; QL (2 tablets per day.)
JYLAMVO ORAL SOLUTION 2 MG/ML (methotrexate)	4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (ofatumumab)	3	PA; QL (0.02 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (anakinra)	4	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	3	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
lenalidomide oral capsule 20 mg, 25 mg	3	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (cladribine)	4	PA; QL (40 tablets per 720 days.); SP; SMCS
MAYZENT ORAL TABLET 0.25 MG (siponimod fumarate)	4	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (siponimod fumarate)	4	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (siponimod fumarate)	4	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (siponimod fumarate)	4	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (siponimod fumarate)	4	PA; QL (7 tablets per 365 days.)
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	4	PA; QL (4 autoinjectors per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	4	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (<i>abatacept</i>)	4	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (<i>abatacept</i>)	4	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	3	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	3	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	3	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	3	PA; QL (1 starter pack per year.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	3	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	3	
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	4	PA; QL (1 ml per month.); SP; SMCS
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	4	PA; QL (2 ml per year without additional quantity notification.); SP; SMCS
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	4	PA; QL (2 ml per year without additional quantity notification.); SP; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	4	PA; QL (1 ml per month.); SP; SMCS
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	4	PA; QL (1 ml per month.); SP; SMCS
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (<i>pomalidomide</i>)	4	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>lenalidomide</i>)	3	PA; QL (28 capsules per 21 days.); SP; CM; SMCS
REVLIMID ORAL CAPSULE 20 MG, 25 MG (<i>lenalidomide</i>)	3	PA; QL (21 capsules per 21 days.); SP; CM; SMCS
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>golimumab</i>)	3	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>golimumab</i>)	3	PA; QL (0.5 ml (1 syringe) per month)
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<i>teriflunomide oral tablet 14 mg</i>	3	PA; QL (1 tablet per day.)
<i>teriflunomide oral tablet 7 mg</i>	3	PA; QL (31 tablets per month.)
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	3	PA; QL (28 capsules per prescription.); SP; CM; SMCS
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (<i>ozanimod hcl</i>)	4	PA; QL (7 capsules per year.)
ZEPOSIA ORAL CAPSULE 0.92 MG (<i>ozanimod hcl</i>)	4	PA; QL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) (<i>ozanimod hcl</i>)	4	PA; QL (1 starter kit (28 capsules) per year.)
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (<i>azathioprine</i>)	4	
<i>azathioprine oral tablet 100 mg, 75 mg</i>	3	
<i>azathioprine oral tablet 50 mg</i>	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	3	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	3	PA; QL (4 ml per month.)
<i>cladribine (10 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (4 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS
<i>cladribine (5 tabs) oral tablet therapy pack 10 mg</i>	1	PA; QL (40 tablets per 720 days.); SP; SMCS

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.); SP; SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.); SP; SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.); SP; SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.); SP; SMCS
cyclophosphamide oral capsule 25 mg, 50 mg	3	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	3	CM
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (methotrexate)	4	PA; CM
leflunomide oral tablet 10 mg, 20 mg	1	
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (cladribine)	4	PA; QL (40 tablets per 720 days.); SP; SMCS
mercaptopurine oral suspension 2000 mg/100ml	3	CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
mycophenolate mofetil oral capsule 250 mg	1	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	1	
mycophenolate mofetil oral tablet 500 mg	1	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>	3	
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>)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	4	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (<i>mercaptopurine</i>)	4	CM
<i>sirolimus oral solution 1 mg/ml</i>	3	
<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>)	4	PA; CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.072 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>lanadelumab-flyo</i>)	3	PA; QL (0.072 ml per day.); SP; SMCS
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (<i>levacetylleucine</i>)	4	PA; QL (112 packets per month.)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	3	PA; QL (4 vials per 21 days.); SP; SMCS
<i>betaine oral powder</i>	3	
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	3	PA
CYSTADANE ORAL POWDER (<i>betaine</i>)	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (<i>cysteamine bitartrate</i>)	3	
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	3	PA; QL (2 tablets per day)
DEMSEER ORAL CAPSULE 250 MG (<i>metirosine</i>)	4	PA
DIABETES MONITOR DIGIT ADD-ON KIT	3	
DIABETES MONITOR DIGIT SOLN KIT	3	
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (<i>prasterone (dhea)</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
ENDARI ORAL PACKET 5 GM (<i>glutamine (sickle cell)</i>)	4	PA; QL (6 packets per day.)
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (<i>risdiplam</i>)	3	PA; QL (6.7 ml per day, 1280 ml per 180 days.); SP; SMCS
EVRYSDI ORAL TABLET 5 MG (<i>risdiplam</i>)	3	PA; QL (30 tablets per month.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	4	PA; QL (1 tablet per day.)
FIRDAPSE ORAL TABLET 10 MG (<i>amifampridine phosphate</i>)	3	PA; QL (300 tablets per month.)
GALAFOLD ORAL CAPSULE 123 MG (<i>migalastat hcl</i>)	4	PA; QL (14 capsules per 21 days.)
<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>)	4	QL (1 tablet per day.)
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>metirosine oral capsule 250 mg</i>	3	PA
<i>miglustat oral capsule 100 mg</i>	3	
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>)	3	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (<i>nitisinone</i>)	3	PA

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	3	PA
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 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	2	
PROCYSBI ORAL PACKET 300 MG, 75 MG (<i>cysteamine bitartrate</i>)	4	SP; SMCS
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (<i>nedosiran sodium</i>)	4	PA; QL (0.04 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (<i>nedosiran sodium</i>)	4	PA; QL (0.03 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>nedosiran sodium</i>)	4	PA; QL (0.04 ml per day.)
<i>sapropterin dihydrochloride oral packet 100 mg</i>	3	PA; QL (16 packets per day.)
<i>sapropterin dihydrochloride oral packet 500 mg</i>	3	PA; QL (4 packets per day.)
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	3	PA; QL (16 tablets per day)
SKYCLARYS ORAL CAPSULE 50 MG (<i>omaveloxolone</i>)	3	PA; QL (3 capsules per day.)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (<i>palovarotene</i>)	4	PA; QL (1 capsule per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	4	QL (1 tablet per day.); SM
<i>tiopronin oral tablet 100 mg</i>	3	CM
<i>tiopronin oral tablet delayed release 100 mg, 300 mg</i>	3	CM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	2	
URELLE ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	4	
<i>uretron d/s oral tablet 81.6 mg</i>	4	
UROGESIC-BLUE ORAL TABLET 81.6 MG (<i>methen-hyosc-meth blue-na phos</i>)	2	
VIJOICE ORAL PACKET 50 MG (<i>alpelisib</i>)	4	PA; QL (28 packets (1 carton) per month.)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (<i>alpelisib</i>)	4	PA; QL (28 tablets (1 blister pack) per month.)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (<i>alpelisib</i>)	4	PA; QL (56 tablets (2 blister packs) per month.)
VILEVEV MB ORAL TABLET 81 MG (<i>meth-hyo-m bl-na phos-ph sal</i>)	4	
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>)	4	PA; QL (12 capsules per 365 days.)
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (<i>vosoritide</i>)	4	PA; QL (1 vial per day.); SP; SMCS
VYNDAMAX ORAL CAPSULE 61 MG (<i>tafamidis</i>)	3	PA; QL (1 capsule per day.)
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<i>zelvysia oral packet 100 mg</i>	3	PA; QL (16 packets per day.)
<i>zelvysia oral packet 500 mg</i>	3	PA; QL (4 packets per day.)
ZOKINVY ORAL CAPSULE 50 MG (<i>lonafarnib</i>)	3	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (<i>lonafarnib</i>)	3	PA; QL (1 tablet per day.)
PROTECTIVE AGENTS		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	3	QL (45 grams per prescription)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
dalfampridine er oral tablet extended release 12 hour 10 mg	3	PA; QL (2 tablets per day)
mesna oral tablet 400 mg	2	CM
MESNEX ORAL TABLET 400 MG (mesna)	4	CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (diaphragm arc-spring)	3	H
CONDOMS	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN (condoms latex lubricated)	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN DEVICE (condoms latex lubricated)	3	QL (12 condoms per month.); H
DUREX TROPICAL (condoms latex lubricated)	3	QL (12 condoms per month.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (nonoxynol-9)	E	H
FC2 FEMALE CONDOM (condoms - female)	3	QL (12 condoms per month.); H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical caps)	3	H
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (diaphragms)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (nonoxynol-9)	E	H
PHEXX VAGINAL GEL 1.8-1-0.4 % (lactic ac-citric ac-pot bitart)	4	H
TODAY SPONGE VAGINAL 1000 MG (nonoxynol-9)	E	H
TRUE COVER DEVICE	3	QL (12 condoms per month.); H
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (nonoxynol-9)	E	H
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (nonoxynol-9)	E	H
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (<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>)	4	QL (28 tablets per year.)
<i>methylergonovine maleate oral tablet 0.2 mg</i>	1	QL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG (<i>mifepristone</i>)	3	SM
<i>mifepristone oral tablet 200 mg</i>	1	SM
PREPIDIL VAGINAL GEL 0.5 MG/3GM (<i>dinoprostone</i>)	3	
PHARMACEUTICAL AIDS		
PHARMACEUTICAL AIDS		
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AG) ANHYDROUS TRANSDERMAL GEL (<i>transdermal base</i>)	3	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (<i>transdermal base</i>)	3	
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (<i>epinephrine hcl (nasal)</i>)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (<i>epinephrine</i>)	2	QL (2 pens per prescription.); SM

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	2	QL (2 injections per prescription.); SM
<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.); SM
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml</i>	1	QL (4 injections per prescription.); SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD		
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	3	QL (0.87 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	4	QL (0.28 grams per day.); SM
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	SM
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	2	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (<i>hyoscyamine sulfate</i>)	4	
LEVSIN ORAL TABLET 0.125 MG (<i>hyoscyamine sulfate</i>)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (<i>hyoscyamine sulfate</i>)	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (<i>tiotropium bromide</i>)	2	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (<i>tiotropium bromide</i>)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>tiotropium bromide</i>)	2	SM
YUPELRI INHALATION SOLUTION 175 MCG/3ML (<i>revefenacin</i>)	4	PA; QL (3 ml per day.); SM
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
<i>pirfenidone oral capsule 267 mg</i>	2	PA; QL (9 capsules per day.)
<i>pirfenidone oral tablet 267 mg</i>	3	PA; QL (9 tablets per day.)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	3	PA; QL (3 tablets per day.)
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	4	PA; QL (0.015 ml per day.)
ANTITUSSIVES - Drugs for Cough and Cold		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	1	
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	1	NTT
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	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.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	1	PA; QL (120 mL per prescription and 360 ml per month.)
maxi-tuss ac oral solution 100-10 mg/5ml	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (phenylephrine-chlorphen-dm)	3	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA; QL (360 ml per month.)
promethazine-dm oral syrup 15-6.25 mg/5ml, 6.25-15 mg/5ml	1	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (chlorpheniramine-codeine)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (fluticasone-salmeterol)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	QL (10.7 grams per prescription.); SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (fluticasone furoate)	2	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (fluticasone furoate)	2	QL (1 packet per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (fluticasone furoate-vilanterol)	3	QL (2 blisters per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	2	SM
budesonide inhalation suspension 0.5 mg/2ml	2	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	2	QL (60 ml (1 box) per 30 days.); SM
flunisolide nasal solution 25 mcg/act (0.025%)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
<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 (34 grams (2 bottles) per copay.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (10.6 grams per month.); SM
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (42.4 grams per month.); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	3	QL (2 blisters per day.); SM
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (2 blisters per day.); SM
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (<i>vanzacaft-tezacaft-deutivacaft</i>)	4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (<i>vanzacaft-tezacaft-deutivacaft</i>)	4	PA; QL (84 tablets per month.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	3	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	3	PA; QL (56 tablets per month. 728 tablets per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 TABLET THERAPY PACK 100-50-75 & 150 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; QL (3 tablets per day. 1092 tablets per 364 days.)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; QL (2 packets per day. 728 packets per 356 days.)
CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (<i>vanzacaft-tezacaft-deutivacaft</i>)	4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (<i>vanzacaft-tezacaft-deutivacaft</i>)	4	PA; QL (84 tablets per month.)
KALYDECO ORAL PACKET 13.4 MG (<i>ivacaftor</i>)	3	PA; QL (2 packets per day. 728 packets per 356 days.)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (<i>ivacaftor</i>)	3	PA; QL (728 packets per 356 days.)
KALYDECO ORAL PACKET 5.8 MG (<i>ivacaftor</i>)	3	PA; QL (2 packets per day and 728 packets per 365 days.)
KALYDECO ORAL TABLET 150 MG (<i>ivacaftor</i>)	3	PA; QL (780 tablets per 356 days.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	3	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	3	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; QL (3 tablets per day. 1092 tablets per 364 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	3	PA; QL (2 packets per day. 728 packets per 356 days.)
ENDOTHELIN RECEPTOR ANTAGONISTS - Drugs for the Lungs		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); SP; SMCS
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	3	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	3	PA; QL (4 tablets per day.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (<i>sparsentan</i>)	4	PA; QL (1 tablet per day.)
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	3	PA; QL (1 tablet per day.); SP; SMCS
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	3	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	4	PA; QL (4 tablets per day.); SP; SMCS
VANRAFIA ORAL TABLET 0.75 MG (<i>atrasentan hcl</i>)	4	PA; QL (30 tablets per month.)
EXPECTORANTS - Drugs for the Lungs		
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>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	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
CLEMSZA ORAL TABLET 2.68 MG (<i>clemastine fumarate</i>)	3	
<i>cypheptadine hcl oral syrup 2 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>cypheptadine hcl oral tablet 4 mg</i>	1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (<i>promethazine hcl</i>)	3	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	3	PA; QL (4 vials per 21 days.); SP; SMCS
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	3	PA; QL (0.09 ml per day.)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	4	PA; QL (1 pen every 2 months.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	4	PA; QL (0.07 ml per day.)
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
ACCOLATE ORAL TABLET 10 MG, 20 MG (<i>zafirlukast</i>)	4	
<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	
MAST-CELL STABILIZERS - Drugs for Inflammation		
ALOCRIL OPHTHALMIC SOLUTION 2 % (<i>nedocromil sodium</i>)	3	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	SM
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
MUCOLYTIC AGENTS - Drugs for the Lungs		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (<i>sodium chloride</i>)	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>)	3	PA; QL (5 ml per day.)
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %</i>	1	
NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	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 (34 grams (2 bottles) per copay.)
ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	3	QL (10.7 grams per prescription.); SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	2	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	2	QL (1 packet per day.); SM
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	2	SM
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	2	QL (120 ml (2 boxes) per 30 days.); SM
<i>budesonide inhalation suspension 1 mg/2ml</i>	2	QL (60 ml (1 box) per 30 days.); SM
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (10.6 grams per month.); SM
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (42.4 grams per month.); SM
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
<i>roflumilast oral tablet 250 mcg</i>	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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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)
ZORYVE EXTERNAL CREAM 0.15 % (roflumilast)	4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (roflumilast)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (roflumilast)	4	PA; QL (60 grams per prescription.)
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; QL (186 ml per month.)
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.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day)
tadalafil oral tablet 10 mg	2	QL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	2	QL (1 tablet per day.)
tadalafil tablet 20 mg oral	2	QL (0.5 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (tadalafil (pah))	4	PA; QL (10 ml per day.)
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (treprostinil diolamine)	4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	4	PA; QL (6 tablets per day.)
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (treprostinil)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 80 MCG (treprostinil)	3	PA; SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 112 X 32MCG & 112 X 64MCG, 112 X 48MCG & 112 X 64MCG, 80 MCG (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	3	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
<i>pirfenidone oral capsule 267 mg</i>	2	PA; QL (9 capsules per day.)
<i>pirfenidone oral tablet 267 mg</i>	3	PA; QL (9 tablets per day.)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	3	PA; QL (3 tablets per day.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	4	PA; QL (0.07 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	3	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	3	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	3	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	3	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; QL (0.04 ml per day.)
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	2	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (<i>levalbuterol tartrate</i>)	3	QL (15 grams per prescription.); SM
VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	3	PA; QL (3 tablets per day.)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	3	PA; QL (1 tablet per day.); SP; SMCS
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	3	PA; QL (2 tablets per day.); SP; SMCS
<i>bosentan oral tablet soluble 32 mg</i>	3	PA; QL (4 tablets per day.); SP; SMCS
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	3	PA; QL (1 tablet per day.); SP; SMCS
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	4	PA; QL (6 tablets per day.)
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	4	PA; QL (186 ml per month.)
<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.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; QL (2 tablets per day)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	4	PA; QL (10 ml per day.)
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	3	PA; QL (2 tablets per day.); SP; SMCS
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>)	3	PA; QL (112 cartridges per 23 days.); SP; SMCS
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (<i>treprostinil</i>)	3	PA; QL (252 cartridges per 365 days.); SP; SMCS
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	3	PA; SP; SMCS
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	4	PA; QL (200 tablets per year.)
VASODILATING AGENTS, MISC (48:48) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	3	PA; QL (3 tablets per day.)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	4	PA; QL (200 tablets per year.)
XANTHINE DERIVATIVES - Drugs for Asthma/COPD		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>	4	QL (60 grams per prescription.)
<i>bexarotene oral capsule 75 mg</i>	3	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>)	4	QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (<i>tirbanibulin</i>)	4	QL (5 units per prescription)
PANRETIN EXTERNAL GEL 0.1 % (<i>alitretinoin</i>)	3	
VALCHLOR EXTERNAL GEL 0.016 % (<i>mechlorethamine hcl (topical)</i>)	3	PA; QL (120 grams per prescription.); SP; SMCS
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ADRENERGIC AGONISTS - Drugs for the Skin		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (<i>brimonidine tartrate</i>)	2	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (<i>brimonidine tartrate</i>)	4	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)
<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)
MIRVASO EXTERNAL GEL 0.33 % (<i>brimonidine tartrate</i>)	3	PA; QL (30 grams per prescription.)
ANTIBACTERIALS (84:04) - Drugs for the Skin		
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	4	
AVIDOXY ORAL TABLET 100 MG	4	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
azelaic acid external gel 15 %	3	
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
benzoyl peroxide-erythromycin external gel 5-3 %	1	QL (23.3 grams per prescription.)
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (clindamycin hcl)	4	
CLEOCIN ORAL CAPSULE 75 MG (clindamycin hcl)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (clindamycin palmitate hcl)	4	
CLEOCIN VAGINAL CREAM 2 % (clindamycin phosphate)	4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	3	
clindacin-p external swab 1 %	1	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	2	
clindamycin phos (twice-daily) external gel 1 %	2	QL (75 grams per prescription.)
clindamycin phos-benzoyl perox external gel 1.2-5 %	3	QL (1 bottle (45 grams) per month.)
clindamycin phosphate external foam 1 %	3	
clindamycin phosphate external lotion 1 %	3	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	2	
CLINDESSE VAGINAL CREAM 2 % (clindamycin phosphate (1 dose))	2	
dapsone oral tablet 100 mg, 25 mg	2	
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg	2	
doxycycline hyclate oral tablet 20 mg	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	3	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
ery external pad 2 %	1	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
FINACEA EXTERNAL FOAM 15 % (azelaic acid)	4	
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))	4	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	4	
METROCREAM EXTERNAL CREAM 0.75 % (metronidazole)	4	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 sulfate oral tablet 500 mg	1	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 % (bacitracin-polymyx-neo-hc)	3	
neuac external gel 1.2-5 %	3	QL (1 bottle (45 grams) per month.)
OVACE PLUS EXTERNAL SHAMPOO 10 % (sulfacetamide sodium)	3	
OVACE PLUS WASH EXTERNAL GEL 10 % (sulfacetamide sodium)	3	
OVACE PLUS WASH EXTERNAL LIQUID 10 % (sulfacetamide sodium)	4	
OVACE WASH EXTERNAL LIQUID 10 % (sulfacetamide sodium)	4	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM (bacitracin-polymyxin b)	3	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sodium sulfacetamide external shampoo 10 %	1	
sodium sulfacetamide wash external liquid 10 %	1	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium (acne) external lotion 10 %	1	
sulfacetamide sodium (cleans) external gel 10 %	1	
sulfacetamide sodium external liquid 10 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (mafenide acetate)	3	
tetracycline hcl oral capsule 250 mg, 500 mg	3	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	4	
XACIATO VAGINAL GEL 2 % (clindamycin phosphate)	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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin		
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	3	
ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	3	QL (60 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	4	PA; QL (60 grams per prescription.)
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	4	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (<i>lidocaine-benzalkonium (pod)</i>)	3	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	
DYCLOPRO EXTERNAL SOLUTION 0.5 %	4	
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	2	
<i>glydo external prefilled syringe 2 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
<i>lidocaine external ointment 5 %</i>	2	QL (1.19 grams per day.)
<i>lidocaine external patch 5 %</i>	3	PA; QL (3 patches per day)
<i>lidocaine hcl external solution 4 %</i>	1	
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	1	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>lidocaine-prilocaine external cream 2.5-2.5 %</i>	1	
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (<i>pramoxine-hc</i>)	4	
<i>premium lidocaine external ointment 5 %</i>	2	QL (1.19 grams per day.)
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	2	
PYRIDIDIUM ORAL TABLET 100 MG, 200 MG (<i>phenazopyridine hcl</i>)	3	
ZTLIDO EXTERNAL PATCH 1.8 % (<i>lidocaine</i>)	3	PA; QL (3 patches per day.)
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
<i>acyclovir external ointment 5 %</i>	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	
ZELSUVMI EXTERNAL GEL 10.3 % (<i>berdazimer sodium</i>)	4	PA; QL (31 grams (1 box) per copay)
ASTRINGENTS (84:12) - Drugs for the Skin		
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	2	QL (0.36 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (<i>glycopyrrolate</i>)	4	
DRYSOL EXTERNAL SOLUTION 20 % (<i>aluminum chloride</i>)	4	
<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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hydrocortisone-iodoquinol external cream 1-1 %	1	
iodine strong oral solution 5 %	1	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (chlorhexidine gluconate)	4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (silver sulfadiazine)	4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
clotrimazole mouth/throat troche 10 mg	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
econazole nitrate external cream 1 %	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	
ketoconazole external cream 2 %	1	QL (30 grams per prescription.)
ketoconazole external foam 2 %	3	
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	3	
miconazole 3 vaginal suppository 200 mg	1	
ORAVIG BUCCAL TABLET 50 MG (miconazole)	4	
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BASIC LOTIONS AND LINIMENTS - Drugs for the Skin		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (<i>salicylic acid-lactic acid</i>)	2	
<i>methyl salicylate external liquid</i>	1	
PRONAL EXTERNAL GEL 40-10 % (<i>urea-lactic acid</i>)	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (<i>salicylic acid-urea in lactac</i>)	3	
<i>turpentine external spirit</i>	1	
VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID	3	
XIRUN EXTERNAL GEL 40-10 %	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (<i>benzoyl peroxide-hyaluronate</i>)	3	
BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin		
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
<i>calcipotriene external cream 0.005 %</i>	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>)	4	QL (60 grams per prescription.)
<i>nitroglycerin rectal ointment 0.4 %</i>	4	QL (30 grams per month.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	4	QL (90 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>)	4	PA; QL (60 grams per prescription.)
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
<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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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		
<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>	3	QL (279 capsules per prescription.); CM
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	4	
<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 1-1 %, 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (<i>hydrocortisone ace-pramoxine</i>)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	4	
<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	
<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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	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>)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (<i>hydrocortisone</i>)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (<i>hydrocortisone</i>)	4	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	2	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	4	QL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	4	
DERMOTIC OTIC OIL 0.01 % (<i>fluocinolone acetonide</i>)	4	
<i>desonide external cream 0.05 %</i>	2	QL (15 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.)
<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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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>)	4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	4	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	
<i>fluocinonide external ointment 0.05 %</i>	1	
<i>fluocinonide external solution 0.05 %</i>	1	
<i>flurandrenolide external lotion 0.05 %</i>	3	QL (120 ml per prescription.)
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>halobetasol propionate external cream 0.05 %</i>	2	QL (15 grams per prescription.)
<i>halobetasol propionate external ointment 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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
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>	4	
<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.)
<i>hydrocortisone valerate external ointment 0.2 %</i>	3	QL (15 grams per prescription.)
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
KOURZEQ MOUTH/THROAT PASTE 0.1 % (<i>triamcinolone acetonide</i>)	2	
<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	
NUCORT EXTERNAL LOTION 2 % (<i>hydrocortisone acetate</i>)	3	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	2	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	2	
ORALONE MOUTH/THROAT PASTE 0.1 % (<i>triamcinolone acetonide</i>)	2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (<i>pramoxine-hc</i>)	4	
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>)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (<i>hc & sal acid-sulfur & shampoo</i>)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	2	
TOPICORT EXTERNAL OINTMENT 0.05 % (<i>desoximetasone</i>)	4	QL (60 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.25 % (<i>desoximetasone</i>)	4	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.)
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
<i>ciclodan external solution 8 %</i>	1	
<i>ciclopirox external gel 0.77 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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	
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.)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	3	PA; QL (0.15 ml per day.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (2 ml (1 syringe) per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (1 syringe per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (2 ml (1 syringe) per month.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (<i>dupilumab</i>)	3	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>dupilumab</i>)	3	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>dupilumab</i>)	3	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>dupilumab</i>)	3	PA; QL (0.15 ml per day.)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	3	PA; QL (2 mL (1 pen) per month.)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (<i>lebrikizumab-lbkz</i>)	3	PA; QL (2 mL (1 syringe) per month.)
HYFTOR EXTERNAL GEL 0.2 % (<i>sirolimus</i>)	4	PA; QL (10 g per 23 days.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (<i>nemolizumab-ilto</i>)	3	PA; QL (2 pens every 4 weeks.)
<i>pimecrolimus external cream 1 %</i>	3	QL (30 grams per prescription.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (<i>tacrolimus</i>)	4	PA
<i>sirolimus oral solution 1 mg/ml</i>	3	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>risankizumab-rzaa</i>)	3	PA; QL (1 ml per 63 days.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>risankizumab-rzaa</i>)	3	PA; QL (1 ml per 63 days.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>spesolimab-sbzo</i>)	4	PA; QL (2 Prefilled syringes per month.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>spesolimab-sbzo</i>)	4	PA; QL (1 prefilled syringe per month.)
<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	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (2ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (2ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	3	PA; QL (4 ml (2 pens/1 box) per month.)
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	3	PA; QL (1 tablet per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	3	PA; QL (2 tablets per day.); CM
LITFULO ORAL CAPSULE 50 MG (<i>ritlecitinib tosylate</i>)	4	PA; QL (1 capsule per day.)
<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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SOTYKTU ORAL TABLET 6 MG (<i>deucravacitinib</i>)	3	PA; QL (1 tablet per day.)
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	4	PA; QL (60 grams per prescription.)
KERATOLYTIC AGENTS - Drugs for the Skin		
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	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)
AKLIEF EXTERNAL CREAM 0.005 % (<i>trifarotene</i>)	4	PA; QL (45 grams per prescription.)
<i>amnestem oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	4	
AVIDOXY DK COMBINATION KIT 100 MG (<i>doxycycline-sunscreen-sal acid</i>)	3	
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	4	
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (<i>salicylic acid-lactic acid</i>)	2	
HYDRO 40 EXTERNAL FOAM 40 % (<i>urea</i>)	3	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
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	
PRONAL EXTERNAL GEL 40-10 % (<i>urea-lactic acid</i>)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RAYASAL EXTERNAL CREAM 5.9 %	3	
SALICATE EXTERNAL LIQUID 10 % (<i>salicylic acid</i>)	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
salicylic acid external solution 26 %	1	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (salicylic acid-urea in lactac)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (hc & sal acid-sulfur & shampoo)	3	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external 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	
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.)
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
XIRUN EXTERNAL GEL 40-10 %	3	
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
KERATOPLASTIC AGENTS - Drugs for the Skin		
coal tar external solution 20 %	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	3	QL (45 grams per prescription)
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
benzoyl peroxide-erythromycin external gel 5-3 %	1	QL (23.3 grams per prescription.)
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	3	QL (1 bottle (45 grams) per month.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxyleneol</i>)	4	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	2	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (<i>lidocaine-benzalkonium (pod)</i>)	3	
FEM PH VAGINAL GEL 0.9-0.025 % (<i>acetic acid-oxyquinoline</i>)	4	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
<i>iodine tincture external tincture 2 %</i>	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
<i>neuac external gel 1.2-5 %</i>	3	QL (1 bottle (45 grams) per month.)
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (<i>chlorhexidine gluconate</i>)	4	
<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>)	4	
<i>silver sulfadiazine external cream 1 %</i>	1	
<i>ssd external cream 1 %</i>	1	
SULFAMYLLON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (<i>benzoyl peroxide-hyaluronate</i>)	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
<i>diclofenac sodium external gel 3 %</i>	2	PA; QL (100 grams per prescription.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	3	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZORYVE EXTERNAL CREAM 0.15 % (<i>roflumilast</i>)	4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	4	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.)
<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>)	4	
<i>malathion external lotion 0.5 %</i>	1	
OVIDE EXTERNAL LOTION 0.5 % (<i>malathion</i>)	4	
<i>permethrin external cream 5 %</i>	1	
PRURADIK EXTERNAL LOTION 10 % (<i>crotamiton</i>)	3	
SOOLANTRA EXTERNAL CREAM 1 % (<i>ivermectin</i>)	4	QL (45 grams per prescription.)
<i>spinosad external suspension 0.9 %</i>	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>sulfurated lime external solution</i>	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	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)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	3	PA; QL (0.15 ml per day.)
AKLIEF EXTERNAL CREAM 0.005 % (<i>trifarotene</i>)	4	PA; QL (45 grams per prescription.)
AMELUZ EXTERNAL GEL 10 % (<i>aminolevulinic acid hcl</i>)	3	
<i>amnestem oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
<i>azelaic acid external gel 15 %</i>	3	
B & C EXTERNAL OINTMENT	3	
<i>balsam peru-castor oil external ointment</i>	1	
<i>bexarotene external gel 1 %</i>	4	QL (60 grams per prescription.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	4	PA; QL (1 syringe per month.)
<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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (abrocitinib)	3	PA; QL (1 tablet per day.); CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
CONDYLOX EXTERNAL GEL 0.5 % (podofilox)	4	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	3	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	3	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (secukinumab)	3	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	3	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	3	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (secukinumab)	3	PA; QL (0.072 ml per day.)
dapsone oral tablet 100 mg, 25 mg	2	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (dupilumab)	3	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (dupilumab)	3	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (dupilumab)	3	PA; QL (0.15 ml per day.)
ENDARI ORAL PACKET 5 GM (glutamine (sickle cell))	4	PA; QL (6 packets per day.)
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (calcipotriene-betameth diprop)	4	QL (60 grams per prescription.)
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid-oxyquinoline)	4	
FILSUEVZ EXTERNAL GEL 10 % (birch triterpenes)	4	PA; QL (14.4 grams per day.)
FINACEA EXTERNAL FOAM 15 % (azelaic acid)	4	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (dermatological products, misc.)	3	PA
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	4	PA; QL (10 g per 23 days.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
imiquimod external cream 5 %	1	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (tirbanibulin)	4	QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (tirbanibulin)	4	QL (5 units per prescription)
L-glutamine oral packet 5 gm	3	PA; QL (6 packets per day.)
LITFULO ORAL CAPSULE 50 MG (ritlecitinib tosylate)	4	PA; QL (1 capsule per day.)
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	2	
MIRVASO EXTERNAL GEL 0.33 % (brimonidine tartrate)	3	PA; QL (30 grams per prescription.)
nitroglycerin rectal ointment 0.4 %	4	QL (30 grams per month.)
OTEZLA ORAL TABLET 20 MG (apremilast)	3	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (apremilast)	3	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	3	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (apremilast)	3	PA; QL (1 starter pack per year.)
PANRETIN EXTERNAL GEL 0.1 % (alitretinoin)	3	
pimecrolimus external cream 1 %	3	QL (30 grams per prescription.)
PODOCON-25 EXTERNAL SOLUTION 25 % (podophyllum resin)	3	
podofilox external gel 0.5 %	3	
podofilox external solution 0.5 %	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (collagenase)	4	QL (90 grams per prescription.)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (risankizumab-rzaa)	3	PA; QL (1 ml per 63 days.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (risankizumab-rzaa)	3	PA; QL (1 ml per 63 days.)
SOTYKTU ORAL TABLET 6 MG (deucravacitinib)	3	PA; QL (1 tablet per day.)
tacrolimus external ointment 0.03 %, 0.1 %	2	QL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>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.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (<i>fibrin sealant component</i>)	3	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	3	PA; QL (1 mL (1 syringe) every 8 weeks.)
VALCHLOR EXTERNAL GEL 0.016 % (<i>mechlorethamine hcl (topical)</i>)	3	PA; QL (120 grams per prescription.); SP; SMCS
VENELEX EXTERNAL OINTMENT (<i>balsam peru-castor oil</i>)	3	
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	4	PA; QL (60 grams per prescription.)
ZELSUVMI EXTERNAL GEL 10.3 % (<i>berdazimer sodium</i>)	4	PA; QL (31 grams (1 box) per copay)
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast</i>)	4	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	
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles		
ANTIMUSCARINICS - Drugs for the Urinary System		
<i>flavoxate hcl oral tablet 100 mg</i>	1	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	2	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride oral tablet 2.5 mg</i>	4	
<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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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>trospium 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>	4	PA; QL (186 ml per month.)
<i>sildenafil citrate oral tablet 20 mg</i>	1	QL (0.5 tablet per day.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
<i>mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg</i>	3	
VITAMINS		
MULTIVITAMIN PREPARATIONS		
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	3	
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (<i>pediatric multivitamins-fl</i>)	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PLUS ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (<i>prenat-fe-methylfol-dha w/o a</i>)	3	
NESTABS ORAL TABLET 32-1 MG (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (<i>prenatal multivit-min-fe-fa</i>)	3	
<i>pnv 27-ca/fe/fa oral tablet 60-1 mg</i>	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (<i>ped multivitamins-fl-iron</i>)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (<i>ped multivitamins-fl-iron</i>)	3	
PREMESISRX ORAL TABLET 1 MG (<i>prenatal ca-b6-b12-fa-ginger</i>)	3	
<i>prenatal oral tablet 27-1 mg</i>	1	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (<i>prenatal-feaspgly-methylfol-fa</i>)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (<i>prenat-fecbn-feasp-meth-fa-dha</i>)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (<i>prenat mv-min-methylfolate-fa</i>)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	4	
TRINATE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-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	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN A		
TRI-VI-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		
CALCIFOL ORAL WAFER 1342-1.6 MG (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	3	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
<i>cyanocobalamin nasal solution 500 mcg/0.1ml</i>	3	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg</i>	4	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	
<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

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
hematinic/folic acid oral tablet 324-1 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (cyanocobalamin)	4	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (prenatal vit-fe fumarate-fa)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (prenat-fe-methylfol-dha w/o a)	3	
NESTABS ORAL TABLET 32-1 MG (prenat-fe bisgly-fa-w/o vit a)	3	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (prenatal multivit-min-fe-fa)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
PREMESISRX ORAL TABLET 1 MG (prenatal ca-b6-b12-fa-ginger)	3	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral oral tablet 27-1 mg	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (prenatal-feaspgly-methylfol-fa)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fechn-feasp-meth-fa-dha)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 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>)	4	
TRINATE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	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	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN C		
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	4	QL (1 kit per prescription.)
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	3	QL (1 kit per prescription.)
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	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	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VITAMIN D		
CALCIFOL ORAL WAFER 1342-1.6 MG (<i>ca carb-fa-d-b6-b12-boron-mg</i>)	3	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	1	
<i>calcitriol oral solution 1 mcg/ml</i>	1	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	1	
DRISDOL ORAL CAPSULE 1.25 MG (50000 UT) (<i>ergocalciferol</i>)	4	
<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	
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>)	4	
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 mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Index of Drugs

abacavir sulfate	32	ADRENALIN.....	60, 180, 263	ALOGLIPTIN-METFORMIN	
abacavir sulfate-lamivudine ...	32	ADVAIR HFA....	67, 173, 190, 266	HCL.....	198, 206
abigale	207, 220	ADVATE.....	75	ALOGLIPTIN-PIOGLITAZONE	
abigale lo	207, 220	ADVOCATE SAFETY		.....	206, 231
abiraterone acetate	42	LANCETS 21G.....	148	ALORA.....	207, 243
abirtega	42	ADVOCATE SAFETY		alose tron hcl	183
ABRYSVO.....	55	LANCETS 23G.....	148	ALPHAGAN P.....	168, 277
acamprosate calcium	15, 124	ADVOCATE SAFETY		ALPHANATE.....	75
acarbose	195	LANCETS 28G.....	148	ALPHANINE SD.....	75
ACCOLATE.....	270	ADYNOVATE.....	75	alprazolam	122
ACCU-CHEK AVIVA.....	147	AEROCHAMBER HOLDING		alprazolam er	122
ACCU-CHEK FASTCLIX		CHAMBER.....	148	alprazolam intensol	122
LANCET KIT.....	147	AEROCHAMBER PLS FLOVU		alprazolam xr	122
ACCU-CHEK GUIDE.....	147	MTHPIECE.....	148	ALPROLIX.....	75
ACCU-CHEK GUIDE		AEROCHAMBER PLUS FLO-		ALREX.....	173
CONTROL.....	147	VU INTERM.....	148	ALTACAIN.....	179, 240
ACCU-CHEK GUIDE ME.....	147	AEROCHAMBER PLUS FLO-		altafrin	179, 180
ACCU-CHEK GUIDE TEST....	158	VU LARGE.....	148	altavera	199, 207, 220
ACCU-CHEK SMARTVIEW		AEROCHAMBER PLUS FLO-		ALTUVIIIO.....	75
CONTROL.....	147	VU MEDIUM.....	148	ALUNBRIG.....	42
ACCU-CHEK SOFTCLIX		AEROCHAMBER PLUS FLO-		ALVAIZ.....	73
LANCET DEVICE KIT.....	147	VU SMALL.....	148	alvimopan	181, 186
accutane	292, 296	AEROCHAMBER2GO ANTI-		alyacen 1/35	199, 207, 220
ACD-A NOCLOT-50.....	71	STATIC.....	148	alyacen 7/7/7	199, 207, 220
acebutolol hcl 69, 88, 94, 96, 102		afirmelle	199, 207, 220	ALYFTREK.....	267, 268
acetaminophen-codeine		AFLURIA.....	55	amantadine hcl	20, 109
.....	110, 129, 131	AFLURIA PRESERVATIVE		ambrisentan	106, 269, 275
acetazolamide		FREE.....	56	amcinonide	285
.....	83, 93, 112, 160, 172	AFSTYLA.....	75	AMELUZ.....	277, 296
acetazolamide er		aftera	196, 199, 220	amethyst	199, 207, 220
.....	83, 93, 112, 160, 172	AIMOVIG.....	123	amiloride hcl	83, 105, 162
acetic acid	178	AIRSUPRA		amiloride-	
acetylcysteine	15, 240, 270	.....	68, 173, 190, 266, 271, 274	hydrochlorothiazide	162, 164
acitretin	292, 296	AKEEGA.....	42	aminocaproic acid	75
ACTEMRA.....	237, 248, 251	AKLIEF.....	292, 296	amiodarone hcl	97
ACTEMRA ACTPEN		AKTEN.....	179	amitriptyline hcl	143
.....	237, 248, 251	AKYNZEO.....	181, 188	AMJEVITA.....	186, 239, 248, 252
ACTHIB.....	55	ALA SCALP.....	173, 190, 285	AMJEVITA-PED 15KG TO	
ACTIMMUNE.....	251	albendazole	22	<30KG.....	186, 239, 248, 252
ACTIVELLA.....	207, 220	albuterol sulfate	68, 274	amlodipine besylate ..	98, 99, 106
ACULAR.....	138, 178	ALBUTEROL SULFATE...	68, 274	amlodipine besylate-	
ACULAR LS.....	138, 178	albuterol sulfate hfa	68, 274	benazepril hcl	87, 98
acyclovir	36, 282	ALCAINE.....	179	amlodipine besylate-	
ADACEL.....	54, 55	alclometasone dipropionate	285	valsartan	85, 98
ADALIMUMAB-ADAZ		ALCOHOL PREP PADS.....	148	amnesteam	292, 296
.....	186, 239, 248, 251, 252	ALECENSA.....	42	amoxapine	143
adapalene-benzoyl peroxide		alendronate sodium	243	amoxicillin	22, 183
.....	261, 292, 293, 296	alfuzosin hcl er	67	amoxicillin-potassium	
ADBRY.....	290, 296	allopurinol	242	clavulanate	22
ADDYI.....	124	almotriptan malate	141	amphetamine sulfate	109
adefovir dipivoxil	36	ALOCRI.....	168, 270	amphetamine-	
ADEMPAS.....	275, 276	ALOGLIPTIN BENZOATE.....	206	dextroamphetamine	109

amphetamine-			
dextroamphetamine er	109		
amphet-dextroamphet 3-			
bead er	109		
ampicillin	22		
anagrelide hcl	82		
ANALPRAM HC			
.....	173, 190, 281, 285		
anastrozole	42, 196		
ANCOBON.....	39		
ANDEMBRY.....	83		
ANGELIQ.....	207, 220		
ANNOVERA.....	199, 208, 220		
ANORO ELLIPTA.....	61, 68		
ANTICOAGULANT SODIUM			
CITRATE.....	71		
ANUCORT-HC.....	173, 190, 285		
ANUSOL-HC.....	173, 190, 285		
ANZEMET.....	181		
apraclonidine hcl	168, 178		
aprepitant	188		
apri	199, 208, 220		
APRISO.....	183		
APTIVUS.....	34		
AQ INSULIN SYRINGE.....	148		
AQINJECT PEN NEEDLE.....	148		
AQNEURSA.....	258		
AQUORAL.....	178		
ARAKODA.....	23		
aranelle	199, 208, 220		
ARANESP (ALBUMIN FREE)			
.....	70, 71, 73		
ARCALYST.....	258, 270		
AREXVY.....	56		
arformoterol tartrate	68, 274		
ARIKAYCE.....	21		
aripiprazole	115, 119		
armodafinil	144		
ARMOUR THYROID.....	231		
ARNUITY ELLIPTA			
.....	173, 190, 191, 266, 271		
ARTISS.....	284, 296		
ARZOL SILVER NIT			
APPLICATORS.....	171		
ascomp-codeine			
.....	121, 131, 136, 139		
asenapine maleate	115, 119		
ashlyna	199, 208, 220		
aspirin	81, 82, 117, 140		
aspirin 81	81, 82, 117, 139		
aspirin adult low dose			
.....	81, 82, 117, 139		
aspirin adult low strength			
.....	81, 82, 117, 139		
aspirin childrens	81, 82, 117, 139		
aspirin ec adult low dose			
.....	81, 82, 117, 139		
aspirin ec low dose			
.....	81, 82, 117, 139		
aspirin ec low strength			
.....	81, 82, 117, 139		
aspirin low dose	81, 82, 117, 140		
aspirin regimen	81, 82, 117, 140		
aspirin-dipyridamole er			
.....	81, 104, 140, 158		
ASSURE CONTROL			
SOLUTION 2/3.....	148		
ASSURE ID DUO PRO PEN			
NEEDLES.....	148		
ASSURE ID PRO PEN			
NEEDLES.....	148		
ASTRINGYN.....	75		
atazanavir sulfate	34		
atenolol	69, 88, 94, 96, 102		
atenolol-chlorthalidone			
.....	88, 94, 166		
atomoxetine hcl	124, 136, 137		
ATORVALIQ.....	101		
atorvastatin calcium	101		
atovaquone	24		
atovaquone-proguanil hcl	23		
atropine sulfate	15, 61, 179, 264		
ATROVENT HFA.....	61, 264		
ATTRUBY.....	93		
aubra eq	199, 208, 220		
AUGTYRO.....	42		
AUM INSULIN SAFETY PEN			
NEEDLE.....	148		
AUM MINI INSULIN PEN			
NEEDLE.....	148		
AUM PEN NEEDLE.....	148		
AUM READYGARD DUO PEN			
NEEDLE.....	148		
AUM SAFETY PEN NEEDLE.....	149		
aurovela 1.5/30	199, 208, 220		
aurovela 1/20	199, 208, 220		
aurovela 24 fe	199, 208, 220		
aurovela fe 1.5/30	199, 208, 220		
aurovela fe 1/20	199, 208, 220		
AUSTEDO.....	143		
AUSTEDO XR.....	143		
AUSTEDO XR PATIENT			
TITRATION.....	143		
AUTOLET LANCING DEVICE			149
AUTOLET LITE LANCING			
DEVICE.....	149		
AUVI-Q.....	60, 263, 264		
avanafil	104, 105		
AVAR CLEANSER.....	277, 292		
AVERI.....	199, 208, 220		
aviane	199, 208, 220		
AVIDOXY.....	23, 41, 277		
AVIDOXY DK.....	41, 292, 299		
AVMAPKI FAKZYNJA CO-			
PACK.....	43		
AVONEX PEN.....	236, 252		
AVONEX PREFILLED....	236, 252		
ayuna	200, 208, 221		
AYVAKIT.....	43		
AZASAN.....	233, 248, 252, 256		
AZASITE.....	168		
azathioprine	233, 248, 252, 256		
azelaic acid	278, 296		
azelastine hcl	168, 273		
azithromycin	37, 38		
AZSTARYS.....	137		
azurette	200, 208, 221		
B & C.....	296		
bac (butalbital-acetamin-			
caff)	110, 121, 129, 137		
bacitracin	27, 168, 278		
bacitracin-polymyxin b			
.....	27, 168, 278		
bacitra-neomycin-			
polymyxin-hc	27, 168, 173, 278		
baclofen	65		
BACTRIM.....	24, 40, 41		
BACTRIM DS.....	24, 40, 41		
BAFIERTAM.....	235, 252		
balsalazide disodium	183		
balsam peru-castor oil	296		
balziva	200, 208, 221		
BAQSIMI ONE PACK.....	15, 216, 240		
BAQSIMI TWO PACK			
.....	15, 216, 240		
BARACLUDE.....	36		
BAXDELA.....	40		
BD AUTOSHIELD DUO PEN			
NEEDLES.....	149		
BD ECLIPSE LUER-LOK			
NEEDLE.....	149		
BD ECLIPSE NEEDLE.....	149		
BD PEN NEEDLE MICRO			
ULTRAFINE.....	149		
BD PEN NEEDLE MINI			
ULTRAFINE.....	149		

BD PEN NEEDLE NANO ULTRAFINE.....	149	BEYFORTUS.....	35	butalbital-apap-caff-cod	110, 121, 130, 131, 137
BD PEN NEEDLE ORIG ULTRAFINE.....	149	bicalutamide	43	butalbital-apap-caffeine	110, 121, 130, 137
BD PEN NEEDLE SHORT ULTRAFINE.....	149	BIGFOOT UNITY PROGRAM	149	BUTALBITAL-APAP- CAFFEINE.....	110, 121, 130, 137
BD SAFETYGLIDE NEEDLE..	149	BIJUVA.....	208, 221	butalbital-asa-caff-codeine	121, 131, 137, 140
BD SHARPS COLLECTOR....	149	BIKTARVY.....	31, 32	butalbital-aspirin-caffeine	121, 137, 140
BD ULTRA-FINE INSULIN SYRINGES.....	149	BILTRICIDE.....	22	butorphanol tartrate	117, 136
BD ULTRA-FINE PEN NEEDLES.....	149	bimatoprost	180	cabergoline	126
BD VEO INSULIN SYR ULTRAFINE.....	149	BIMZELX.....	290, 296	CABLIVI.....	71, 82
BELBUCA.....	135	bisacodyl ec	183	CABOMETYX.....	43
belladonna alkaloids-opium	61, 131	bisoprolol fumarate	70, 88, 94, 96, 102	caffeine citrate	117, 137
BELSOMRA.....	118, 136	bisoprolol- hydrochlorothiazide	88, 94, 165	CALCIFOL.....	162, 302, 305
benazepril hcl	86, 87	blisovi 24 fe	200, 208, 221	calcipotriene	284, 296
benazepril- hydrochlorothiazide	87, 165	blisovi fe 1.5/30	200, 208, 221	calcitonin (salmon)	198, 243
BENEFIX.....	75	blisovi fe 1/20	200, 208, 221	CALCITRENE.....	284, 296
BENLYSTA.....	235, 256	BONSITY.....	219, 243	calcitriol	296, 305
benzalkonium chloride	282, 293	BOOSTRIX.....	55, 56	calcium acetate	161, 162
BENZNIDAZOLE.....	24, 36	bosentan	106, 269, 275	calcium acetate (phos binder)	161, 162
benzoin	284	BOSULIF.....	43	CALQUENCE.....	43
benzonatate	265	BREATHE COMFORT CHAMBER/ADULT.....	149	camila	200, 221
benzoyl peroxide- erythromycin	278, 293	BREATHE COMFORT CHAMBER/CHILD.....	150	camrese	200, 208, 221
benztropine mesylate	63, 111	BRENZAVVY.....	229	camrese lo	200, 208, 221
BERINERT.....	247	BREO ELLIPTA 68, 173, 191, 266	61, 68, 191	CAMZYOS.....	93
BESIVANCE.....	169	BREZTRI AEROSPHERE	200, 208, 221	candesartan cilexetil	85
BETADINE OPHTHALMIC PREP.....	171	brillevyn	200, 208, 221	candesartan cilexetil-hctz	85, 165
betaine	258	brimonidine tartrate	168, 277, 296	capecitabine	43
betamethasone dipropionate	191, 285	brinzolamide	173	CAPLYTA.....	119
betamethasone dipropionate aug	191, 285	bromfenac sodium (once- daily)	178	CAPRELSA.....	43
betamethasone valerate	191, 285	bromocriptine mesylate	126	captopril	86, 87
BETAPACE AF	65, 88, 94, 96, 97, 102	BRUKINSA.....	43	captopril- hydrochlorothiazide	87, 165
BETASERON.....	236, 252	budesonide	191, 266, 271, 285	CAPVAXIVE.....	56
betaxolol hcl	69, 88, 94, 96, 102, 172	bumetanide	83, 101, 160	carbamazepine	112, 115
bethanechol chloride	66	BUMEX.....	83, 101, 161	carbamazepine er	112, 115
BETIMOL.....	65, 88, 96, 172	buprenorphine	135, 136	carbidopa	125
BETOPTIC-S.....	70, 96, 172	buprenorphine hcl	135	carbidopa-levodopa	125, 126
BEVESPI AEROSPHERE	61, 68, 282	buprenorphine hcl-naloxone hcl	134, 135	carbidopa-levodopa er	125
bexarotene	43, 277, 296	bupropion hcl	114	carbidopa-levodopa- entacapone	124, 126
BEXSERO.....	56	bupropion hcl er (smoking det)	59, 114	carbinoxamine maleate	17, 18, 269
		bupropion hcl er (sr)	114	CARBZAH.....	17, 18, 269
		bupropion hcl er (xl)	114	CARDURA.....	66, 84, 88
		buspirone hcl	119, 129	CARDURA XL.....	66, 84, 88
		butalbital-acetaminophen	110, 121, 130	CAREPOINT POLY HUB NEEDLE.....	150

CAREPOINT SAFETY 1ST NEEDLE.....150	chlordiazepoxide- amitriptyline.....122, 143	cladribine (9 tabs) 44, 233, 253, 257
CARESENS CONTROL SOLUTION A/B.....150	chlorhexidine gluconate 20, 171, 172, 282, 293	claravis.....292, 297
CARESENS LANCETS 30G...150	chloroquine phosphate 23	clarithromycin 25, 38, 183
CARESENS S CONTROL SOLN A/B.....150	chlorpromazine hcl.....136	clarithromycin er .25, 37, 38, 183
CARETOUCH CONTROL SOL LEVEL 2.....150	chlorthalidone 84, 106, 166	clearlax.....183
CARETOUCH HYPODERMIC NEEDLE.....150	chlorzoxazone 64	clemastine fumarate . 17, 18, 269
CARETOUCH LANCING/EJECTOR.....150	CHOLBAM.....185, 186	CLEMSZA.....17, 18, 269
carglumic acid.....160	cholestyramine.....90	CLENPIQ.....184
carisoprodol.....64	cholestyramine light.....90	CLEOCIN.....34, 278
CAROSPIR.....83, 101, 102, 105, 106, 162	CHORIONIC GONADOTROPIN.....216	CLEVER CHOICE COMFORT EZ.....150
carteolol hcl.....172	CHOSEN LANCETS 30G.....150	CLIMARA PRO.....208, 221
cartia xt.....90, 91, 92, 97, 106	CHOSEN LANCING DEVICE.150	clindacin.....35, 278
carvedilol.....65, 67, 84, 88, 94, 96, 102	CHOSEN SAFETY LANCETS 28G.....150	clindacin etz.....34, 278
CAVERJECT.....100, 107	CIBINQO.....237, 248, 291, 297	clindacin-p.....35, 278
CAVERJECT IMPULSE..100, 106	ciclodan.....289	clindamycin hcl.....35, 278
CAYA.....262	ciclopirox.....289, 290	clindamycin palmitate hcl.....35, 278
cefaclor.....20	ciclopirox olamine.....290	clindamycin phos (twice- daily).....35, 278
cefaclor er.....20	cilostazol.....81, 104, 105	clindamycin phos-benzoyl perox.....35, 278, 293
cefadroxil.....19, 20	CILOXAN.....169	clindamycin phosphate ..35, 278
cefdinir.....20	CIMDUO.....32	CLINDESSE.....35, 278
cefixime.....20	cimetidine.....18, 188	CLINPRO 5000.....145, 245
cefpodoxime proxetil.....20	cimetidine hcl.....18, 188	clobazam.....121, 122
cefprozil.....20	CIMZIA (2 SYRINGE) .....187, 234, 239, 248, 252	clobetasol propionate.....286
cefuroxime axetil.....20	CIMZIA-STARTER.....187, 234, 239, 248, 252	clobetasol propionate e.....285
celecoxib.....125	cinacalcet hcl.....198	clocortolone pivalate.....286
CELONTIN.....142	CIPRO.....25, 40	CLOMID.....207
cephalexin.....20	ciprofloxacin hcl.....25, 40, 169	clomiphene citrate.....207
CEQUR SIMPLICITY 2U.....150	ciprofloxacin- dexamethasone.....169, 173	clomipramine hcl.....143
CERDELGA.....166, 258	ciprofloxacin-hydrocortisone.....169, 173	clonazepam.....121, 122
CERVIDIL.....263	cialopram hydrobromide.....141	clonidine.....61, 94, 100
CETRAXAL.....169	citroma.....183	clonidine hcl.....61, 94, 100
CETROTIDE.....196	cladribine (10 tabs) .....43, 232, 252, 256	clonidine hcl er.....60, 100
cevimeline hcl.....67	cladribine (4 tabs) .....43, 232, 252, 256	clopidogrel bisulfate.....81
CHANTIX.....59, 63	cladribine (5 tabs) .....43, 232, 252, 256	clorazepate dipotassium.....121, 122
CHANTIX CONTINUING MONTH PAK.....59, 63	cladribine (6 tabs) .....43, 232, 253, 257	clotrimazole.....283
CHANTIX STARTING MONTH PAK.....59, 63	cladribine (7 tabs) .....43, 232, 253, 257	clotrimazole-betamethasone.....283, 286
charlotte 24 fe.....200, 208, 221	cladribine (8 tabs) .....43, 233, 253, 257	clozapine.....119
chateal eq.....200, 208, 221		CLOZARIL.....119
CHEMET.....15, 190, 240		COAGADEX.....75
CHEMSTRIP BG LOG BOOK.150		coal tar.....293
CHEMSTRIP K.....158		COARTEM.....23
CHEMSTRIP UGK.....159		codeine sulfate.....131, 265
chlordiazepoxide hcl.....122		colchicine.....242
		colchicine-probenecid ..166, 242
		colesevelam hcl.....90, 196
		COLESTID.....90

colestipol hcl	90	COTELLIC.....	44	deferasirox	190
colistimethate sodium (cba) ..	39	COVARYX.....	195, 209	deferasirox granules	190
COLY-MYCIN M.....	39	COVARYX HS.....	195, 208	deferiprone	190
COMBIGAN.....	168, 172, 277	CRENESSITY.....	75, 76, 219	DELESTROGEN.....	209, 243
COMBIPATCH.....	208, 221	CREON.....	167, 185	DELSTRIGO.....	31, 32
COMBIVENT RESPIMAT		CRESEMBA.....	26	delyla	200, 209, 221
.....	61, 68, 264	CREXONT.....	126	demeclocycline hcl	41
COMETRIQ.....	44	CRINONE.....	221	DEMSEER.....	158, 259
COMFORT EZ PRO PEN		cromolyn sodium ..	168, 178, 270	DENG VAXIA.....	56
NEEDLES.....	150	CROTAN.....	295	DENTA 5000 PLUS	144, 145, 245
COMFORT TOUCH TWIST		CTEXLI.....	185	DENTA 5000 PLUS	
LANCET 30G.....	150	CUVPOSA.....	61, 282	SENSITIVE.....	145, 245
COMIRNATY.....	56	cyanocobalamin	80, 302	DENTAGEL.....	144, 145, 245
COMIRNATY 5-11 YEARS.....	56	CYANOCOBALAMIN.....	80, 302	DEPAKOTE....	112, 115, 117, 126
COMPLERA.....	31, 32, 36	cyclobenzaprine hcl	64	DEPAKOTE ER	
CONDOMS.....	262	CYCLOGYL.....	179	.....	112, 115, 117, 126
CONDYLOX.....	292, 297	CYCLOMYDRIL.....	179, 180	DEPAKOTE SPRINKLES	
constulose	160	cyclopentolate hcl	179	.....	112, 115, 117
CONTOUR CONTROL.....	150	cyclophosphamide ..	44, 235, 257	DEPEN TITRATABS..	15, 190, 249
CONTOUR NEXT CONTROL..	151	CYCLOPHOSPHAMIDE		DEPO-ESTRADIOL.....	209, 243
CONTOUR NEXT EZ.....	151	.....	44, 235, 257	DEPO-PROVERA.....	200, 221
CONTOUR NEXT GEN		cycloserine	25	DEPO-SUBQ PROVERA	104
MONITOR.....	151	cyclosporine		.....	200, 221
CONTOUR NEXT MONITOR..	151	.....	171, 233, 249, 253, 257	DEPO-TESTOSTERONE	195, 196
CONTOUR NEXT ONE.....	151	cyclosporine modified		DERMA-SMOOTH/FS BODY	
CONTOUR NEXT TEST.....	158	.....	171, 233, 249, 253, 257	.....	174, 286
CONTOUR PLUS BLUE.....	151	cyproheptadine hcl		DERMA-SMOOTH/FS	
CONTOUR PLUS CONTROL		.....	17, 18, 269, 270	SCALP.....	174, 286
SOLUTION.....	151	cyred eq	200, 209, 221	DERMOTIC.....	174, 286
CONTOUR PLUS TEST.....	158	CYSTADANE.....	258	DESCOVY.....	32, 37
COPIKTRA.....	44	CYSTADROPS.....	178, 179	desipramine hcl	143
CORDRAN.....	286	CYSTAGON.....	259	desmopressin ace spray	
CORIFACT.....	75	CYSTARAN.....	178, 179	refrig	76, 219
CORLANOR.....	93, 107	CYTOTEC.....	189	desmopressin acetate	76, 219
CORTANE-B		cytra k crystals	159	desmopressin acetate pf	76, 219
.....	174, 191, 281, 286, 294	dabigatran etexilate		desmopressin acetate spray	
CORTEF.....	174, 191, 286	mesylate	73	.....	76, 219
CORTENEMA.....	174, 191, 286	dalfampridine er	259, 262	desogestrel-ethinyl estradiol	
CORTIFOAM.....	174, 191, 286	danazol	195	.....	200, 209, 222
CORTISPORIN-TC.....	169, 174	DANTRIUM.....	65	desonide	286
CORTROSYN.....	158	dantrolene sodium	65	desoximetasone	286, 287
COSENTYX (300 MG DOSE)		dapsone	23, 24, 278, 297	desvenlafaxine succinate er	140
.....	237, 249, 297	DAPTACEL.....	55, 56	dexamethasone	174, 192
COSENTYX 150 MG/ML		DARAPRIM.....	23	dexamethasone intensol	
.....	237, 249, 297	darunavir	34	.....	174, 191
COSENTYX SENSOREADY		dasatinib	44	dexamethasone sodium	
(300 MG).....	237, 249, 297	dasetta 1/35 (28)	200, 209, 221	phosphate	174
COSENTYX SENSOREADY		dasetta 7/7/7	200, 209, 221	DEXCOM G6 RECEIVER.....	151
PEN.....	237, 249, 297	DAURISMO.....	44	DEXCOM G6 SENSOR.....	151
COSENTYX UNOREADY		DAYBUE.....	124	DEXCOM G6 TRANSMITTER	151
.....	237, 249, 297	daysee	200, 209, 221	DEXCOM G7 15 DAY	
COSOPT.....	172, 173	DEBACTEROL.....	178, 294	SENSOR.....	151
cosyntropin	158	deblitane	200, 221	DEXCOM G7 RECEIVER.....	151

DEXCOM G7 SENSOR.....	151	divalproex sodium	 112, 115, 117, 127	EASYMAX 15 LEVEL 2-3	
dexmethylphenidate hcl	137	divalproex sodium er	 112, 115, 117, 127	CONTROL.....	152
dexmethylphenidate hcl er ...	137	DIVIGEL.....	209, 243	EASYMAX CONTROL.....	152
dextroamphetamine sulfate ..	110	dofetilide	97	EASYMAX CONTROL	
dextroamphetamine sulfate		DOJOLVI.....	160	NORMAL/HIGH.....	152
er	109, 110	dolishale	200, 209, 222	EBGLYSS.....	290
DIABECIN HR.....	281, 294	donepezil hcl	67	econazole nitrate	283
DIABETES MONITOR DIGIT		DOPTelet	73	econtra one-step ...	196, 200, 222
ADD-ON.....	151, 259	DOPTelet SPRINKLE.....	73	EC-RX DHEA.....	259
DIABETES MONITOR DIGIT		DORZOLAMIDE HCL.....	173	EDEX.....	100, 107
SOLN.....	151, 259	dorzolamide hcl	173	EDURANT	31
DIASTIX REAGENT	159	dorzolamide hcl-timolol mal	 172, 173	EDURANT PED.....	31
diazepam	121, 123	dotti	209, 243	EEMT	195, 209
diazepam intensol	121, 123	DOVATO.....	31, 32	EEMT HS.....	195, 209
diazoxide	197	doxazosin mesylate	66, 84, 88	efavirenz	31
dichlorphenamide	83, 245	doxepin hcl	143, 281	efavirenz-emtricitab-tenofo	
diclofenac potassium	130	doxercalciferol	305	df	31, 32
diclofenac sodium		doxycycline hyclate ..	23, 41, 278	efavirenz-lamivudine-	
.....	130, 138, 144, 178, 294	doxycycline monohydrate	 23, 41, 279	tenofovir	32, 33
diclofenac sodium er	130	DRISDOL	305	EFFER-K.....	162
diclofenac-misoprostol ..	130, 189	DRIZALMA SPRINKLE.....	140	effer-k	162
dicloxacillin sodium	39	dronabinol	182, 187	EGATEN.....	22
dicyclomine hcl	61	DROPLET MICRON.....	151	ELESTRIN.....	209, 243
DIFICID	38	DROPSAFE ACTI-LANCE		eletriptan hydrobromide	141
diflorasone diacetate	287	23G.....	151	ELIMITE.....	295
diflunisal	130, 138	DROPSAFE SAFETY		elinest	200, 209, 222
difluprednate	174	SYRINGE/NEEDLE.....	151	ELIQUIS.....	72
digoxin	88, 93	DROPSAFE SICURA.....	152	ELIQUIS (1.5 MG PACK).....	72
dihydroergotamine mesylate		drospiren-eth estrad-		ELIQUIS (2 MG PACK).....	72
.....	66, 117	levomefol	200, 209, 222, 302	ELIQUIS DVT/PE STARTER	
DILANTIN.....	95, 127	DROXIA.....	44	PACK	72
DILANTIN INFATABS.....	95, 127	DRYSOL.....	282	ELITE-OB	79, 300, 302
DILANTIN-125.....	95, 127	DUAVEE.....	207, 209	elixophyllin	
diltiazem hcl	91, 92, 98, 107	DUETACT	230, 231	.....	100, 137, 160, 276, 300
diltiazem hcl er		duloxetine hcl	126, 140	ELLA.....	200, 222
.....	90, 91, 92, 98, 107	DUOPA.....	126	eltrombopag olamine	73
diltiazem hcl er beads		DUPIXENT.....	270, 290, 297	eluryng	201, 209, 222
.....	90, 91, 92, 97, 107	DUREX EXTRA SENSITIVE		EMBECTA AUTOSHIELD	
diltiazem hcl er coated		THIN	262	DUO	152
beads	90, 91, 92, 98, 107	DUREX TROPICAL	262	EMBECTA INS SYR U/F 1/2	
dilt-xr	91, 92, 98, 107	dutasteride	240	UNIT.....	152
dimethyl fumarate	235, 253	DYCLOPRO	281	EMBECTA INSULIN SYR	
dimethyl fumarate starter		E.E.S. GRANULES.....	27	ULTRAFINE.....	152
pack	235, 253	EASIVENT	152	EMBECTA INSULIN SYRINGE	
diphenhydramine hcl		EASY COMFORT SHARPS		.....	152
.....	17, 18, 63, 111, 119, 265, 270	CONTAINER.....	152	EMBECTA INSULIN SYRINGE	
diphenoxylate-atropine ..	61, 182	EASY TOUCH HEALTHPRO		U-100	152
DIPROLENE.....	192, 287	HIGH/LOW	152	EMBECTA INSULIN SYRINGE	
dipyridamole	81, 104, 107, 158	EASYGEL.....	144, 145, 245	U-500	152
disopyramide phosphate	95			EMBECTA PEN NEEDLE	
disulfiram	15, 240			NANO.....	152
DIURIL.....	84, 106, 165			EMBECTA PEN NEEDLE	
				NANO 2 GEN.....	152

EMBECTA PEN NEEDLE		
ULTRAFINE	152	
EMBRACE PEN NEEDLES	152	
EMEND	188	
EMGALITY	123, 124	
EMPAVELI	247	
emtricitabine	33	
emtricitabine-tenofovir df	33, 37	
emtricitab-rilpivir-tenofovir df	32, 33, 37	
EMTRIVA	33	
EMVERM	22	
emzahn	201, 222	
enalapril maleate	86, 87	
enalapril-hydrochlorothiazide	87, 165	
ENBRACE HR	79, 259, 300, 302	
ENBREL	239, 249, 253	
ENBREL MINI	239, 249, 253	
ENBREL SURECLICK	239, 249, 253	
ENCARE	262	
ENDARI	259, 297	
endocet	110, 130, 132	
ENDOMETRIN	222	
ENFLONIA	35	
ENERGIX-B	56	
enilloring	201, 209, 222	
ENLITE GLUCOSE SENSOR	152	
enoxaparin sodium	78	
enpresse-28	201, 209, 222	
enskyce	201, 209, 222	
ENSTILAR	284, 287, 297	
entacapone	124	
entecavir	37	
ENTRESTO	85, 105	
ENTYVIO PEN	181, 187, 234	
enulose	160	
EPANED	86, 87	
EPCLUSA	28, 29	
EPIDIOLEX	112	
EPIFOAM	281, 287	
epinastine hcl	19, 168	
epinephrine	60, 264	
EPINEPHRINE	60, 264	
epinephrine hcl (nasal)	60, 180, 264	
eplerenone	83, 101, 102, 105, 106, 162	
ergocalciferol	305	
ergotamine-caffeine	66, 117, 137	
ERIVEDGE	44	
ERLEADA	44	
erlotinib hcl	44	
errin	201, 222	
ery	27, 169, 279	
ERYPED 400	27	
erythromycin	28, 169, 279	
erythromycin base	28	
erythromycin ethylsuccinate	28	
escitalopram oxalate	141	
eslicarbazepine acetate	112, 128	
esomeprazole magnesium	189	
est estrogens-methyltest	195, 210	
est estrogens-methyltest ds	195, 209	
est estrogens-methyltest hs	195, 210	
estarylla	201, 210, 222	
estazolam	123	
estradiol	210, 243, 244	
estradiol valerate	210, 244	
estradiol-norethindrone acet	210, 222	
ESTRATEST H.S.	195, 210	
ESTRING	210, 244	
ESTROGEL	210, 244	
estrogens conjugated	210, 244	
eszopiclone	119, 129	
ethacrynic acid	83, 101, 161	
ethambutol hcl	25	
ethosuximide	142	
ethynodiol diac-eth estradiol	201, 210, 222	
etodolac	130, 131, 138	
etodolac er	130, 138	
etonogestrel-ethinyl		
estradiol	201, 210, 222	
etoposide	44	
etravirine	32	
EUCRISA	281, 294	
EVAMIST	210, 244	
everolimus	44, 45, 235, 236	
EVEXITHROID	231	
EVOTAZ	34, 259	
EVRYSDI	259	
EXELDERM	283	
exemestane	45, 196	
EXENATIDE	217	
EXODERM	17, 281, 292	
EYSUVIS	174	
EZALLOR SPRINKLE	101	
ezetimibe	95	
FABHALTA	233, 247	
falmina	201, 210, 222	
famciclovir	37	
famotidine	18, 188	
FASENRA PEN	270	
FC2 FEMALE CONDOM	262	
febuxostat	242	
FEIBA	76	
feirza 1.5/30	201, 210, 222	
feirza 1/20	201, 210, 222	
felbamate	112	
FELBATOL	112	
felodipine er	98, 99	
FEM PH	294, 297	
FEMCAP	262	
FEMLYV	201, 211, 222	
FEMRING	211, 244	
fenofibrate	100	
fenofibrate micronized	100	
fenofibric acid	100	
fentanyl	132	
fidaxomicin	38	
FILSPARI	105, 251, 259, 269	
FILSUVEZ	297	
FINACEA	279, 297	
finasteride	240, 285	
finaglimod hcl	238, 253	
finzala	201, 211, 222	
FIORICET	110, 121, 130, 137	
FIRDAPSE	67, 259	
FIRMAGON	45, 196	
FIRMAGON (240 MG DOSE)	45, 196	
FIRST-LANSOPRAZOLE	189	
FIRVANQ	28	
FLAREX	174	
flavoxate hcl	299	
flecainide acetate	96	
FLEQSUVY	65	
FLEXICHAMBER	153	
FLEXICHAMBER ADULT		
MASK/SMALL	152	
FLEXICHAMBER CHILD		
MASK/LARGE	153	
FLEXICHAMBER CHILD		
MASK/SMALL	153	
FLOLIPID	101	
FLORIVA	144, 146, 245, 305	
FLOTREX	144, 146, 245, 300	
FLUAD	56	
FLUARIX	56	
FLUCELVAX	56	
fluconazole	26	
flucytosine	39	
fludrocortisone acetate	192	

FLULAVAL.....	56	FORA TEST N'GO ADV-VOICE-6 CON.....	158	GALZIN.....	162
FLUMIST.....	56	FORANE.....	128	ganirelix acetate	196
flunisolide	174, 192, 266, 271	formaldehyde	159	GARDASIL 9.....	57
fluocinolone acetonide	174, 175, 287	FOSAMAX.....	244	gatifloxacin	169
fluocinolone acetonide body	174, 287	FOSAMAX PLUS D.....	244, 305	GATTEX.....	185, 187
fluocinolone acetonide scalp	175, 287	fosamprenavir calcium	34	gavilax	184
fluocinonide	287	fosfomycin tromethamine	41	gavilyte-c	184
fluocinonide emulsified base	287	fosinopril sodium	86, 87	gavilyte-g	184
FLUORIDEX.....	146, 245	fosinopril sodium-hctz	87, 165	gavilyte-n with flavor pack	184
FLUORIDEX DAILY.....	144, 146, 245	FOSRENOL.....	161, 240	GAVRETO.....	45
FLUORIDEX ENHANCED.....	146, 245	FRAICHE 5000 DENTAL.....	145, 146, 245	gefitinib	45
WHITENING.....	146, 245	FREESTYLE LIBRE 14 DAY.....	153	GELFILM.....	76
FLUORIMAX 5000.....	146, 245	READER.....	153	gemfibrozil	101
FLUORIMAX 5000 SENSITIVE.....	146, 245	FREESTYLE LIBRE 14 DAY.....	153	gemmily	201, 211, 222
fluorometholone	175	SENSOR.....	153	generlac	160
fluorouracil	45, 277, 297	FREESTYLE LIBRE 2 PLUS.....	153	gengraf	171, 233, 249, 253, 257
fluoxetine hcl	141	SENSOR.....	153	gentamicin sulfate	21, 169, 279
fluphenazine hcl	136	FREESTYLE LIBRE 2.....	153	gentle laxative	184
flurandrenolide	287	READER.....	153	GENVOYA.....	31, 33
flurazepam hcl	123	FREESTYLE LIBRE 2.....	153	GILOTRIF.....	45
flurbiprofen	131, 138, 178	SENSOR.....	153	glatiramer acetate	232, 253, 254
flurbiprofen sodium	139, 178	FREESTYLE LIBRE 3 PLUS.....	153	glatopa	232, 254
fluticasone propionate	175, 192, 267, 271, 287	SENSOR.....	153	GLEOSTINE.....	45
fluticasone-salmeterol	69, 175, 192, 267	FREESTYLE LIBRE 3.....	153	glimepiride	231
FLUTICASONE-SALMETEROL.. ..	69, 175, 192, 267	READER.....	153	glipizide	231
fluvastatin sodium	101	FREESTYLE LIBRE 3.....	153	glipizide er	231
fluvoxamine maleate	142	READER.....	153	glipizide-metformin hcl	198, 231
fluvoxamine maleate er	142	FREESTYLE LIBRE 3.....	153	GLOPERBA.....	242
FLUZONE.....	57	SENSOR.....	153	glucagon emergency kit	15, 216, 240
FLUZONE HIGH-DOSE.....	56	FREESTYLE LIBRE READER.....	153	GLUCOTROL XL.....	231
FML FORTE.....	175	frovatriptan succinate	141	glutaraldehyde	159
FML LIQUIFILM.....	175	FRUZAQLA.....	45	glyburide	231
folic acid	302	ft aspirin	81, 82, 118, 140	glyburide micronized	231
FOLLISTIM AQ.....	216	ft aspirin low dose	81, 82, 117, 140	glyburide-metformin	198, 231
fondaparinux sodium	71, 79	ft clearlax	184	glycerol phenylbutyrate	160
FONDCIRCLE CONTROL.....	153	ft folic acid	302	glycolax	184
SOLUTION.....	153	ft laxative	184	glycopyrrolate	61, 282
FONDCIRCLE LANCING.....	153	ft magnesium citrate	184	glydo	281
DEVICE.....	153	ft naloxone hcl	15, 134	GLYXAMBI.....	206, 229
FONDCIRCLE SINGLE USE.....	153	ft nicotine	59, 63, 64	GOLYTELY.....	184
LANCETS.....	153	ft nicotine mini	59, 63	GOMEKLI.....	45
FORA TEST N' GO ADVANCE.....	153	furosemide	83, 101, 161	GONAL-F.....	216
		fyavolv	211, 222	GONAL-F RFF REDIRECT	216
		FYCOMPA.....	112	goodsense aspirin low dose	81, 82, 118, 140
		FYREMADEL.....	196	goodsense nicotine	59, 64
		gabapentin	110, 111, 113, 127	goodsense nicotine policrilex	59, 64
		GALAFOLD.....	166, 259	GORDOFILM.....	284, 292
		galantamine hydrobromide	67	granisetron hcl	181
		galantamine hydrobromide er	67	GRASTEK.....	53
		galbriela	201, 211, 222	griseofulvin microsize	22
		gallifrey	222		

griseofulvin ultramicrosize	22	HETLIOZ.....	119, 128	hydromorphone hcl	132
guaifenesin-codeine	265, 269	HETLIOZ LQ.....	119, 128	hydromorphone hcl er	132
guanfacine hcl	94, 100, 124	HIBERIX.....	57	hydroxychloroquine sulfate	
guanfacine hcl er	124	HIPREX.....	41	.....	23, 234, 249, 254
GUARDIAN 4 GLUCOSE		HUMALOG.....	228	hydroxyurea	46
SENSOR.....	153	HUMALOG KWIKPEN.....	228	hydroxyzine hcl	18, 19, 119
GUARDIAN 4 TRANSMITTER	153	HUMALOG MIX 50/50		hydroxyzine pamoate	18, 19, 119
GUARDIAN LINK 3		KWIKPEN.....	228	HYFTOR.....	238, 257, 290, 297
TRANSMITTER.....	153	HUMALOG MIX 75/25		HYMPAVZI.....	76
GUARDIAN REAL-TIME		KWIKPEN.....	228	hyoscyamine sulfate	
CHARGER.....	154	HUMALOG MIX 75/25 VIAL....	228	.....	15, 16, 62, 264
GUARDIAN REAL-TIME TEST		HUMALOG U-100 JUNIOR		hyoscyamine sulfate er	
PLUG.....	154	KWIKPEN.....	228	.....	15, 62, 264
GUARDIAN SENSOR 3.....	154	HUMATE-P.....	76	hyoscyamine sulfate sl	
GVOKE HYPOPEN 1-PACK		HUMATIN.....	20, 21	.....	16, 62, 264
.....	15, 216, 241	HUMULIN 70/30 KWIKPEN		hyosyne	16, 62, 264
GVOKE HYPOPEN 2-PACK		.....	218, 229	HYPERSAL.....	270
.....	15, 216, 241	HUMULIN 70/30 VIAL....	218, 229	ibandronate sodium	244
GVOKE KIT.....	15, 216, 241	HUMULIN N KWIKPEN.....	218	ibuprofen	118, 131, 139
GVOKE PFS.....	15, 216, 241	HUMULIN N VIAL.....	218	icatibant acetate	82, 244, 247
GYNAZOLE-1.....	283	HUMULIN R U-500 KWIKPEN	229	iclevia	201, 211, 223
habitrol	59, 64	HUMULIN R VIAL.....	229	ICLUSIG.....	46
HAEGARDA.....	247	HYCANTIN.....	45, 46	IDELVION.....	76
hailey 1.5/30	201, 211, 222	hydralazine hcl	100	IDHIFA.....	46
hailey 24 fe	201, 211, 223	HYDRO 40.....	83, 161, 179, 292	IHEALTH CONTROL	
hailey fe 1.5/30	201, 211, 223	hydrochlorothiazide	84, 106, 165	SOLUTION.....	154
hailey fe 1/20	201, 211, 223	hydrocod poli-chlorphe poli		IHEALTH LANCING DEVICE.	154
HALCION.....	123	er	18, 19, 265	imatinib mesylate	46
halobetasol propionate	287	hydrocodone bitartrate er	132	IMBRUVICA.....	46
haloette	201, 211, 223	hydrocodone bit-homatrop		imipramine hcl	143
haloperidol	123	mbr	62, 265, 266	imipramine pamoate	143
haloperidol lactate	123	hydrocodone-		imiquimod	277, 298
HALUCORT.....	297	acetaminophen	111, 130, 132	IMKELDI.....	46
HARVONI.....	28, 29, 30	hydrocodone-ibuprofen		IMPAVIDO.....	24, 36
HAVRIX.....	57	.....	131, 132, 139	IMVEXXY MAINTENANCE	
heather	201, 223	hydrocortisone	175, 192, 288	PACK.....	211
hematinic/folic acid	79, 303	hydrocortisone (perianal)		IMVEXXY STARTER PACK...	211
HEMLIBRA.....	76	.....	175, 192, 288	INBRIJA.....	126
HEMMOREX-HC....	175, 192, 288	hydrocortisone ace-		incassia	201, 223
HEMOFIL M.....	76	pramoxine	175, 192, 281, 288	INCRELEX.....	230
heparin na (pork) lock flsh pf.	78	hydrocortisone acetate		indapamide	84, 106, 166
heparin sod (pork) lock flush.	78	.....	175, 192, 288	INDOCIN.....	131, 139, 242
heparin sodium (porcine)	78	hydrocortisone butyrate		indomethacin	131, 139, 242
heparin sodium (porcine)		.....	175, 192, 288	indomethacin er	131, 139, 242
+rfid	78	hydrocortisone valerate		INFANRIX.....	55, 57
heparin sodium (porcine) pf.	78	.....	175, 193, 288	INGREZZA.....	144
HEPLISAV-B.....	57	hydrocortisone-acetic acid		INLYTA.....	46
HEPZATO W/50MM		.....	175, 178, 193, 288	INPEN 100-BLUE-LILLY-	
CATHETER.....	45	hydrocortisone-iodoquinol		HUMALOG.....	154
HEPZATO W/62MM		.....	21, 283, 288, 294	INPEN 100-BLUE-NOVOLOG-	
CATHETER.....	45	hydrocort-pramoxine		FIASP.....	154
her style	196, 201, 223	(perianal)	176, 193, 281, 288	INPEN 100-GREY-LILLY-	
HERNEXEOS.....	45	hydromet	62, 266	HUMALOG.....	154

INPEN 100-GREY-NOVOLOG-FIASP	154	jaimiess	201, 211, 223	KLOXXADO	16, 134
INPEN 100-PINK-LILLY-HUMALOG	154	JAKAFI	46, 291	KOATE	76
INPEN 100-PINK-NOVOLOG-FIASP	154	jantoven	72	KOATE-DVI	76
INQOVI	46	JARDIANCE	229	KOGENATE FS	76
INSPIREASE RESERVOIR BAGS	154	JAYPIRCA	46, 47	KOSELUGO	47
INSULIN LISPRO	229	jencycla	201, 223	KOURZEQ	288
INSULIN LISPRO (1 UNIT DIAL)	229	JENTADUETO	198, 206	KOVALTRY	76
INSULIN LISPRO JUNIOR KWIKPEN	229	JENTADUETO XR	198, 206	K-PHOS	163
INSULIN LISPRO PROT & LISPRO	229	jinteli	211, 223	K-PHOS NO 2	159
INSULIN PEN NEEDLES	154, 156	JIVI	76	K-PHOS-NEUTRAL	163
INSULIN SYRINGES	154, 155	JOENJA	254	KRAZATI	47
INSUPEN32G EXTR3ME	155	jolessa	201, 211, 223	KRINTAFEL	23
INTELENCE	32	JORNAY PM	137	KRISTALOSE	160
introvale	201, 211, 223	JOURNAVX	111	KT TAPE CGM PATCH	155
INVELTYS	176	joyeaux	202, 211, 223	kurvelo	202, 212, 223
iodine strong	16, 22, 198, 269, 283	juleber	202, 211, 223	KYZATREX	195, 197
iodine tincture	283, 294	JULUCA	31, 32	labetalol hcl	65, 67, 84, 89, 94, 96, 102
IOPIDINE	168, 178	junel 1.5/30	202, 211, 223	lacosamide	113, 128
IPOL	57	junel 1/20	202, 211, 223	lactulose	160
ipratropium bromide	62, 264	junel fe 1.5/30	202, 211, 223	lactulose encephalopathy	160
ipratropium-albuterol	62, 69, 264	junel fe 1/20	202, 211, 223	LAGEVRIO	37
IQIRVO	185, 187	junel fe 24	202, 211, 223	lamivudine	33
irbesartan	85	JUST RIGHT 5000	146, 245	lamivudine-zidovudine	33
irbesartan-hydrochlorothiazide	85, 165	JYLAMVO	47, 234, 249, 254, 257	lamotrigine	113, 115
IRESSA	46	kaitlib fe	202, 211, 223	lamotrigine starter kit-blue	113, 115
ISENTRESS	31	KALETRA	34	lamotrigine starter kit-green	113, 115
ISENTRESS HD	31	kalliga	202, 212, 223	lamotrigine starter kit-orange	113, 116
isibloom	201, 211, 223	KALYDECO	268	LAMPIT	24
isoflurane	128	KAPSPARGO SPRINKLE	70, 89, 94, 96, 102	LANCETS	155
isoniazid	25	kariva	202, 212, 223	LANCETS 28G THIN	155
isosorb dinitrate-hydralazine	100, 102, 103	kelnor 1/35	202, 212, 223	LANCETS SUPER THIN	155
isosorbide dinitrate	102, 103	KESIMPTA	254	LANOXIN	88, 93
isosorbide mononitrate	102, 103	ketoconazole	26, 283	lansoprazole	189
isosorbide mononitrate er	102, 103	ketodan	26, 283	lanthanum carbonate	161, 241
isotretinoin	292, 298	KETO-DIASTIX	159	LANTUS SOLOSTAR	218
isradipine	98, 99	KETONE CARE	159	LANTUS U-100 VIAL	218
ISTALOL	65, 88, 96, 172	ketorolac tromethamine	131, 139, 178	lapatinib ditosylate	47
ITOVEBI	46	KETOSTIX	158	larin 1.5/30	202, 212, 223
itraconazole	26	KINERET	237, 249, 254	larin 1/20	202, 212, 223
ivabradine hcl	93, 107	KISQALI (200 MG DOSE)	47	larin 24 fe	202, 212, 223
ivermectin	22	KISQALI (400 MG DOSE)	47	larin fe 1.5/30	202, 212, 223
IWILFIN	46	KISQALI (600 MG DOSE)	47	larin fe 1/20	202, 212, 223
		KLARON	279	LASIX	83, 101, 161
		klayesta	39, 295	latanoprost	180
		KLISYRI (250 MG)	277, 298	LAZCLUZE	47
		KLISYRI (350 MG)	277, 298	LEDIPASVIR-SOFOSBUVIR	29, 30
		klor-con	163	leflunomide	238, 249, 254, 257
		klor-con 10	162	lenalidomide	47, 254
		klor-con m10	162		
		klor-con m15	163		
		klor-con m20	163		

LENVIMA.....	47	LITFULO.....	291, 298	LYTGOBI (16 MG DAILY DOSE).....	48
lessina	202, 212, 223	lithium	116	LYTGOBI (20 MG DAILY DOSE).....	48
letrozole	47, 196	lithium carbonate	116	LYUMJEV KWIKPEN.....	229
leucovorin calcium .	17, 241, 303	lithium carbonate er	116	LYUMJEV VIAL.....	229
LEUKERAN.....	47	LITHOBID.....	116	lyza	203, 224
LEUKINE.....	74	LITHOSTAT.....	160	MACROBID.....	41
leuprolide acetate	47, 216	LIVDELZI.....	185	MACRODANTIN.....	41
levalbuterol hcl	69, 274	LIVMARLI.....	185	magnesium citrate	184
LEVALBUTEROL HFA.....	69, 274	LIVTENCITY.....	26	MALARONE.....	23
LEVVID.....	16, 62, 264	LO LOESTRIN FE...202, 212, 224		malathion	295
levetiracetam	113	LODOCO.....	71, 259	maraviroc	30
levetiracetam er	113	lofexidine hcl	61	marlissa	203, 212, 224
levobunolol hcl	172	lojaimiess	202, 212, 224	MATULANE.....	48
levocarnitine	259	LOKELMA.....	161	matzim la	91, 92, 98, 107
levocarnitine sf	259	LOMOTIL.....	62, 182	MAVENCLAD....48, 233, 254, 257	
levocetirizine dihydrochloride	19	lomustine	48	MAVYRET.....	29, 30
levofloxacin	25, 40, 169, 279	LOPID.....	101	MAXIDEX.....	176
levonest	202, 212, 224	lopinavir-ritonavir	34	MAXITROL.....	169, 176
levonorgest-eth est & eth est	202, 212, 224	LOPRESSOR..70, 89, 94, 96, 102		maxi-tuss ac	266, 269
levonorgest-eth estrad 91-day	202, 212, 224	lorazepam	122, 123	MAYZENT.....	238, 254
levonorgest-eth estradiol-iron	202, 212, 224	lorazepam intensol	122, 123	MAYZENT STARTER PACK.....	239, 254
levonorgestrel	197, 202, 224	LORBRENA.....	48	me/naphos/mb/hyo1 .	41, 62, 259
levonorgestrel-ethinyl estrad	202, 212, 224	losartan potassium	85, 86	meclofenamate sodium	131, 139
levonorg-eth estrad triphasic	202, 212, 224	losartan potassium-hctz	86, 165	MEDROL.....	193
levo-t	231	LOTEMAX.....	176	medroxyprogesterone acetate	203, 224
levothyroxine sodium	231	LOTEMAX SM.....	176	mefenamic acid	131, 139
levoxyl	231	LOTENSIN.....	86, 87	mefloquine hcl	23
LEVSIN.....	16, 62, 264	LOTENSIN HCT.....	87, 165	megestrol acetate	48, 224
LEVSIN/SL.....	16, 62, 264	loteprednol etabonate	176	MEKINIST.....	48
l-glutamine	259, 298	lovastatin	101	meleya	203, 224
lidocaine	281	low-ogestrel	203, 212, 224	MELOXICAM.....	131, 139
lidocaine hcl	179, 281	loxapine succinate	118, 125	meloxicam	131, 139
lidocaine hcl urethral/mucosal	281	lubiprostone	180, 187	memantine hcl	124, 125
lidocaine viscous hcl	179	LUCEMYRA.....	61	memantine hcl er	124
lidocaine-prilocaine	282	LUGOLS STRONG IODINE.....	283, 294	MENOPUR.....	217
LIKMEZ.....	21, 24, 36, 183, 279	luizza 1.5/30	203, 212, 224	MENOSTAR.....	212, 244
linezolid	38	luizza 1/20	203, 212, 224	MENQUADFI.....	57
LINZESS.....	180, 187	LUMAKRAS.....	48	MENVEO.....	57
liomny	232	LUMIGAN.....	180	meperidine hcl	132
liothyronine sodium	232	LUMRYZ.....	124, 144, 242	meprobamate	119, 129
liraglutide	111, 217	LUMRYZ STARTER PACK.....	144, 242	mercaptopurine	48, 236, 257
lisdexamfetamine dimesylate	110	lurasidone hcl	120	mesalamine	183
lisinopril	86, 87	LURBIRO.....	131, 139, 179	mesalamine-cleanser	183
lisinopril-hydrochlorothiazide	87, 165	lutura	203, 212, 224	mesna	262
		lyleq	203, 224	MESNEX.....	262
		lyllana	212, 244	MESTINON.....	67
		LYNPARZA.....	48	metformin hcl	198
		LYRICA.....	113, 126, 127	metformin hcl er	198
		LYSODREN.....	48	methadone hcl	132, 133
		LYTGOBI (12 MG DAILY DOSE).....	48		

methadone hcl intensol	132	MICROLET NEXT LANCING		MULPLETA	74
METHADOSE	133	DEVICE	155	multivitamin w/fluoride	
methadose	133	midazolam hcl	123	.....	145, 146, 245, 300
METHADOSE SUGAR-FREE	133	midodrine hcl	61	multivitamin/fluoride	
methamphetamine hcl	110	MIEBO	171, 178	.....	145, 146, 245, 300, 303
methazolamide	83, 93, 173	MIFEPREX	263	multi-vitamin/fluoride	
methenamine hippurate	41	mifepristone	196, 263	.....	145, 146, 245, 300
methenamine mandelate	41	MIGERGOT	66, 118, 138	multi-vitamin/fluoride/iron	
METHERGINE	263	miglitol	195	.....	79, 245, 300
methimazole	198	miglustat	166, 259	mupirocin	279
METHITEST	195	mili	203, 213, 225	mupirocin calcium	279
methocarbamol	32, 64	milophene	207	my choice	197, 203, 225
methotrexate sodium		mimvey	213, 225	my way	197, 203, 225
.....	49, 234, 249, 250, 254, 257	mineral oil heavy	184	MYALEPT	218
methotrexate sodium (pf)		minocycline hcl	23, 41, 169, 279	mycophenolate mofetil	233, 257
.....	48, 234, 249, 254, 257	minocycline hcl er		mycophenolate sodium	257
methoxsalen rapid	295	.....	23, 41, 169, 279, 298	mycophenolic acid	258
methscopolamine bromide	62	minoxidil	100, 285	MYFEMBREE	197, 213, 225
methsuximide	142	minzoya	203, 213, 225	MYHIBBIN	258
methyl salicylate	284	MIPLYFFA	166	MYLERAN	49
methyldopa	61, 94, 100	mirabegron er	300	MYXREDLIN	163, 229
methylergonovine maleate ...	263	mirtazapine	114, 142	na sulfate-k sulfate-mg sulf	184
methylphenidate hcl	138	MIRVASO	168, 277, 298	nabumetone	131, 139
methylphenidate hcl er	138	misoprostol	189	nadolol	65, 70, 84, 89, 94, 96, 102
methylphenidate hcl er (cd) ...	137	MITIGARE	242	naloxone hcl	16, 135, 241
methylphenidate hcl er (la)		MITOSOL	169	naltrexone hcl	
.....	137, 138	mm aspirin	81, 82, 118, 140	.....	15, 16, 59, 135, 240, 241
methylphenidate hcl er		mm clearlax	184	naproxen	118, 131, 139, 242
(osm)	138	M-M-R II	57	naproxen dr ...	118, 131, 139, 242
methylprednisolone	193	M-NATAL PLUS	79, 300, 303	naproxen sodium	
methyldtestosterone	195	MNEXSPIKE	57	.....	118, 131, 139, 242
metoclopramide hcl	189	MOBILE LANCETS 30G	155	naratriptan hcl	141
metolazone	84, 106, 166	modafinil	144	NARCAN	16, 135
METOPIRONE	159	moexipril hcl	86, 87	NARDIL	129
metoprolol succinate er		molindone hcl	118, 125	NASCOBAL	81, 303
.....	70, 89, 94, 96, 102	mometasone furoate		NATACYN	171
metoprolol tartrate		.....	176, 193, 267, 271, 288	NATAL PNV	79, 300, 303
.....	70, 89, 94, 96, 102	mono-lynyah	203, 213, 225	NATAZIA	203, 213, 225
metoprolol-		MONSELS FERRIC		nateglinide	218
hydrochlorothiazide	89, 94, 165	SUBSULFATE	77	NAYZILAM	122, 123
METROCREAM	21, 36, 279	montelukast sodium	270	nebivolol hcl	65, 89, 94, 96
metronidazole		morphine sulfate	133	NEBUSAL	271
.....	21, 24, 36, 183, 279	morphine sulfate		necon 0.5/35 (28) ...	203, 213, 225
metryrosine	158, 259	(concentrate)	133	nefazodone hcl	142
mexiletine hcl	95	morphine sulfate er	133	NEFFY	60
MIACALCIN	198, 244	morphine sulfate er beads ...	133	NEMLUVIO	290
mibelas 24 fe	203, 212, 224	MOTPOLY XR	113, 128	neomycin sulfate	21, 169, 280
miconazole 3	283	MOUNJARO	217	neomycin-bacitracin zn-	
microgestin 1.5/30	203, 213, 224	MOVIPREP	184, 304	polymyx	170
microgestin 1/20	203, 213, 225	moxifloxacin hcl	25, 40, 169, 279	neomycin-polymyxin-	
microgestin fe 1.5/30		moxifloxacin hcl (2x day)	40, 169	dexameth	170, 176
.....	203, 213, 225	MOZOBIL	74	neomycin-polymyxin-	
microgestin fe 1/20	203, 213, 225	MUCOSITISRX	178	gramicidin	170

neomycin-polymyxin-hc	NITROSTAT	103, 104	NUEDEXTA.....	125
..... 170, 176	NITRO-TIME.....	103, 104	NULEV	16, 62, 265
NEONATAL COMPLETE	NIVA THYROID	232	NUPLAZID	120
..... 79, 300, 303	NIVESTYM	74	NURTEC.....	124
NEONATAL PLUS....	nora-be	203, 225	NUWIQ.....	77
NEO-POLYCIN	NORDIPEN 5 INJECTION		NUZYRA.....	21
NEO-POLYCIN HC	DEVICE.....	155	nyamyc	39, 295
..... 27, 170, 176, 280	NORDITROPIN FLEXP		nylia 1/35	204, 214, 226
NEOTUSS PLUS..	 219, 230		nylia 7/7/7	204, 214, 226
NERLYNX.....	norelgestromin-eth estradiol		NYMALIZE.....	99, 107
NESTABS.....	 203, 213, 225		nystatin	39, 295
NESTABS ONE	norethin ace-eth estrad-fe		nystatin-triamcinolone	
79, 259, 301, 303	 203, 204, 213, 225		 39, 288, 295	
neuac	norethindrone	204, 225	nystop	39, 295
NEULASTA.....	norethindrone acetate	225	OBIZUR.....	77
NEVANAC.....	norethindrone acet-ethinyl		OICALIVA.....	185, 187
nevirapine	est	204, 213, 225	octreotide acetate	187, 230
nevirapine er	norethindrone-eth estradiol		OCUFLOX.....	40, 170
new day	 213, 225		ODACTRA.....	53
NEXIUM.....	norethin-eth estradiol-fe		ODEFSEY.....	32, 33, 37
NEXLETOL.....	 204, 213, 225		ODOMZO.....	49
NEXLIZET.....	norgestimate-eth estradiol		ofloxacin	40, 170
NEXTSTELLIS.....	 204, 213, 225		OGSIVEO.....	49
NGENLA.....	norgestimate-ethinyl		OJEMDA.....	49
niacin er	estradiol triphasic	204, 213, 226	OJJAARA.....	49
(antihyperlipidemic)	NORLIQVA.....	99, 107	olanzapine	116, 120, 182
nicardipine hcl	norlyroc	204, 226	olanzapine-fluoxetine hcl	
NICORETTE.....	NORPACE.....	95	 116, 120, 142, 182	
NICORETTE MINI.....	NORPACE CR.....	95	olmesartan medoxomil	85, 86
nicotine	NORPRAMIN.....	143	olmesartan medoxomil-hctz	
nicotine mini	nortrel 0.5/35 (28)	204, 213, 226	 86, 165	
nicotine polacrilex	nortrel 1/35 (21)	204, 213, 226	olopatadine hcl	19, 168
nicotine polacrilex mini	nortrel 1/35 (28)	204, 213, 226	OLUMIANT.....	238, 250
nicotine step 1	nortrel 7/7/7	204, 214, 226	omega-3-acid ethyl esters	
nicotine step 2	nortriptyline hcl	143	 88, 104	
nicotine step 3	NORVIR.....	34	omeprazole	189
NICOTROL NS.....	NOVAREL.....	217	OMNIFLEX DIAPHRAGM.....	262
nifedipine	NOVOEIGHT.....	77	OMNIPOD 5 DEXG7G6	
nifedipine er	NOVOFINE PEN NEEDLE.....	155	INTRO GEN 5.....	155
nifedipine er osmotic release	NOVOFINE PLUS PEN		OMNIPOD 5 DEXG7G6 PODS	
..... 99, 107	NEEDLE.....	155	GEN 5.....	155
nilotinib hcl	NOVOLIN R FLEXPEN.....	229	OMNIPOD 5 LIBRE2 G6	
nimodipine	NOVOLIN R FLEXPEN		INTRO GEN5.....	155
NIMODIPINE.....	RELION.....	229	OMNIPOD 5 LIBRE2 PLUS G6	
NINLARO.....	NOVOPEN ECHO.....	155	PODS.....	155
nisoldipine er	NOVOSEVEN RT.....	77	OMNITROPE.....	219, 220, 230
nitazoxanide	NOXAFIL.....	26	OMVOH.....	181, 187
NITRO-BID.....	np thyroid	232	OMVOH (300 MG DOSE).....	181
NITRO-DUR.....	NUBEQA.....	49	ondansetron hcl	181
nitrofurantoin	NUCALA.....	265	ondansetron odt	182
nitrofurantoin macrocrystal	NUCORT.....	176, 193, 288	ONE VITE WOMENS PLUS	
nitrofurantoin monohydrate	NUCYNTA.....	134	 79, 301, 303	
macrocrystals	NUCYNTA ER.....	133	ONENATAL RX.....	79, 163, 301, 303
nitroglycerin				

ONETOUCH DELICA PLUS			
LANCING	155		
ONETOUCH DELICA SAFETY			
LANCING	156		
ONETOUCH ULTRA	156		
ONETOUCH VERIO	156		
ONFI	122, 123		
ONUREG	49		
ONYDA XR	61		
opcon one-step ..	197, 204, 226		
OPFOLDA	166, 259		
OPILL	204, 226		
opium	134, 182		
OPSUMIT	108, 269, 275		
option 2	197, 204, 226		
OPTIONS GYNOL II			
CONTRACEPTIVE	262		
OPVEE	135		
ORACIT	159		
ORAL CITRATE	159		
ORALAIR	54		
ORALAIR ADULT STARTER			
PACK	54		
ORALAIR CHILDRENS			
STARTER PACK	54		
ORALONE	288		
ORAPRED ODT	176, 193		
ORAVIG	283		
ORENCIA	234, 250, 255		
ORENCIA CLICKJECT			
.....	234, 250, 254		
ORENITRAM	108, 272, 275		
ORENITRAM MONTH 1			
.....	108, 272, 275		
ORENITRAM MONTH 2			
.....	108, 272, 275		
ORENITRAM MONTH 3			
.....	108, 272, 275		
ORFADIN	167, 259, 260		
ORGOVYX	49, 197		
ORIAHNN	197, 214, 226		
ORILISSA	197		
ORKAMBI	267, 268		
ORLYNVAH	42, 166, 242		
orphenadrine citrate er			
.....	65, 70, 112		
orquidea	204, 226		
ORSERDU	49		
OSCIMIN	16, 62, 265		
oseltamivir phosphate	35		
OSPHENA	207		
OTEZLA	238, 250, 255, 298		
OVACE PLUS	280		
OVACE PLUS WASH	280		
OVACE WASH	280		
OVIDE	295		
OVIDREL	217		
oxaprozin	131, 139		
oxazepam	123		
oxcarbazepine	113, 128		
OXERVATE	171, 178		
oxybutynin chloride	299		
oxybutynin chloride er	299		
oxycodone hcl	134		
oxycodone-acetaminophen			
.....	111, 130, 134		
oxymorphone hcl	134		
oxymorphone hcl er	134		
OZEMPIC	217		
OZOBAX DS	65		
PACERONE	97		
PALFORZIA	54		
PALFORZIA (1 MG DAILY			
DOSE)	54		
PALFORZIA INITIAL DOSE 1-			
3YRS	54		
PALFORZIA INITIAL DOSE 4-			
17YRS	54		
PANRETIN	277, 298		
pantoprazole sodium	189		
PARI VORTEX ADULT MASK	156		
PARI VORTEX PEDIATRIC			
MASK	156		
paricalcitol	305		
PARNATE	129		
paroxetine hcl	142		
paroxetine hcl er	142		
PAXLOVID (150/100)	26, 27		
PAXLOVID (300/100 &			
150/100)	26, 27		
PAXLOVID (300/100)	26, 27		
pazopanib hcl	49		
PEDIARIX	55, 57		
PEDVAX HIB	57		
peg 3350	184		
peg 3350-kcl-na bicarb-nacl ..	184		
peg-3350/electrolytes	184		
peg-			
3350/electrolytes/ascorbat			
.....	184, 304		
PEGASYS	34, 49, 50, 236, 255		
peg-kcl-nacl-nasulf-na asc-c			
.....	184, 304		
PEG-PREP	184		
PEMAZYRE	50		
PEN NEEDLE/5-BEVEL TIP ...	156		
PENBRAYA	57		
penicillamine	16, 190, 250		
penicillin v potassium	35		
PENMENVY	57		
PENTACEL	55, 58		
pentamidine isethionate	24		
pentazocine-naloxone hcl			
.....	135, 136		
pentoxifylline er	74		
perampanel	113		
PERFECT POINT SAFETY			
LANCETS	156		
PERFECT POINT SAFETY			
NEEDLE	156		
PERIDEX ..	21, 171, 172, 283, 294		
perindopril erbumine	86, 87		
periogard ..	21, 171, 172, 283, 294		
permethrin	295		
perphenazine	136		
perphenazine-amitriptyline			
.....	136, 143		
PERTZYE	167, 186		
phenazopyridine hcl	282		
phenelzine sulfate	129		
phenobarbital	120, 121		
phenoxybenzamine hcl ..	66, 106		
phenylephrine hcl	179, 180		
phenytekt	95, 127		
phenytoin	95, 127		
phenytoin infatabs	95, 127		
phenytoin sodium extended			
.....	95, 128		
PHEXX	262		
philith	204, 214, 226		
PHOSPHA 250 NEUTRAL	163		
PHOSPHOLINE IODIDE	179		
phosphorous	163		
phospho-trin 250 neutral	163		
PHOXILLUM B22K4/0	163		
PHOXILLUM BK4/2.5	163		
phytonadione	16, 241, 305		
PIFELTRO	32		
pilocarpine hcl	67, 179		
pimecrolimus	258, 290, 298		
pimozide	118, 125		
pimtrea	204, 214, 226		
pindolol	65, 89, 94, 96, 103		
pioglitazone hcl	231		
pioglitazone hcl-glimepiride	231		
pioglitazone hcl-metformin			
hcl	198, 231		
PIP GLUCOSE CONTROL			
SOLUTION	156		

PIQRAY	50	prenatal plus vitamin/mineral	80, 301, 303	PROCTOFOAM HC	177, 194, 282, 289
pirfenidone	265, 273	PRENATE	164, 301, 304	procto-med hc	177, 194, 289
piroxicam	131, 139	PRENATE DHA	80, 163, 260, 301, 303	PROCTOSOL HC...	177, 194, 289
PLAN B ONE-STEP	197, 204, 226	PRENATE ELITE	80, 301, 303	PROCTOZONE-HC	177, 194, 289
PLEGRIDY	255	PRENATE ENHANCE	80, 164, 260, 301, 303	PROCYSBI	260
PLEGRIDY STARTER PACK	255	PRENATE ESSENTIAL	80, 164, 260, 301, 303	PROFILNINE	77
PLENVU	184, 304	PRENATE MINI	80, 164, 260, 301, 303	progesterone	226
plerixafor	74	PRENATE PIXIE	80, 164, 260, 301, 304	PROGLYCEM	198
PNEUMOVAX 23	58	PRENATE RESTORE	80, 164, 260, 301, 304	PROGRAF	233, 258, 291
pnv 27-cal/fel/fa	79, 301, 303	PREPIDIL	263	PROMACTA	74
PODOCON-25	292, 298	PRETOMANID	25	promethazine hcl	17, 18, 19, 119, 182, 186, 270
podofilox	292, 298	prevalite	90	promethazine-codeine	18, 19, 266
POKONZA	163	PREVIDENT	145, 146, 246	promethazine-dm	18, 19, 266
POLY HUB NEEDLE	156	PREVIDENT 5000 BOOSTER	146, 245	promethazine-phenylephrine	18, 19, 61
POLYCIN	27, 170, 280	PLUS	146, 245	PROMETHEGAN	18, 19, 119, 182, 186, 270
polyethylene glycol 3350	185	PREVIDENT 5000 DRY	145, 146, 246	PRONAL	284, 292
polymyxin b-trimethoprim	39, 170, 280	MOUTH	145, 146, 246	propafenone hcl	96
POLY-VI-FLOR/IRON	79, 245, 301	PREVIDENT 5000 ENAMEL	146, 246	propafenone hcl er	96
POMALYST	50, 255	PROTECT	146, 246	proparacaine hcl	179
portia-28	204, 214, 226	PREVIDENT 5000 KIDS	146, 246	propranolol hcl	65, 66, 89, 95, 97, 103, 118
posaconazole	26	PREVIDENT 5000 ORTHO	146, 246	propranolol hcl er	65, 89, 94, 96, 103, 118
potassium chloride	163	DEFENSE	146, 246	propylthiouracil	198
potassium chloride crys er ..	163	PREVIDENT 5000 PLUS	145, 146, 246	PROQUAD	58
potassium chloride er	163	PREVIDENT 5000 SENSITIVE	146, 246	protriptyline hcl	143
potassium citrate er	159	PREVNAR 20	58	PROVERA	226
potassium citrate-citric acid	159	PREVYMIS	26	prucalopride succinate	187
potassium iodide		PREZCOBIX	34, 260	PRURADIK	295
(expectorant)	269	PREZISTA	34	pseudoephedrine-	
pramipexole dihydrochloride	129	PRIFTIN	25, 40	bromphen-dm	18, 19, 60, 266
PRAMOSONE	282, 289	primaquine phosphate	23	PULMOSAL	271
PRAMOTIC	171, 179	primidone	120	PULMOZYME	167, 271
prasugrel hcl	81	PRIORIX	58	PURE COMFORT SAFETY	
pravastatin sodium	101	PRISMASOL B22GK 4/0	164	PEN NEEDLE	156
praziquantel	22	PRISMASOL BGK 0/2.5	164	PURIXAN	50, 236, 258
prazosin hcl	66, 84, 85, 89	PRISMASOL BGK 2/0	164	pyrazinamide	25
PRED MILD	176, 193	PRISMASOL BGK 2/3.5	164	PYRIDIDIUM	282
prednisolone	177, 193	PRISMASOL BGK 4/0/1.2	164	pyridostigmine bromide	67
prednisolone acetate	177, 193	PRISMASOL BGK 4/2.5	164	pyridostigmine bromide er	67
prednisolone sodium		PRISMASOL BK 0/0/1.2	164	PYRIDOSTIGMINE BROMIDE	
phosphate	177, 193	probenecid	166, 242	ER	67
prednisone	193	prochlorperazine	136, 182	pyrimethamine	23
prednisone intensol	193	prochlorperazine maleate	136, 182	PYROGALLIC ACID	263, 292, 298
pregabalin	113, 126, 127			PYRUKYND	72
PREGNYL	217			PYRUKYND TAPER PACK	72
PREMARIN	214, 244			QBRELIS	87
PREMESISRX	163, 260, 301, 303			QFITLIA	77
premium lidocaine	282				
PREMPHASE	214, 226				
PREMPRO	214, 226				
prenatal	79, 301, 303				

QUADRACEL.....	55, 58	REZLIDHIA.....	50	scopolamine	62, 182, 188
QUESTRAN.....	90	RHOPRESSA.....	180	SELECT-OB.....	80, 302, 304
QUESTRAN LIGHT.....	90	ribavirin	37	selegiline hcl	128, 129
quetiapine fumarate	116, 120	rifabutin	25, 40	selenium sulfide	283, 294
quetiapine fumarate er	116, 120	rifampin	25, 40	SELZENTRY.....	30
QUICK TOUCH INSULIN PEN		riluzole	109, 125	SEREVENT DISKUS.....	69, 274
NEEDLE.....	156	rimantadine hcl	20	sertraline hcl	142
quinapril hcl	86, 87	RINVOQ.....	238, 250, 251	setlakin	204, 214, 227
quinapril-		RINVOQ LQ.....	238	sevelamer carbonate	
hydrochlorothiazide	87, 165	risedronate sodium	244	.....	17, 161, 241
quinidine gluconate er	23, 95	risperidone	116, 120	sevoflurane	128
quinidine sulfate	23, 95	ritonavir	34	sf	145, 147, 246
quinine sulfate	23	rivaroxaban	72	sf 5000 plus	145, 147, 246
QULIPTA.....	124	rivastigmine	67	sharobel	204, 227
QVAR REDHALER.....	194, 267, 271	rivastigmine tartrate	67	SHARPS COLLECTOR.....	156
rabeprazole sodium	189	rivelsa	204, 214, 226	SHARPS CONTAINER.....	156
RADICAVA ORS.....	109, 125	RIVFLOZA.....	260	shewise	197, 205, 227
RADICAVA ORS STARTER		RIVIVE.....	16, 135	SHINGRIX.....	58
KIT.....	109, 125	RIXUBIS.....	77	sildenafil citrate	
RADIOGARDASE.....	17, 161, 241	rizatriptan benzoate	141	.....	104, 105, 272, 275, 300
RAGWITEK.....	54	ROCKLATAN.....	180	silodosin	67
raloxifene hcl	207, 244	roflumilast	271, 272, 291, 294	SILVADENE.....	283, 294
ramelteon	119, 128	ROMVIMZA.....	50	silver nitrate	171
ramipril	86, 87	ropinirole hcl	129	silver sulfadiazine	283, 294
ranolazine er	93	rosuvastatin calcium	101	simliya	205, 214, 227
RASUVO.....	234, 250	rosyrah	204, 214, 226	simpesse	205, 214, 227
RAYA SURE PEN NEEDLE...	156	ROTARIX.....	58	SIMPONI.....	187, 240, 251, 255, 256
RAYASAL.....	292	ROTATEQ.....	58	simvastatin	101
react	197, 204, 226	roweepra	113	SINEMET.....	126
reclipsen	204, 214, 226	ROZLYTREK.....	50	SINGULAIR.....	270
RECOMBINATE.....	77	RUCONEST.....	247	sirolimus	238, 258, 291
RECOMBIVAX HB.....	58	rufinamide	113, 128	SIRTURO.....	25
RECOTHROM.....	77	RUKOBIA.....	30	SKYCLARYS.....	260
RECOTHROM SPRAY KIT.....	77	RYBELSUS.....	217	SKYRIZI.....	188, 291, 298
REGLAN.....	189	RYDAPT.....	50	SKYRIZI PEN.....	291, 298
RELENZA DISKHALER.....	36	sacubitril-valsartan ...	85, 86, 105	SKYTROFA.....	220
RELISTOR.....	135, 181, 187	SAFETY PEN NEEDLES.....	156	SLYND.....	197, 205, 227
RELNATE DHA.....	80, 260, 301, 304	SALAGEN.....	67, 179	smooth lax	185
RENTHYROID.....	232	SALICATE.....	292	sod citrate-citric acid	159
repaglinide	218	salicylic acid	293	sod fluoride-potassium	
REPATHA.....	104	salsalate	140	nitrate	147, 246
REPATHA SURECLICK.....	104	SALVAX DUO PLUS.....	284, 293	sodium chloride	271
RESTASIS.....	171, 177, 233	SANTYL.....	167, 284, 298	sodium fluoride	145, 147, 246
RESTORIL.....	123	sapropterin dihydrochloride		sodium fluoride 5000 enamel	
RETACRIT.....	71, 74	.....	166, 260	.....	147, 246
RETEVMO.....	50	SAVELLA.....	126, 140	sodium fluoride 5000 plus	
RETROVIR.....	33	SAVELLA TITRATION PACK		.....	145, 147, 246
REVLIMID.....	50, 255	.....	126, 140	sodium fluoride 5000 ppm	
REVUFORJ.....	50	saxagliptin hcl	206	.....	145, 147, 246
REXTOVY.....	16, 135	saxagliptin-metformin er		sodium fluoride 5000	
REXULTI.....	120	.....	198, 206, 207	sensitive	147, 246
REYATAZ.....	34	SCALACORT DK.....	289, 293	SODIUM OXYBATE.....	125, 144, 242
REZDIFFRA.....	232	SCSEMBLIX.....	51	sodium phenylbutyrate	160

sodium polystyrene		
sulfonate	17, 161, 241	
sodium sulfacetamide	280	
sodium sulfacetamide wash	280	
SOFOSBUVIR-VELPATASVIR		
.....	29, 30	
SOHONOS	260	
solifenacin succinate	299	
SOLIQUEA	218	
SOOLANTRA	295	
sorafenib tosylate	51	
sotalol hcl	66, 89, 95, 97, 103	
sotalol hcl (af)	66, 89, 95, 97, 103	
SOTYKTU	292, 298	
SOTYLIZE	66, 89, 95, 97, 103	
SOVALDI	29	
SPEVIGO	291	
SPIKEVAX	58	
SPIKEVAX 6M-11Y	58	
spinosad	295	
SPIRIVA HANDIHALER	63, 265	
SPIRIVA RESPIMAT	63, 265	
spironolactone		
.....	84, 101, 102, 105, 106, 162	
spironolactone-hctz		
.....	84, 101, 106, 162, 165	
SPORANOX	26	
SPRAVATO (56 MG DOSE)		
.....	114, 129	
SPRAVATO (84 MG DOSE)		
.....	114, 129	
sprintec 28	205, 214, 227	
SPS (SODIUM		
POLYSTYRENE SULF)		
.....	17, 162, 241	
sronyx	205, 214, 227	
ssd	283, 294	
SSKI	269	
sss 10-5	280, 293	
ST JOSEPH LOW DOSE		
.....	81, 82, 118, 140	
STENDRA	104, 105	
STEQEYMA	237	
STIOLTO RESPIMAT	63, 69	
STIVARGA	51	
STRENSIQ	167	
STRIBILD	31, 33, 260	
STRIVERDI RESPIMAT ..	69, 274	
STROMEKTOL	22	
SUBOXONE	135, 136	
subvenite	113, 116	
subvenite starter kit-blue		
.....	113, 116	
subvenite starter kit-green		
.....	113, 116	
subvenite starter kit-orange		
.....	113, 116	
SUCRAID	167	
sucralfate	189	
SUFLAVE	185	
SULAR	99	
SULCONAZOLE NITRATE	283	
sulfacetamide sodium ..	170, 280	
sulfacetamide sodium (acne)		
.....	280	
sulfacetamide sodium		
(cleans)	280	
sulfacetamide sodium-sulfur		
.....	280, 293	
sulfacetamide sod-sulfur		
wash	280, 293	
sulfacetamide-prednisolone		
.....	170, 177	
sulfacetamide-sulfur in urea		
.....	280, 293	
sulfadiazine	40	
sulfamethoxazole-		
trimethoprim	24, 40, 42	
SULFAMYLLON	280, 294	
sulfasalazine		
.....	40, 183, 234, 251, 256	
sulfatrim pediatric	24, 40, 42	
sulfurated lime	296	
sulindac	131, 139	
sumatriptan	141	
sumatriptan succinate	141	
sunitinib malate	51	
SUNLENCA	25, 30	
SUNOSI	144	
SUPREP BOWEL PREP KIT ..	185	
SUTAB	185	
SYMBICORT	69, 194	
SYMBYAX	116, 120, 142, 182	
SYMDEKO	267, 268	
SYMFI	32, 33	
SYMPAZAN	122, 123	
SYMPROIC	181, 188	
SYNAREL	217	
SYNDROS	182, 188	
SYNJARDY	199, 230	
SYNJARDY XR	199, 230	
TABLOID	51	
TABRECTA	51	
tacrolimus	233, 258, 291, 298	
tadalafil	104, 105, 272	
tadalafil (pah)	104, 105, 272, 275	
TADLIQ	104, 105, 272, 275	
TAFINLAR	51	
tafluprost (pf)	180	
TAGRISSE	51	
take action	197, 205, 227	
TAKHZYRO	83, 248, 258	
tamoxifen citrate	51, 207	
tamsulosin hcl	67	
TANLOR	64	
TAPERDEX 12-DAY	177, 194	
TAPERDEX 6-DAY	177, 194	
TAPERDEX 7-DAY	177, 194	
tarina 24 fe	205, 214, 227	
tarina fe 1/20 eq	205, 214, 227	
tasimelteon	119, 128	
TAVALISSE	72	
taysofy	205, 214, 227	
TAYTULLA	205, 214, 227	
tazarotene	293, 299	
TAZVERIK	51	
TECHLITE LANCETS 26G	156	
TECHLITE PLUS PEN		
NEEDLES	156	
TEGLUTIK	109, 125	
TEGRETOL	114, 116	
telmisartan	85, 86	
telmisartan-hctz	86, 165	
temazepam	123	
TEMBEXA	37	
temozolomide	51	
TENCON	111, 121, 130	
TENIVAC	55	
tenofovir disoproxil fumarate	33	
terazosin hcl	66, 84, 85, 89	
terbinafine hcl	20	
terbutaline sulfate	69, 274	
terconazole	283	
teriflunomide	233, 256	
TERIPARATIDE	219, 243	
terrell	128	
TESTIM	195, 197	
testosterone	196, 197	
testosterone cypionate ..	195, 197	
testosterone enanthate ..	196, 197	
tetrabenazine	144	
tetracaine hcl	179, 240	
tetracycline hcl ..	24, 41, 183, 280	
TEXACORT	177, 194, 289	
TEZSPIRE	270, 273	
THALOMID	51, 256	
THEO-24	100, 138, 160, 276, 300	

theophylline	100, 138, 160, 276, 277, 300	tramadol hcl (er biphasic) 134	TRIUMEQ PD..... 31, 33
theophylline er	100, 138, 160, 276, 300	tramadol hcl er 134	TRI-VI-FLORO
thioridazine hcl.....136		tramadol-acetaminophen	 145, 147, 246, 302, 304, 305
thiothixene.....142		 111, 130, 134	tri-vite/fluoride
THROMBIN-JMI..... 77		trandolapril 86, 87	 145, 147, 246, 302, 304, 305
THROMBIN-JMI EPISTAXIS.... 77		trandolapril-verapamil hcl er	tri-vylibra.....205, 215, 227
THROMBOGEN..... 77, 78		 87, 93	tri-vylibra lo 205, 215, 227
thyroid.....232		tranexamic acid 78	tropium chloride.....300
tiadylt er 91, 92, 98, 108		tranylcypromine sulfate 129	TRUE COMFORT SAFETY
tiagabine hcl 114, 127		travoprost (bak free) 180	PEN NEEDLE..... 157
TIAZAC..... 91, 92, 98, 108		trazodone hcl.....142	TRUE COVER..... 262
TIBSOVO..... 51		TRELEGY ELLIPTA	TRUE FOLIC ACID..... 304
ticagrelor.....81		 63, 69, 177, 194, 267	true laxative 185
TIGLUTIK..... 109, 125		TREMFYA.....235, 291, 299	TRUE METRIX LEVEL 1..... 157
TIKOSYN..... 97		TREMFYA ONE-PRESS	TRUE METRIX LEVEL 2..... 157
tilia fe.....205, 214, 227		 235, 291, 299	TRUE METRIX LEVEL 3..... 157
timolol hemihydrate		TREMFYA PEN..... 235, 291	TRULICITY..... 218
..... 66, 89, 97, 172		TREMFYA-CD/UC	TRUMENBA.....58
timolol maleate		INDUCTION.....235, 291	TRUQAP..... 52
..... 66, 89, 95, 97, 103, 118, 172		tretinoin.....52, 285	TRUVADA.....33, 37
timolol maleate (once-daily)		TRETEN..... 78	TRYNGOLZA..... 88, 195, 242
..... 66, 89, 97, 172		TREXALL.. 52, 235, 251, 256, 258	TUKYSA.....52
timolol maleate ocudose		triamcinolone acetanide	TURALIO..... 52
..... 66, 89, 97, 172		 194, 289	turpentine 284
timolol maleate pf 66, 89, 97, 172		triamterene 84, 105, 162	turqoz 205, 215, 227
TIMOPTIC OCUDOSE		triamterene-hctz 162, 165	TUXARIN ER..... 18, 19, 266
..... 66, 90, 97, 172		triazolam 123	TWIIST REFILL KIT..... 157
tinidazole 25		TRICITRASOL..... 71	TWIIST REFILL
tiopronin 260		tricitrates.....159	KIT/INFUSION SET..... 157
TISSEEL..... 284, 299		triderm.....194, 289	TWIIST STARTER KIT..... 157
TIVICAY..... 31		trientine hcl.....190	TWINRIX.....58
TIVICAY PD..... 31		tri-estarylla.....205, 214, 227	TWIRLA..... 205, 215, 227
tizanidine hcl 64, 65		trifluoperazine hcl 136	TYBLUME..... 205, 215, 227
TOBRADEX..... 21, 170, 177		trifluridine 171	TYBOST.....261
tobramycin.....21, 170		trihexyphenidyl hcl 63, 112	tydemy 205, 215, 227, 304
tobramycin-dexamethasone		TRIJARDY XR..... 199, 207, 230	TYENNE..... 237
..... 21, 170, 177		TRIKAFTA.....268, 269	TYMLOS..... 219, 243
TOBREX..... 21, 170		tri-legest fe.....205, 214, 227	TYVASO..... 108, 273, 276
TODAY SPONGE..... 262		tri-linyah.....205, 214, 227	TYVASO DPI INSTITUTIONAL
tolterodine tartrate 299		tri-lo-estarylla 205, 214, 227	KIT..... 108, 272, 275
tolvaptan 166		tri-lo-marzia 205, 215, 227	TYVASO DPI MAINTENANCE
TOPICORT..... 289		tri-lo-mili.....205, 215, 227	KIT..... 108, 273, 276
topiramate.....114, 118		tri-lo-sprintec.....205, 215, 227	TYVASO DPI TITRATION KIT
toremifene citrate 51, 207		trimethobenzamide hcl 182	 108, 273, 276
torpenz 51, 236		trimethoprim 42	TYVASO REFILL KIT
torsemide.....83, 101, 161		tri-mili 205, 215, 227	 108, 273, 276
TOUJEO MAX SOLOSTAR.... 218		trimipramine maleate 143	TYVASO STARTER KIT
TOUJEO SOLOSTAR..... 218		TRINATE.....80, 302, 304	 109, 273, 276
TRACLEER..... 108, 269, 275		TRINTELLIX.....142	UBRELVY..... 124
TRADJENTA..... 207		tri-sprintec 205, 215, 227	UDENYCA..... 74
tramadol hcl.....134		TRISTART DHA	ULTANE..... 128
		 80, 164, 261, 302, 304	
		TRIUMEQ..... 31, 33	

UNIFINE OTC PEN NEEDLES	VENCLEXTA STARTING	VITAMIN C BRIGHTENING
..... 157	PACK..... 52	SERUM..... 284
UNIFINE PROTECT PEN	VENELEX..... 299	vitamin d (ergocalciferol) 305
NEEDLE.....157	venlafaxine hcl 141	VITATHELY WITH GINGER
UNISTRIP CONTROL.....157	venlafaxine hcl er.....141	 80, 302, 304
unithroid 232	VEOZAH..... 125	VITRAKVI.....52
UPTRAVI..... 276	verapamil hcl . 91, 92, 93, 98, 109	VIVAGUARD INO CONTROL
UPTRAVI TITRATION..... 276	verapamil hcl er	SOLUTION.....157
urea 83, 161, 180, 293	 91, 92, 93, 98, 109	VIVAGUARD LANCETS 30G. 158
URELLE..... 42, 63, 111, 261	VERIFINE INSULIN PEN	VIVAGUARD LANCING
UREMEZ-40.....83, 161, 180, 293	NEEDLE.....157	DEVICE.....158
uretron d/s 42, 63, 111, 261	VERIFINE INSULIN SYRINGE	VIVAGUARD SAFETY
UROCIT-K 10.....159	 157	LANCETS 28G.....158
UROCIT-K 15.....159	VERIFINE PLUS PEN	VIVJOA..... 27
UROGESIC-BLUE..... 42, 63, 261	NEEDLE.....157	VIZIMPRO.....52
ursodiol 185	VERIFINE SAFE LANCET	volnea.....206, 215, 228
valacyclovir hcl 37	MINI 21G.....157	VONVENDI..... 78
VALCHLOR.....277, 299	VERIFINE SAFE LANCET	VOQUEZNA..... 188, 189, 190
valganciclovir hcl.....37	MINI 23G.....157	VOQUEZNA DUAL PAK... 22, 188
valproic acid	VERIFINE SAFE LANCET	VOQUEZNA TRIPLE PAK
..... 114, 116, 117, 118, 127	MINI 28G.....157	 22, 38, 189
valsartan 85, 86	VERIFINE SAFE LANCET	VORANIGO.....52, 53
valsartan-	MINI 30G.....157	voriconazole 27
hydrochlorothiazide.....86, 165	VERIFINE SHARPS	VORTEX VALVE CHAMBER-
VALTOCO 10 MG DOSE.....122	CONTAINER.....157	PEDI MASK..... 158
VALTOCO 15 MG DOSE.....122	VERISAFE SAFETY STERILE	VORTEX VALVED HOLDING
VALTOCO 20 MG DOSE.....122	NEEDLE.....157	CHAMBER..... 158
VALTOCO 5 MG DOSE.....122	VERKAZIA..... 171, 177, 233	VOSEVI.....29, 30
valtya 1/35.....205, 215, 227	VERSAPENN (AG)	VOWST..... 188, 261
valtya 1/50.....205, 215, 228	ANHYDROUS..... 263	VOXZOGO.....261
VANCOCIN..... 28	VERSAPENN (AL) ANHYD	VOYDEYA.....247
vancomycin hcl 28	LIPID..... 263	VRAYLAR..... 120
VANDAZOLE..... 21, 36, 280	VERZENIO.....52	VTAMA.....281, 284, 299
VANFLYTA..... 52	VFEND..... 27	vyfemla.....206, 215, 228
VANRAFIA..... 251, 269	VIBERZI..... 182, 188	VYLEESI..... 125, 190
VAQTA.....58	vienna 206, 215, 228	vylibra 206, 215, 228
varidenafil hcl.....104, 105	vigabatrin 114, 127	VYNDAMAX.....93, 125, 261
varenicline tartrate 60, 64	VIGADRONE..... 114, 127	VYVGART HYTRULO.....238
varenicline tartrate (starter)	VIGAFYDE..... 127	WAINUA.....242
..... 60, 64	VIJOICE..... 261	WAKIX..... 144
varenicline tartrate(continue)	vilazodone hcl 142	warfarin sodium 72
..... 60, 64	VILEVEV MB.....42, 63, 111, 261	WELIREG..... 53
VARIVAX..... 59	VIMPAT.....114, 128	wera 206, 215, 228
VAXELIS..... 55, 59	VIOKACE..... 167, 186	WESCAP-PN DHA
VAXNEUVANCE.....59	violele 206, 215, 228	 80, 164, 261, 302, 304
VCF VAGINAL	VIRACEPT..... 34	WESNATAL DHA COMPLETE
CONTRACEPTIVE..... 262	VIREAD.....33	 80, 164, 261, 302, 304
VECAMYL.....106	VISTOGARD.....17, 241	WESNATE DHA 80, 261, 302, 304
velivet.....205, 215, 228	VITAFOL FE+	WESTGEL DHA
VELPHORO..... 161	 80, 164, 261, 302, 304	 80, 164, 261, 302, 304
VELTASSA..... 162	VITAFOL-OB+DHA	WEZLANA.....237
VENCLEXTA.....52	 80, 164, 261, 302, 304	wheat germ oil.....305
		WIDE-SEAL DIAPHRAGM 60 262

WIDE-SEAL DIAPHRAGM 65	262	YORVIPATH	219
WIDE-SEAL DIAPHRAGM 70	263	YUPELRI	63, 265
WIDE-SEAL DIAPHRAGM 75	263	yuvaferm	215, 244
WIDE-SEAL DIAPHRAGM 80	263	ZACARE	284, 294
WIDE-SEAL DIAPHRAGM 85	263	ZACLIR CLEANSING	294
WIDE-SEAL DIAPHRAGM 90	263	zafemy	206, 215, 228
WIDE-SEAL DIAPHRAGM 95	263	zafirlukast	270
WILATE	78	zaleplon	119, 129
wixela inhub	69, 177, 195, 267	ZANAFLEX	65
wymzya fe	206, 215, 228	ZARONTIN	142
XACIATO	35, 280	ZARXIO	74
xarah fe	206, 215, 228	ZAVZPRET	124
XARELTO	72, 73	ZEGALOGUE	17, 216, 241, 242
XARELTO STARTER PACK	73	ZELBORAF	53
XATMEP	53, 235, 251, 256, 258	ZELSUVMI	282, 299
XDEMVI	171	zelvysia	166, 261
XELJANZ	238, 251	ZEMPLAR	305
XELJANZ XR	238, 251	zenatane	293, 299
XELPROS	180	ZENPEP	167, 186
xelria fe	206, 215, 228	ZEPATIER	29, 30
XELSTRYM	110	ZEPOSIA	256
XERMELO	182	ZEPOSIA 7-DAY STARTER	
XIIDRA	171, 178	PACK	256
XIRUN	284, 293	ZEPOSIA STARTER KIT	256
XOFLUZA (40 MG DOSE)	26, 27	zidovudine	33
XOFLUZA (80 MG DOSE)	26, 27	ZILBRYSQ	233, 234, 247
XOLAIR	236, 273	ZIOPTAN	180
XOLREMDI	74	ziprasidone hcl	117, 120
XOPENEX HFA	69, 275	ZIRGAN	37, 172
XOSPATA	53	ZITHROMAX	38
XPHOZAH	161, 162, 188	ZITHROMAX TRI-PAK	38
XPOVIO (100 MG ONCE		ZITHROMAX Z-PAK	38
WEEKLY)	53	ZOKINVY	167, 261
XPOVIO (40 MG ONCE		ZOLINZA	53
WEEKLY)	53	zolmitriptan	141
XPOVIO (40 MG TWICE		zolpidem tartrate	119, 129
WEEKLY)	53	zolpidem tartrate er	119, 129
XPOVIO (60 MG ONCE		ZOMIG	141
WEEKLY)	53	ZONISADE	114, 128
XPOVIO (60 MG TWICE		zonisamide	114, 128
WEEKLY)	53	ZONTIVITY	81
XPOVIO (80 MG ONCE		ZORYVE	272, 292, 295, 299
WEEKLY)	53	zovia 1/35 (28)	206, 215, 228
XPOVIO (80 MG TWICE		ZTALMY	114, 127
WEEKLY)	53	ZTLIDO	240, 282
XTAMPZA ER	134	ZUBSOLV	135, 136
XTANDI	53	ZURNAL	135
xulane	206, 215, 228	ZURZUVAE	115
XYWAV	125	ZYDELIG	53
YASMIN 28	206, 215, 228	ZYLET	171, 177
YAZ	206, 215, 228	ZYVOX	39
YESINTEK	237		
YEZTUGO	30		