2027 Illinois Traditional Large Group 3 and 4-Tier Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of Jan. 1, 2027, 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 All previous versions of this PDL are no longer in effect.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 **2026-IL-LrgGrp-SBC.pdf**.

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

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

- Heritage Plus
- Heritage Select

Updated 9/1/2026

9/26 © 2027 United HealthCare Services, Inc. All Rights Reserved. WF22413508-D

United Healthcare®

Contents

Understand your medication options 3

How do I use my PDL? 5

What are tiers? 6

When does the PDL change? 6

Additional programs and details 7

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

Requesting a prior authorization 9

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

Prescription delivery options 9

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

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

Nondiscrimination notice and access to communication services . . . 11

Prescription drug list 15

Understand your medication options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do I use my PDL?

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

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

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

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

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

Below is a list of drug tier numbers, abbreviations and designations used in the PDL as well as an explanation for each. If you have a plan with 3 Tiers, Tier 3/4 drugs will be placed on Tier 3. If you have a plan with 4 Tiers, Tier 3/4 drugs will be placed on Tier 4.

Drug Tier 1	Your lowest cost medications
Drug Tier 2	Your mid-range cost medications
Drug Tier 3	Your mid-range to high-cost medications
Drug Tier 3/4	Your highest cost medications
PA	Prior authorization required
QL	Quantity limit
H	Part of health care reform
H-N	Part of health care reform preventive with confirmation of age and/or condition appropriate preventive use

SP	Specialty medication
CM	Orally administered anti-cancer medication
SMCS	Specialty medication cost share may apply
E	Excluded from coverage unless covered as part of health care reform preventive
SM	Cost-share cap by state mandate applies when condition appropriate

What are tiers?

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

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

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

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

When does the PDL change?

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

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

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

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

Additional programs and details

Based on your benefit, the following may apply.

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

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

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

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

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

These medications are mandated to have the cost-share capped:

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

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

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

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

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

Your right to request access to a non-formulary drug

This plan must cover all medically necessary Prescription Drug Products.

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

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

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

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

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

Requesting a prior authorization

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

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

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

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

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

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

Prescription delivery options

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

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

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

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

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

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

How do I get updated information about my pharmacy benefit?

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

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

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

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

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

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

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

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

Learn more

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

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

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

ملحوظة: اذا كنت تتحدث اللغة **العربية** (Arabic)، فإن خدمات المساعدة اللغوية المجانية والمعلومات المجانية بتنسيقات أخرى متاحة لك أيضًا. اتصل بالرقم المجاني الموجود على بطاقة هويتك.

দেখুন: আপনি যদি **বাংলায়** (Bengali-Bangla) কথা বলেন, তাহলে আপনার ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণে নমুনা অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্য পরিচয়পত্রের পিছনে টোল-ফ্রি নম্বরে কল করুন।

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ** (Cambodian-Mon-Khmer)
សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត
ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

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

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

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

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

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 કૉલ કરો.

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

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

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

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

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

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

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

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

توجه: اگر به زبان **فارسی** (Persian-Farsi) صحبت می‌کنید، خدمات رایگان کمک زبانی و اطلاعات به صورت رایگان در قالب‌های دیگر، مانند چاپ درشت، در دسترس شما هستند. لطفاً با شماره‌ای که روی کارت شناسایی عضویت شما درج شده است تماس بگیرید.

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

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

ਦਿਆਨ ਦਿਓ ਿ ਤੁਸ਼ੀਂ **ਪੰਜਾਬੀ** (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸ਼ਹਾਇਤਾ ਸ਼ੇਵਾਵਾਂ ਅਤੇ ਹੋ ਫਾ ਮੈਟਾਂ, ਜਿੰ ਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸ਼ੰਚਾ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬ ਪਛਾਣ ਕਾ ਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬ 'ਤੇ ਕਾਲ ਕ ੇ।

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

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

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

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

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

اردو (Urdu): اگر آپ اردو بولتے ہیں تو آپ کی زبان میں مفت زبان سے متعلق مدد اور خدمات دستیاب ہیں۔ آپ کے ممبر کارڈ پر موجود فون نمبر پر کال کریں، جو آپ کے لیے مفت ہے، اور ہمیں بتائیں کہ آپ کو کس مدد کی ضرورت ہے۔

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

State of Illinois

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION 1
ANTIDOTE THERAPEUTICS 15
ANTIHISTAMINE DRUGS - Drugs for Allergy 17
ANTI-INFECTIVE AGENTS - Drugs for Infections 20
ANTINEOPLASTIC AGENTS - Drugs for Cancer 44
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM 57
AUTONOMIC DRUGS 62
AUTONOMIC DRUGS - Drugs for the Nervous System 63
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood 74
CARDIOVASCULAR DRUGS 87
CARDIOVASCULAR DRUGS - Drugs for the Heart 88
CENTRAL NERVOUS SYSTEM AGENTS 115
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System 115
DENTAL AGENTS 157
DENTAL AGENTS - Oral Care 158
DEVICES - Medical Supplies and Durable Medical Equipment 160
DIAGNOSTIC AGENTS 173
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants 174
ELECTROLYTIC, CALORIC, AND WATER BALANCE 175
ENZYMES 182
EYE, EAR, NOSE AND THROAT (EENT) PREPS. 184
GASTROINTESTINAL DRUGS 197
GASTROINTESTINAL DRUGS - Drugs for the Stomach 198
GOLD COMPOUNDS 207
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron 207
HORMONES AND SYNTHETIC SUBSTITUTES 208
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones 208
IMMUNOMODULATORY AGENTS (90:00) 251
LOCAL ANESTHETICS - Drugs for Numbing 261
MISCELLANEOUS THERAPEUTIC AGENTS 261
NONHORMONAL CONTRACEPTIVES - Drugs for Women 284
OXYTOCICS - Drugs for Women 285
PHARMACEUTICAL AIDS 285
RESPIRATORY TRACT AGENTS 286
RESPIRATORY TRACT AGENTS - Drugs for the Lungs 286
SKIN AND MUCOUS MEMBRANE AGENTS 300
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin 300
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles 325
VITAMINS 326

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy		
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy		
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA; QL (360 ml per month.)
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA; QL (360 ml per month.)
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA; QL (360 ml per month.)
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)
OTHER ANTIHISTAMINES - Drugs for Allergy		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
olopatadine hcl nasal solution 0.6 %	1	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA; QL (360 ml per month.)
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA; QL (360 ml per month.)
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA; QL (360 ml per month.)
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	PA; QL (10 tablets per prescription and 30 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
epinastine hcl ophthalmic solution 0.05 %	1	QL (5 ml per prescription)
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	1	
levocetirizine dihydrochloride oral tablet 5 mg	1	
ANTI-INFECTIVE AGENTS - Drugs for Infections		
1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefadroxil oral capsule 500 mg	1	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	1	
cefadroxil oral tablet 1 gm	1	
cephalexin oral capsule 250 mg, 500 mg, 750 mg	1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cephalexin oral tablet 250 mg, 500 mg	1	
2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefaclor er oral tablet extended release 12 hour 500 mg	1	
cefaclor oral capsule 250 mg, 500 mg	1	
cefaclor oral suspension reconstituted 250 mg/5ml	1	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefprozil oral tablet 250 mg, 500 mg	1	
cefuroxime axetil oral tablet 250 mg, 500 mg	1	
3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefixime oral capsule 400 mg	1	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
CEFIXIME ORAL TABLET 400 MG	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	1	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	1	
ADAMANTANE ANTIVIRALS - Drugs for Viral Infections		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	
amantadine hcl oral tablet 100 mg	1	
rimantadine hcl oral tablet 100 mg	1	
ALLYLAMINE ANTIFUNGALS - Drugs for Fungus		
terbinafine hcl oral tablet 250 mg	1	
AMEBICIDES - Drugs for the Mouth and Throat		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
HUMATIN ORAL CAPSULE 250 MG (***paromomycin sulfate***)	2	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
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 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (***amikacin sulfate liposome***)	3/4	PA; QL (8.4 ml per day.)
gentamicin sulfate external cream 0.1 %	1	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	QL (3.5 grams per prescription.)
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (***omadacycline tosylate***)	3/4	QL (30 tablets per prescription.)
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml	1	
amoxicillin-potassium clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	1	
amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	1	
amoxicillin-potassium clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	1	
ampicillin oral capsule 500 mg	1	
PIVYA ORAL TABLET 185 MG (***pivmecillinam hcl***)	3/4	QL (9 tablets per course of therapy.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
albendazole oral tablet 200 mg	1	QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (***praziquantel***)	3/4	
EGATEN ORAL TABLET 250 MG (***triclabendazole***)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (***mebendazole***)	3/4	QL (6 tablets per 3 days.)
ivermectin oral tablet 3 mg	1	PA; QL (20 tablets per 3 months.)
ivermectin oral tablet 6 mg	1	PA
praziquantel oral tablet 600 mg	1	
STROMECTOL ORAL TABLET 3 MG (***ivermectin***)	3/4	PA; QL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
griseofulvin microsize oral suspension 125 mg/5ml	1	
griseofulvin microsize oral tablet 500 mg	1	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	1	
iodine strong oral solution 5 %	1	
ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
dapsone external gel 5 %, 7.5 %	1	QL (60 grams per prescription.)
dapsone oral tablet 100 mg, 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	QL (30 grams per prescription.)
ARAKODA ORAL TABLET 100 MG (***tafenoquine succinate***)	3/4	QL (16 tablets per month.)
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	1	
AVIDOXY ORAL TABLET 100 MG	3/4	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG (***artemether-lumefantrine***)	2	
DARAPRIM ORAL TABLET 25 MG (***pyrimethamine***)	3/4	PA
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 20 mg	1	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
KRINTAFEL ORAL TABLET 150 MG (***tafenoquine succinate***)	1	QL (2 tablets per prescription.)
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (***atovaquone-proguanil hcl***)	3/4	
mefloquine hcl oral tablet 250 mg	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	1	
pyrimethamine oral tablet 25 mg	1	PA
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
quinine sulfate oral capsule 324 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA; QL (30 grams per prescription.)
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
dapsone oral tablet 100 mg, 25 mg	1	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
nitazoxanide oral tablet 500 mg	1	QL (6 tablets per prescription.)
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
atovaquone oral suspension 750 mg/5ml	1	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
dapsone external gel 5 %, 7.5 %	1	QL (60 grams per prescription.)
dapsone oral tablet 100 mg, 25 mg	1	
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (***nifurtimox***)	3/4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (***nifurtimox***)	3/4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (***pentamidine isethionate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nitazoxanide oral tablet 500 mg	1	QL (6 tablets per prescription.)
pentamidine isethionate inhalation solution reconstituted 300 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (***secnidazole***)	3/4	QL (1 packet per prescription.)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
tinidazole oral tablet 250 mg, 500 mg	1	
ANTIPROTOZOALS,NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat		
tinidazole oral tablet 250 mg, 500 mg	1	
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (5 tablets per 365 days.)
ANTITUBERCULOSIS AGENTS - Antibiotics		
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***)	3/4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
cycloserine oral capsule 250 mg	1	
ethambutol hcl oral tablet 100 mg, 400 mg	1	
isoniazid oral syrup 50 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
isoniazid oral tablet 100 mg, 300 mg	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
PRETOMANID ORAL TABLET 200 MG	3/4	
PRIFTIN ORAL TABLET 150 MG (***rifapentine***)	2	
pyrazinamide oral tablet 500 mg	1	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
rifapentine oral tablet 150 mg	1	
SIRTURO ORAL TABLET 100 MG, 20 MG (***bedaquiline fumarate***)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (***maribavir***)	3/4	PA; QL (4 tablets per day.)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
PREVYMIS ORAL PACKET 120 MG, 20 MG (***letermovir***)	2	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG (***letermovir***)	2	PA
TPOXX ORAL CAPSULE 200 MG (***tecovirimat***)	3/4	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
AZOLE ANTIFUNGALS - Drugs for Fungus		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (***isavuconazonium sulfate***)	3	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
itraconazole oral capsule 100 mg	1	QL (180 capsules per 365 days)
itraconazole oral solution 10 mg/ml	1	QL (1800 ml per 365 days)
ketoconazole external cream 2 %	1	QL (30 grams per prescription.)
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	1	
ketodan external foam 2 %	1	
NOXAFIL ORAL PACKET 300 MG (***posaconazole***)	2	
posaconazole oral suspension 40 mg/ml	1	
posaconazole oral tablet delayed release 100 mg	1	
SPORANOX ORAL CAPSULE 100 MG (***itraconazole***)	3/4	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***voriconazole***)	3/4	
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (***oteseconazole***)	3	PA; QL (18 capsules per 84 days.)
voriconazole oral suspension reconstituted 40 mg/ml	1	
voriconazole oral tablet 200 mg	1	QL (62 tablets per prescription.)
voriconazole oral tablet 50 mg	1	QL (124 tablets per prescription)
BACITRACIN ANTIBIOTICS - Antibiotics		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
CORONAVIRUS (COVID-19) - Drugs for Viral Infections		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ENDONUCLEASE INHIBITORS - Drugs for Viral Infections		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
ENTRY INHIBITORS - Drugs for Viral Infections		
HEPCLUDEX SUBCUTANEOUS SOLUTION RECONSTITUTED 8.5 MG (***bulevirtide acetate-gmod***)	3/4	PA; QL (30 vials per month.); CM
ERYTHROMYCIN ANTIBIOTICS - Antibiotics		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***)	3	
ERY EXTERNAL PAD 2 %	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (***erythromycin ethylsuccinate***)	3/4	
erythromycin base oral capsule delayed release particles 250 mg	1	
erythromycin base oral tablet 250 mg, 500 mg	1	
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	1	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	1	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	1	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (***vancomycin hcl***)	3/4	
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (***vancomycin hcl***)	3/4	
vancomycin hcl oral capsule 125 mg, 250 mg	1	
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; QL (1 tablet per day and 28 tablets per month.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
SOVALDI ORAL PACKET 150 MG, 200 MG (***sofosbuvir***)	3/4	PA; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.)
SOVALDI ORAL TABLET 200 MG, 400 MG (***sofosbuvir***)	3/4	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days.)
HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
MAVYRET ORAL PACKET 50-20 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days.)
HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections		
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; QL (1 tablet per day and 28 tablets per month.)
MAVYRET ORAL PACKET 50-20 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
BIXLENVO ORAL TABLET 75-50 MG (***bictegravir-lenacapavir***)	3/4	
SUNLENCA ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	PA; QL (24 tablets per year.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	QL (4 tablets per year.); SM
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
maraviroc oral tablet 150 mg, 300 mg	1	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (***fostemsavir tromethamine***)	3/4	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (***maraviroc***)	3/4	PA
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
BIXLENVO ORAL TABLET 75-50 MG (***bictegravir-lenacapavir***)	3/4	
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	3/4	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL PACKET 100 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET 400 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (***raltegravir potassium***)	2	SM
JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***)	2	QL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
TIVICAY ORAL TABLET 50 MG (***dolutegravir sodium***)	3	SM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (***dolutegravir sodium***)	3	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
VOCABRIA ORAL TABLET 30 MG (***cabotegravir sodium***)	3/4	SM
HIV NONNUCLEOSIDE REV.TRANSCRIP. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***)	2	QL (1 tablet per day.)
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (***rilpivirine hcl***)	2	SM
efavirenz oral tablet 600 mg	1	
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
etravirine oral tablet 100 mg, 200 mg	1	SM
IDVYNSO ORAL TABLET 100-0.25 MG (***doravirine-islatravir***)	3/4	QL (30 tablets per month.)
INTELENCE ORAL TABLET 100 MG, 200 MG (***etravirine***)	3/4	SM
INTELENCE ORAL TABLET 25 MG (***etravirine***)	2	SM
JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***)	2	QL (1 tablet per day.)
methocarbamol oral tablet 500 mg	1	
nevirapine er oral tablet extended release 24 hour 400 mg	1	
nevirapine oral suspension 50 mg/5ml	1	
nevirapine oral tablet 200 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (***doravirine***)	3	
rilpivirine hcl oral tablet 25 mg	1	SM
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections		
abacavir sulfate oral solution 20 mg/ml	1	
abacavir sulfate oral tablet 300 mg	1	
abacavir sulfate-lamivudine oral tablet 600-300 mg	1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (***lamivudine-tenofovir***)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitabine oral capsule 200 mg	1	SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
EMTRIVA ORAL CAPSULE 200 MG (***emtricitabine***)	3/4	SM
EMTRIVA ORAL SOLUTION 10 MG/ML (***emtricitabine***)	2	SM
EPIVIR ORAL SOLUTION 10 MG/ML (***lamivudine***)	3/4	SM
EPIVIR ORAL TABLET 150 MG, 300 MG (***lamivudine***)	3/4	SM
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	3/4	QL (1 tablet per day.)
IDVYNSO ORAL TABLET 100-0.25 MG (***doravirine-islatravir***)	3/4	QL (30 tablets per month.)
lamivudine oral solution 10 mg/ml	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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-tenofov af***)	3/4	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (***zidovudine***)	3/4	SM
RETROVIR ORAL SYRUP 50 MG/5ML (***zidovudine***)	3	SM
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	1	H-N
TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	3/4	QL (1 tablet per day.); SM
VIREAD ORAL POWDER 40 MG/GM (***tenofovir disoproxil fumarate***)	3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (***tenofovir disoproxil fumarate***)	2	
ZIAGEN ORAL SOLUTION 20 MG/ML (***abacavir sulfate***)	3/4	
zidovudine oral capsule 100 mg	1	SM
zidovudine oral syrup 50 mg/5ml	1	SM
zidovudine oral tablet 300 mg	1	SM
HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
APTIVUS ORAL CAPSULE 250 MG (***tipranavir***)	2	
atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg	1	SM
darunavir oral tablet 600 mg, 800 mg	1	SM
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
fosamprenavir calcium oral tablet 700 mg	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML (***lopinavir-ritonavir***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (***lopinavir-ritonavir***)	3/4	
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	1	
NORVIR ORAL PACKET 100 MG (***ritonavir***)	2	SM
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (***darunavir***)	2	SM
PREZISTA ORAL TABLET 150 MG, 75 MG (***darunavir***)	2	SM
REYATAZ ORAL PACKET 50 MG (***atazanavir sulfate***)	2	SM
ritonavir oral tablet 100 mg	1	SM
VIRACEPT ORAL TABLET 250 MG, 625 MG (***nelfinavir mesylate***)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM; SMCS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
LINCOMYCIN ANTIBIOTICS - Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	3/4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	3/4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
clindamycin phos (twice-daily) external gel 1 %	1	QL (75 grams per prescription.)
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	QL (1 gel tube (8 grams) per prescription.)
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (***aztreonam lysine***)	3/4	PA; QL (84 vials per 56 days.); SP; SMCS
MONOCLONAL ANTIBODIES (08:18) - Drugs for Viral Infections		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (***nirsevimab-alip***)	3	H
ENFLONSIA INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 105 MG/0.7ML (***clesrovimab-cfor***)	3	H
NATURAL PENICILLIN ANTIBIOTICS - Antibiotics		
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	1	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	1	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (***zanamivir***)	3	
NITROIMIDAZOLE DERIVATIVE, ANTI-LEISHMAL - Drugs for the Mouth and Throat		
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)
NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL - Drugs for the Mouth and Throat		
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
NITROIMIDAZOLE DERIVATIVES, MISC - Drugs for the Mouth and Throat		
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
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 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
adefovir dipivoxil oral tablet 10 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BARACLUDE ORAL SOLUTION 0.05 MG/ML (***entecavir***)	2	
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
entecavir oral tablet 0.5 mg, 1 mg	1	
famciclovir oral tablet 125 mg, 250 mg, 500 mg	1	
LAGEVRIO ORAL CAPSULE 200 MG (***molnupiravir***)	2	QL (80 capsules per 365 days. 40 capsules per prescription.)
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
ribavirin oral capsule 200 mg	1	
ribavirin oral tablet 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (***brincidofovir***)	3/4	
TEMBEXA ORAL TABLET 100 MG (***brincidofovir***)	3/4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	3/4	QL (1 tablet per day.); SM
valacyclovir hcl oral tablet 1 gm	1	QL (31 tablets per prescription)
valacyclovir hcl oral tablet 500 mg	1	
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***fidaxomicin***)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***fidaxomicin***)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
linezolid oral suspension reconstituted 100 mg/5ml	1	
linezolid oral tablet 600 mg	1	
SIVEXTRO ORAL TABLET 200 MG (***tedizolid phosphate***)	3	QL (6 tablets per prescription.)
PENICILLINASE-RESISTANT PENICILLINS - Antibiotics		
dicloxacillin sodium oral capsule 250 mg, 500 mg	1	
POLYENE ANTIFUNGALS - Drugs for Fungus		
klayesta external powder 100000 unit/gm	1	QL (120 grams per prescription.)
nystatin external cream 100000 unit/gm	1	QL (90 grams per prescription.)
nystatin external ointment 100000 unit/gm	1	QL (90 grams per prescription.)
nystatin external powder 100000 unit/gm	1	QL (120 grams per prescription.)
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	QL (120 grams per prescription.)
POLYMYXIN ANTIBIOTICS - Antibiotics		
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (***colistimethate sodium***)	3/4	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (***flucytosine***)	3/4	
ANCOBON ORAL CAPSULE 500 MG (***flucytosine***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
flucytosine oral capsule 250 mg, 500 mg	1	
QUINOLONE ANTIBIOTICS - Antibiotics		
BAXDELA ORAL TABLET 450 MG (***delafloxacin meglumine***)	3	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***)	3/4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
moxifloxacin hcl oral tablet 400 mg	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin oral tablet 400 mg	1	
ofloxacin otic solution 0.3 %	1	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (***rifapentine***)	2	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
rifapentine oral tablet 150 mg	1	
XIFAXAN ORAL TABLET 200 MG (***rifaximin***)	3	PA; QL (9 tablets per prescription)
XIFAXAN ORAL TABLET 550 MG (***rifaximin***)	3	PA; QL (62 tablets per month.)
SULFONAMIDES - Antibiotics		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
sulfadiazine oral tablet 500 mg	1	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	QL (30 grams per prescription.)
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
demeclocycline hcl oral tablet 150 mg, 300 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 20 mg	1	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
tetracycline hcl oral capsule 250 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA; QL (30 grams per prescription.)
TRIAZAACENAPHTHYLENES - Antibiotics		
BLUJEPA ORAL TABLET 750 MG (***gepotidacin mesylate***)	3/4	QL (20 tablets per course of therapy.)
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
fosfomycin tromethamine oral packet 3 gm	1	
MACROBID ORAL CAPSULE 100 MG (***nitrofurantoin monohyd macro***)	3/4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methenamine hippurate oral tablet 1 gm	1	
methenamine mandelate oral tablet 0.5 gm, 1 gm	1	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	1	
nitrofurantoin monohydrate macrocrystals oral capsule 100 mg	1	
nitrofurantoin oral suspension 25 mg/5ml	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	QL (10 tablets per course of therapy.)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
trimethoprim oral tablet 100 mg	1	
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	1	QL (4 tablets per day.); CM
abirtega oral tablet 250 mg	1	QL (4 tablets per day.); CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (***niraparib-abiraterone acetate***)	3/4	PA; QL (2 tablets per day.); CM
ALECENSA ORAL CAPSULE 150 MG (***alectinib hcl***)	2	PA; QL (8 capsules per day.); CM
ALUNBRIG ORAL TABLET 180 MG, 90 MG (***brigatinib***)	2	PA; QL (1 tablet per day.); CM
ALUNBRIG ORAL TABLET 30 MG (***brigatinib***)	2	PA; QL (4 tablets per day.); CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (***brigatinib***)	2	PA; QL (30 packs per year.); CM
anastrozole oral tablet 1 mg	1	H-N
AUGTYRO ORAL CAPSULE 160 MG (***repotrectinib***)	2	PA; QL (60 capsules per month.); CM
AUGTYRO ORAL CAPSULE 40 MG (***repotrectinib***)	2	PA; QL (8 capsules per day.); CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (***avutometinib-defactinib***)	3/4	PA; QL (66 capsules/tablets per month.); CM
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (***avapritinib***)	3/4	PA; QL (1 tablet per day.); CM
BALVERSA ORAL TABLET 3 MG (***erdafitinib***)	3/4	PA; QL (3 tablets per day.); CM
BALVERSA ORAL TABLET 4 MG (***erdafitinib***)	3/4	PA; QL (2 tablets per day.); CM
BALVERSA ORAL TABLET 5 MG (***erdafitinib***)	3/4	PA; QL (1 tablet per day.); CM
BEQALZI ORAL TABLET 1 MG, 20 MG, 5 MG, 80 MG (***sonrotoclax***)	3/4	
BEQALZI STARTER PACK ORAL TABLET THERAPY PACK 1 & 5 & 20 & 80 MG (***sonrotoclax***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM; SMCS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
bexarotene external gel 1 %	1	QL (60 grams per prescription.)
bexarotene oral capsule 75 mg	1	CM
bicalutamide oral tablet 50 mg	1	CM
BOSULIF ORAL CAPSULE 100 MG (***bosutinib***)	2	PA; QL (3 Capsules per day.); SP; CM; SMCS
BOSULIF ORAL CAPSULE 50 MG (***bosutinib***)	2	PA; QL (1 Capsule per day.); SP; CM; SMCS
bosutinib oral tablet 100 mg	1	PA; QL (4 tablets per day.); SP; CM; SMCS
bosutinib oral tablet 400 mg, 500 mg	1	PA; QL (1 tablet per day.); SP; CM; SMCS
BRAFTOVI ORAL CAPSULE 75 MG (***encorafenib***)	3/4	PA; QL (6 capsules per day.); CM
BRUKINSA ORAL CAPSULE 80 MG (***zanubrutinib***)	3	PA; QL (60 capsules per month.); CM
BRUKINSA ORAL TABLET 160 MG (***zanubrutinib***)	3	PA; QL (60 tablets per month.); CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (***cabozantinib s-malate***)	2	PA; QL (1 tablet per day.); CM
CALQUENCE ORAL TABLET 100 MG (***acalabrutinib maleate***)	2	PA; QL (2 tablets per day.); CM
capecitabine oral tablet 150 mg, 500 mg	1	CM
CAPRELSA ORAL TABLET 100 MG (***vandetanib***)	2	PA; QL (2 tablets per day.); CM
CAPRELSA ORAL TABLET 300 MG (***vandetanib***)	2	PA; QL (1 tablet per day.); CM
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
COMETRIQ ORAL KIT 20 MG (***cabozantinib s-malate***)	2	PA; QL (93 capsules per month.); CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (***cabozantinib s-malate***)	2	PA; QL (124 capsules per month.); CM
COMETRIQ ORAL KIT 80 & 20 MG (***cabozantinib s-malate***)	2	PA; QL (62 capsules per month.); CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (***duvelisib***)	3/4	PA; QL (2 capsules per day.); CM
COTELLIC ORAL TABLET 20 MG (***cobimetinib fumarate***)	2	PA; QL (63 tablets per 21 days); CM
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	1	PA; QL (1 tablet per day.); CM
dasatinib oral tablet 20 mg	1	PA; QL (90 tablets per month.); CM
DAURISMO ORAL TABLET 100 MG, 25 MG (***glasdegib maleate***)	2	PA; QL (2 tablets per day.); CM
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (***hydroxyurea***)	1	CM
ENSACOVE ORAL CAPSULE 100 MG, 25 MG (***ensartinib hcl***)	2	PA; QL (60 capsules per month.); CM
ERIVEDGE ORAL CAPSULE 150 MG (***vismodegib***)	2	PA; QL (1 capsule per day.); CM
ERLEADA ORAL TABLET 240 MG (***apalutamide***)	2	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ERLEADA ORAL TABLET 60 MG (***apalutamide***)	2	PA; QL (4 tablets per day.); CM
erlotinib hcl oral tablet 100 mg, 150 mg	1	PA; QL (1 tablet per day.); CM
erlotinib hcl oral tablet 25 mg	1	PA; QL (2 tablets per day.); CM
ETCAMAH ORAL TABLET 75 MG (***camizestrant***)	3/4	
etoposide oral capsule 50 mg	1	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
exemestane oral tablet 25 mg	1	H-N
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (***tivozanib hcl***)	3/4	PA; QL (0.75 capsules per day.); CM
FRUZAQLA ORAL CAPSULE 1 MG (***fruquintinib***)	3/4	PA; QL (84 capsules per 21 days.); CM
FRUZAQLA ORAL CAPSULE 5 MG (***fruquintinib***)	3/4	PA; QL (21 capsules per 21 days.); CM
GAVRETO ORAL CAPSULE 100 MG (***pralsetinib***)	3/4	PA; QL (4 capsules per day.); CM
gefitinib oral tablet 250 mg	1	PA; QL (2 tablets per day.); CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (***afatinib dimaleate***)	3	PA; QL (1 tablet per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***lomustine***)	2	CM
GOMEKLI ORAL CAPSULE 1 MG (***mirdametinib***)	3/4	PA; QL (42 capsules per 4 weeks.)
GOMEKLI ORAL CAPSULE 2 MG (***mirdametinib***)	3/4	PA; QL (84 capsules per 4 weeks.)
GOMEKLI ORAL TABLET SOLUBLE 1 MG (***mirdametinib***)	3/4	PA; QL (168 tablets per 4 weeks.)
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	
HERNEXEOS ORAL TABLET 60 MG (***zongertinib***)	3/4	PA; QL (90 tablets per month.); CM
HYCAMTIN ORAL CAPSULE 0.25 MG (***topotecan hcl***)	2	PA; QL (20 capsules per three weeks.); CM
HYCAMTIN ORAL CAPSULE 1 MG (***topotecan hcl***)	2	PA; QL (30 capsules per 3 weeks.); CM
hydroxyurea oral capsule 500 mg	1	CM
HYRNUO ORAL TABLET 10 MG (***sevabertinib***)	2	PA; QL (120 tablets per month.); CM
IBRANCE ORAL CAPSULE 125 MG (***palbociclib***)	3/4	PA; QL (21 capsules per month.); CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (***palbociclib***)	3/4	PA; QL (0.75 tablets per day.); CM
IBTROZI ORAL CAPSULE 200 MG (***taletrectinib adipate***)	3/4	PA; QL (90 capsules per month.); CM
ICLUSIG ORAL TABLET 15 MG, 45 MG (***ponatinib hcl***)	3	PA; QL (1 tablet per day.); CM
IDHIFA ORAL TABLET 100 MG, 50 MG (***enasidenib mesylate***)	2	PA; QL (1 tablet per day.); CM
imatinib mesylate oral tablet 100 mg	1	QL (6 tablets per day.); CM
imatinib mesylate oral tablet 400 mg	1	QL (1 tablet per day.); CM
IMBRUVICA ORAL CAPSULE 140 MG (***ibrutinib***)	2	PA; QL (4 capsules per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IMBRUVICA ORAL CAPSULE 70 MG (***ibrutinib***)	2	PA; QL (1 capsule per day.); CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (***ibrutinib***)	2	PA; QL (7.2 ml per day.); CM
IMBRUVICA ORAL TABLET 420 MG (***ibrutinib***)	2	PA; QL (1 tablet per day.); CM
IMKELDI ORAL SOLUTION 80 MG/ML	3/4	PA; QL (280 ml (2 bottles) per month.); CM
INLURIYO ORAL TABLET 200 MG (***imlunestrant tosylate***)	2	PA; QL (56 tablets per month.); CM
INLYTA ORAL TABLET 1 MG (***axitinib***)	3	PA; QL (6 tablets per day.); SP; CM; SMCS
INLYTA ORAL TABLET 5 MG (***axitinib***)	3	PA; QL (124 tablets per 30 days.); SP; CM; SMCS
INQOVI ORAL TABLET 35-100 MG (***decitabine-cedazuridine***)	3/4	PA; QL (5 tablets per month.); CM
IRESSA ORAL TABLET 250 MG (***gefitinib***)	3/4	PA; QL (2 tablets per day.); CM
ITOVEBI ORAL TABLET 3 MG (***inavolisib***)	2	PA; QL (56 tablets per month.); CM
ITOVEBI ORAL TABLET 9 MG (***inavolisib***)	2	PA; QL (28 tablets per month.); CM
IWILFIN ORAL TABLET 192 MG (***eflornithine hcl***)	2	PA; QL (8 tablets per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; CM
JAYPIRCA ORAL TABLET 100 MG (***pirtobrutinib***)	3/4	PA; QL (3 tablets per day.); CM
JAYPIRCA ORAL TABLET 50 MG (***pirtobrutinib***)	3/4	PA; QL (1 tablet per day.); CM
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (21 tablets per month.); CM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (42 tablets per 21 days.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (63 tablets per 21 days.); CM
KOMZIFTI ORAL CAPSULE 200 MG (***ziftomenib***)	3/4	PA; QL (90 capsules per month.); CM
KOSELUGO ORAL CAPSULE 10 MG (***selumetinib sulfate***)	3	PA; QL (8 capsules per day.); CM
KOSELUGO ORAL CAPSULE 25 MG (***selumetinib sulfate***)	3	PA; QL (4 capsules per day.); CM
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (***selumetinib sulfate***)	3	PA
KRAZATI ORAL TABLET 200 MG (***adagrasib***)	3/4	PA; QL (6 tablets per day.); CM
lapatinib ditosylate oral tablet 250 mg	1	PA; QL (186 tablets per month.); CM
LAZCLUZE ORAL TABLET 240 MG (***lazertinib mesylate***)	3	PA; QL (30 tablets per month.); CM
LAZCLUZE ORAL TABLET 80 MG (***lazertinib mesylate***)	3	PA; QL (60 tablets per month.); CM
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (2 capsules per day.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (3 capsules per day.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (***lenvatinib mesylate***)	2	PA; QL (1 capsule per day.); CM
letrozole oral tablet 2.5 mg	1	H-N
LEUKERAN ORAL TABLET 2 MG (***chlorambucil***)	2	CM
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; SM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (1 carton (18 capsules) per 28 days.); CM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (3 blister paks (18 capsules) per 28 days.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (9 blister paks (18 capsules) per 28 days.); CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (1 carton (27 capsules) per 28 days.); CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (3 blister paks (27 capsules) per 28 days.); CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (9 blister paks (27 capsules) per 28 days.); CM
lomustine oral capsule 10 mg, 100 mg, 40 mg	1	CM
LONSURF ORAL TABLET 15-6.14 MG (***trifluridine-tipiracil***)	3/4	PA; QL (100 tablets per month.); CM
LONSURF ORAL TABLET 20-8.19 MG (***trifluridine-tipiracil***)	3/4	PA; QL (80 tablets per 21 days.); CM
LORBRENA ORAL TABLET 100 MG (***lorlatinib***)	3	PA; QL (30 tablets per month.); CM
LORBRENA ORAL TABLET 25 MG (***lorlatinib***)	3	PA; QL (90 tablets per month.); CM
LUMAKRAS ORAL TABLET 120 MG (***sotorasib***)	3/4	PA; QL (240 tablets per month.); CM
LUMAKRAS ORAL TABLET 240 MG (***sotorasib***)	3/4	PA; QL (120 tablets per month.); CM
LUMAKRAS ORAL TABLET 320 MG (***sotorasib***)	3/4	PA; QL (3 tablets per day.); CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (***olaparib***)	2	PA; QL (4 tablets per day.); CM
LYSODREN ORAL TABLET 500 MG (***mitotane***)	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (84 tablets per month.); CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (112 tablets per month.); CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (140 tablets per month.); CM
MATULANE ORAL CAPSULE 50 MG (***procarbazine hcl***)	2	CM
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	1	
megestrol acetate oral tablet 20 mg, 40 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (***trametinib dimethyl sulfoxide***)	3/4	QL (17.4 ml per day.); CM
MEKINIST ORAL TABLET 0.5 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; QL (2 tablets per day.); CM
MEKINIST ORAL TABLET 2 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; QL (1 tablet per day.); CM
MEKTOVI ORAL TABLET 15 MG (***binimetinib***)	3/4	PA; QL (6 tablets per day.); CM
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
MODEYSO ORAL CAPSULE 125 MG (***dordaviprone hcl***)	3/4	PA; QL (20 capsules per month.); CM
MYLERAN ORAL TABLET 2 MG (***busulfan***)	2	CM
NERLYNX ORAL TABLET 40 MG (***neratinib maleate***)	2	PA; QL (6 tablets per day.); CM
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	1	PA; QL (4 capsules per day.); CM
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (***ixazomib citrate***)	2	PA; QL (3 capsules per prescription.); CM
NUBEQA ORAL TABLET 300 MG (***darolutamide***)	2	PA; QL (4 tablets per day.); CM
ODOMZO ORAL CAPSULE 200 MG (***sonidegib phosphate***)	2	PA; QL (1 capsule per day.); CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (***nirogacestat hydrobromide***)	2	PA; QL (56 tablets per month.); CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (***tovorafenib***)	3/4	PA; QL (96 ml per month.); CM
OJEMDA ORAL TABLET 100 MG (***tovorafenib***)	3/4	PA; QL (24 tablets per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (***momelotinib dihydrochloride***)	3/4	PA; QL (1 tablet per day.); CM
ONUREG ORAL TABLET 200 MG, 300 MG (***azacitidine***)	2	PA; QL (14 tablets per 24 days.); CM
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
ORGOVYX ORAL TABLET 120 MG (***relugolix***)	3	PA; QL (1 tablet per day); CM
ORSERDU ORAL TABLET 345 MG (***elacestrant hydrochloride***)	2	PA; QL (1 tablet per day.); CM
ORSERDU ORAL TABLET 86 MG (***elacestrant hydrochloride***)	2	PA; QL (3 tablets per day.); CM
pazopanib hcl oral tablet 200 mg	1	PA; QL (4 tablets per day.); CM
pazopanib hcl oral tablet 400 mg	1	PA; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (***pemigatinib***)	3/4	PA; QL (31 tablets per month.); CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (***alpelisib***)	2	PA; QL (2 tablets per day.); CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (***alpelisib***)	2	PA; QL (1 tablet per day.); CM
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	1	PA; QL (21 capsules per 21 days.); CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
QINLOCK ORAL TABLET 50 MG (***ripretinib***)	3/4	PA; QL (3 tablets per day.); CM
RASONQUE ORAL TABLET 100 MG, 150 MG (***daraxonrasib***)	3/4	PA; CM
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (***selpercatinib***)	3/4	PA; QL (60 tablets per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RETEVMO ORAL TABLET 40 MG (***selpercatinib***)	3/4	PA; QL (90 tablets per month.); CM
REVUFORJ ORAL TABLET 110 MG (***revumenib citrate***)	3/4	PA; QL (120 tablets per month.); CM
REVUFORJ ORAL TABLET 160 MG (***revumenib citrate***)	3/4	PA; QL (60 tablets per month.); CM
REVUFORJ ORAL TABLET 25 MG (***revumenib citrate***)	3/4	PA; QL (240 tablets per month.); CM
REZLIDHIA ORAL CAPSULE 150 MG (***olutasidenib***)	2	PA; QL (2 capsules per day.); CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (***vimseltinib***)	2	PA; QL (8 capsules per 4 weeks.); CM
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (***entrectinib***)	2	PA; QL (3 capsules per day.); CM
ROZLYTREK ORAL PACKET 50 MG (***entrectinib***)	2	PA; QL (84 packets (2 boxes) per month.); CM
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (***rucaparib camsylate***)	3	PA; QL (4 tablets per day.); CM
RYDAPT ORAL CAPSULE 25 MG (***midostaurin***)	2	PA; QL (8 capsules per day.); CM
SCEMBLIX ORAL TABLET 100 MG (***asciminib hcl***)	3/4	PA; QL (120 tablets per month.); CM
SCEMBLIX ORAL TABLET 20 MG, 40 MG (***asciminib hcl***)	3/4	PA; QL (2 tablets per day.); CM
sorafenib tosylate oral tablet 200 mg	1	PA; QL (4 tablets per day.); CM
STIVARGA ORAL TABLET 40 MG (***regorafenib***)	2	PA; QL (84 tablets per 21 days.); CM
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA; QL (1 capsule per day.); CM
TABLOID ORAL TABLET 40 MG (***thioguanine***)	2	CM
TABRECTA ORAL TABLET 150 MG, 200 MG (***capmatinib hcl***)	3/4	PA; QL (4 tablets per day.); CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (***dabrafenib mesylate***)	3/4	PA; QL (4 capsules per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAFINLAR ORAL TABLET SOLUBLE 10 MG (***dabrafenib mesylate***)	3/4	QL (420 tablets per month.); CM
TAGRISSO ORAL TABLET 40 MG, 80 MG (***osimertinib mesylate***)	3	PA; QL (1 tablet per day.); CM
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (***talazoparib tosylate***)	3/4	PA; QL (1 capsule per day.); CM
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	CM
TEPMETKO ORAL TABLET 225 MG (***tepotinib hcl***)	3/4	PA; QL (2 tablets per day.); CM
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; QL (28 capsules per prescription.); CM
TIBSOVO ORAL TABLET 250 MG (***ivosidenib***)	2	PA; QL (2 tablets per day.); CM
toremifene citrate oral tablet 60 mg	1	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	QL (20 grams per prescription.)
tretinoin oral capsule 10 mg	1	QL (279 capsules per prescription.); CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
TRUQAP ORAL TABLET 200 MG (***capivasertib***)	2	PA; QL (64 tablets per month.)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (***capivasertib***)	2	PA; QL (64 tablets every month.); CM
TUKYSA ORAL TABLET 150 MG (***tucatinib***)	2	PA; QL (4 tablets per day.); CM
TUKYSA ORAL TABLET 50 MG (***tucatinib***)	2	PA; QL (10 tablets per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TURALIO ORAL CAPSULE 125 MG (***pexidartinib hcl***)	2	PA; QL (4 capsules per day.); CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (***quizartinib dihydrochloride***)	3/4	PA; QL (2 tablets per day.); CM
VENCLEXTA ORAL TABLET 10 MG (***venetoclax***)	2	PA; QL (14 tablets per month.); CM
VENCLEXTA ORAL TABLET 100 MG (***venetoclax***)	2	PA; QL (4 tablets per day.); CM
VENCLEXTA ORAL TABLET 50 MG (***venetoclax***)	2	PA; QL (1 tablet per day.); CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (***venetoclax***)	2	PA; QL (42 tablets per year.); CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***abemaciclib***)	2	PA; QL (2 tablets per day.); CM
VITRAKVI ORAL CAPSULE 100 MG (***larotrectinib sulfate***)	2	PA; QL (2 capsules per day.); CM
VITRAKVI ORAL CAPSULE 25 MG (***larotrectinib sulfate***)	2	PA; QL (6 capsules per day.); CM
VITRAKVI ORAL SOLUTION 20 MG/ML (***larotrectinib sulfate***)	2	PA; QL (10 mL per day.); CM
VORANIGO ORAL TABLET 10 MG (***vorasidenib***)	2	PA; QL (62 tablets per month.); CM
VORANIGO ORAL TABLET 40 MG (***vorasidenib***)	2	PA; QL (31 tablets per month.); CM
WELIREG ORAL TABLET 40 MG (***belzutifan***)	3/4	PA; QL (3 tablets day.); CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
XOSPATA ORAL TABLET 40 MG (***gilteritinib fumarate***)	3	PA; QL (3 tablets per day.); CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (***selinexor***)	3/4	PA; QL (0.26 tablet per day.); CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (***selinexor***)	3/4	PA; QL (16 tablets per month.); CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (***selinexor***)	3/4	PA; QL (1 therapy pack per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (0.86 tablets per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (***selinexor***)	3/4	PA; QL (4 tablets per month.); CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (1.15 tablets per day.); CM
XROMI ORAL SOLUTION 100 MG/ML (***hydroxyurea***)	3/4	PA
XTANDI ORAL CAPSULE 40 MG (***enzalutamide***)	2	PA; QL (4 capsules per day.); CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
ZELBORAF ORAL TABLET 240 MG (***vemurafenib***)	2	PA; QL (8 tablets per day.); CM
ZENBEXUS ORAL CAPSULE 0.75 MG, 1 MG (***iberdomide hydrochloride***)	3/4	PA; CM
ZOLINZA ORAL CAPSULE 100 MG (***vorinostat***)	2	PA; QL (4 capsules per day.); CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (***idelalisib***)	3/4	PA; QL (60 tablets per month.); CM
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (***timothy grass pollen allergen***)	3/4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (***dust mite mixed allergen ext***)	3/4	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (3 tablets per year.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (3 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (1 tablet per day.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***)	3/4	PA; QL (1 tablet per day.)
TOXOIDS - Vaccines		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	2	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (***diphth-acell pertussis-tetanus***)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***dtap-hepatitis b recomb-ipv***)	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (***dtap-ipv-hib vaccine***)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (***dtap-ipv vaccine***)	3	H
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (***tetanus-diphtheria toxoids td***)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***dtap-ipv-hib-hepatitis b recmb***)	3	H
VACCINES - Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (***rsv pre-fusion f a&b vac rcmb***)	3	H
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (***haemophilus b polysac conj vac***)	2	H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (***rsvpref3 vac recomb adjuvanted***)	3	H
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***meningococcal b recomb omv adj***)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	2	H
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (***pneumococcal 21-valent conjuga***)	3	H
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (***covid-19 mrna virus vaccine***)	3	H
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (***covid-19 mrna virus vaccine***)	3	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (***diphth-acell pertussis-tetanus***)	2	H
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (***dengue virus vaccine live tetr***)	3	H
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (***hepatitis b vac recombinant***)	2	H
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (***hepatitis b vac recombinant***)	2	H
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac a&b surf ant adj***)	3	H
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac tiss-cult subunt***)	3	H
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
FLUMIST NASAL LIQUID (***influenza virus vaccine live***)	3	H
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac split high-dose***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***influenza virus vacc split pf***)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (***hpv 9-valent recomb vaccine***)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***hpv 9-valent recomb vaccine***)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (***hepatitis a vaccine***)	3	H
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (***hepatitis b vac recomb adj***)	3	H
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (***haemophilus b polysac conj vac***)	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	H
IPOL INJECTION SUSPENSION (***poliovirus vaccine inactivated***)	2	H
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (***mening acy&w-135 tetanus conj***)	3	H
MENVEO INTRAMUSCULAR SOLUTION (***meningococcal a c y&w-135 olig***)	3	H
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (***meningococcal a c y&w-135 olig***)	3	H
M-M-R II INJECTION SOLUTION RECONSTITUTED (***measles, mumps & rubella vac***)	2	H
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (***covid-19 mrna virus vaccine***)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***dtap-hepatitis b recomb-ipv***)	3	H
PEDVAXHIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (***haemophilus b polysac conj vac***)	2	H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (***mening acyw(tet conj)-b(rcmb)***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***varicella virus vaccine live***)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***dtap-ipv-hib-hepatitis b recmb***)	3	H
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***pneumococcal 15-val conj vacc***)	3	H
AUTONOMIC DRUGS		
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat gum 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	1	H
goodsense nicotine mouth/throat gum 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
goodsense nicotine policrilex mouth/throat gum 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
naltrexone hcl oral tablet 50 mg	1	
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine polacrilex mini mouth/throat lozenge 2 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (***epinephrine***)	3/4	QL (2 nasal sprays (1 box) per copay.)
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs		
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	1	
JAVADIN ORAL SOLUTION 0.02 MG/ML (***clonidine hcl***)	3/4	PA
lofexidine hcl oral tablet 0.18 mg	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
ONYDA XR ORAL SUSPENSION EXTENDED RELEASE 0.1 MG/ML (***clonidine hcl***)	3	QL (120 mL per month.)
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	SM
atropine sulfate ophthalmic solution 1 %	1	
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 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	3	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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	3/4	
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	1	
dicyclomine hcl oral tablet 20 mg	1	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA; QL (120 mL per prescription and 360 ml per month.)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	1	QL (0.87 grams per day.); SM
ipratropium bromide inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***)	3/4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***)	2	
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System		
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat gum 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	1	H
goodsense nicotine mouth/throat gum 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
goodsense nicotine policrilex mouth/throat gum 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine polacrilex mini mouth/throat lozenge 2 mg	1	H
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	1	H
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine step 1 transdermal patch 24 hour 21 mg/24hr	1	H
nicotine step 2 transdermal patch 24 hour 14 mg/24hr	1	H
nicotine step 3 transdermal patch 24 hour 7 mg/24hr	1	H
nicotine transdermal kit 21-14-7 mg/24hr	1	H
nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (***nicotine***)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles		
ATMEKSI ORAL SUSPENSION 750 MG/5ML (***methocarbamol***)	3/4	PA
carisoprodol oral tablet 350 mg	1	
chlorzoxazone oral tablet 500 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
metaxalone oral tablet 400 mg, 800 mg	1	
methocarbamol oral tablet 500 mg, 750 mg	1	
ONTRALFY ORAL SOLUTION 2 MG/5ML (***tizanidine hcl***)	3/4	PA
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	3/4	PA; QL (60 sublingual tablets per month.)
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (***dantrolene sodium***)	3/4	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	1	
GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
baclofen oral solution 10 mg/5ml	1	PA
baclofen oral solution 5 mg/5ml	1	
baclofen oral suspension 25 mg/5ml	1	PA
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (6.7 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (8.5 grams per prescription.); SM
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	PA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	SM
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	3	QL (0.28 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	1	QL (90 ml per prescription.); SM
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	1	QL (30 vials per prescription); SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.); SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.); SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	QL (15 grams per prescription.); SM
SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood		
ANTIANEMIA DRUGS - Vitamins and Minerals		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	QL (4 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
ACD-A NOCLOT-50 EXTRACORPOREAL SOLUTION 0.73-2.45-2.2 GM/100ML (***anticoagulant cit dext soln a***)	3	
ANTICOAGULANT SODIUM CITRATE EXTRACORPOREAL SOLUTION 4 %, 4 GM/100ML	3	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml	1	QL (24 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	1	QL (15 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 5 mg/0.4ml	1	QL (12 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml	1	QL (18 ml (30 syringes) per prescription)
TRICITRASOL EXTRACORPOREAL CONCENTRATE 46.7 % (***anticoagulant sodium citrate***)	3	
ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***)	2	PA; QL (1 vial per day and 58 vials per 120 days.); SP; SMCS
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
AQVESME ORAL TABLET 100 MG (***mitapivat sulfate***)	3/4	PA; QL (60 tablets per month.); SP; CM; SMCS
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (***mitapivat sulfate***)	3	PA; QL (56 tablets per 28 days.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (***mitapivat sulfate***)	3	PA; QL (7 tablets per 365 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (***mitapivat sulfate***)	3	PA; QL (14 tablets per 365 days.); CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (***fostamatinib disodium***)	3/4	PA; QL (2 tablets per day.); SP; SMCS
WAYRILZ ORAL TABLET 400 MG (***rilzabrutinib***)	3/4	PA; QL (60 tablets per month.)
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (***apixaban***)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (***apixaban***)	2	QL (76 sprinkle capsules per month.)
ELIQUIS ORAL TABLET 2.5 MG (***apixaban***)	2	QL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG (***apixaban***)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
rivaroxaban oral suspension reconstituted 1 mg/ml	1	QL (20 ml per day.)
rivaroxaban oral tablet 2.5 mg	1	QL (2 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (***edoxaban tosylate***)	3/4	QL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (***rivaroxaban***)	2	QL (20 ml per day.)
XARELTO ORAL TABLET 10 MG (***rivaroxaban***)	2	QL (1 tablet per day.)
XARELTO ORAL TABLET 15 MG (***rivaroxaban***)	2	QL (52 tablets per month initial 1 tablet per day for maintenance.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***rivaroxaban***)	2	QL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG (***rivaroxaban***)	2	QL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (***rivaroxaban***)	2	QL (51 tablets per year.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
dabigatran etexilate mesylate oral capsule 110 mg	1	QL (2 capsules per day.)
dabigatran etexilate mesylate oral capsule 150 mg, 75 mg	1	QL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (***dabigatran etexilate mesylate***)	3/4	PA; QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (***dabigatran etexilate mesylate***)	3/4	PA; QL (2 packets per day.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (***eltrombopag choline***)	3/4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	QL (4 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DOPTELET ORAL TABLET 20 MG (***avatrombopag maleate***)	3/4	PA; QL (60 tablets per month.)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (***avatrombopag maleate***)	3/4	PA; QL (60 capsules per month.)
eltrombopag olamine oral packet 12.5 mg, 25 mg	1	PA; QL (6 packets per day.)
eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg	1	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (***sargramostim***)	2	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (***plerixafor***)	3/4	
MULPLETA ORAL TABLET 3 MG (***lusutrombopag***)	3/4	PA; QL (7 tablets per prescription.)
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim***)	2	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (***filgrastim-aafi***)	2	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-aafi***)	2	
plerixafor subcutaneous solution 24 mg/1.2ml	1	
PROMACTA ORAL PACKET 12.5 MG, 25 MG (***eltrombopag olamine***)	3/4	PA; QL (6 packets per day.)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
VAFSEO ORAL TABLET 150 MG, 300 MG (***vadadustat***)	3/4	PA; QL (31 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (***factor xiii concentrate human***)	2	
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	3/4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	
desmopressin acetate spray nasal solution 0.01 %	1	
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (***antihem fact (bdd-rfviiifc)***)	2	
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (***antiinhibitor coagulant cmplx***)	2	
GELFILM OPHTHALMIC FILM (***gelatin adsorbable***)	2	
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (***emicizumab-kxwh***)	2	PA; SP; SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (***antihemophilic factor-vwf***)	2	
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***marstacimab-hncq***)	2	PA; QL (4 mL (4 Auto-injectors) per month.)
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***marstacimab-hncq***)	2	PA; QL (4 ml (8 auto-injector/prefilled pens) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (***coagulation factor ix (rix-fp)***)	3	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (***antihemophilic factor***)	2	
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***)	2	
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact bd truncated***)	2	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (***coagulation factor viia recomb***)	2	
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***)	2	
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***)	2	
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	3	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***factor ix complex***)	2	
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (***fitusiran sodium***)	3/4	PA; QL (0.2 mL (1 vial) per month.)
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***fitusiran sodium***)	3/4	PA; QL (0.5 mL (1 pen) per month.)
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (***antihem factor recomb (rfviii)***)	2	
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 5000 UNIT (***thrombin (recombinant)***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT (***thrombin (recombinant)***)	3	
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	2	
THROMBIN-JMI EPISTAXIS EXTERNAL KIT 5000 UNIT (***thrombin***)	3	
THROMBIN-JMI EXTERNAL KIT 20000 UNIT, 5000 UNIT (***thrombin***)	3	
THROMBOGEN EXTERNAL KIT 10000 UNIT (***thrombin***)	3	
THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED 1000 UNIT, 10000 UNIT (***thrombin***)	3	
tranexamic acid oral tablet 650 mg	1	QL (Benefit maximum quantity 1 per day.)
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (***coagulation factor xiii a-sub***)	3	SP; SMCS
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (***von willebrand factor (recomb)***)	2	
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (***antihemophilic factor-vwf***)	2	
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA
HEPARINS - Drugs to Prevent Blood Clots		
enoxaparin sodium injection solution 300 mg/3ml	1	QL (42 ml (14 vials) per prescription)
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml	1	QL (30 syringes per prescription)
enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml	1	QL (24 ml (30 syringes) per prescription)
enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml	1	QL (9 ml (30 syringes) per prescription)
enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml	1	QL (12 ml (30 syringes) per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml	1	QL (18 ml (30 syringes) per prescription)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (***dalteparin sodium***)	3/4	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML (***dalteparin sodium***)	3/4	QL (10 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12500 UNIT/0.5ML (***dalteparin sodium***)	3/4	QL (5 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 15000 UNIT/0.6ML (***dalteparin sodium***)	3/4	QL (6 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 18000 UNT/0.72ML (***dalteparin sodium***)	3/4	QL (8 ml (10 syringes) per prescription)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML, 5000 UNIT/0.2ML (***dalteparin sodium***)	3/4	QL (2 ml (10 syringes) per prescription.)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 7500 UNIT/0.3ML (***dalteparin sodium***)	3/4	QL (3 ml (10 syringes) per prescription.)
heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml	1	
heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml	1	
heparin sodium (porcine) +rfid injection solution 1000 unit/ml	1	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	1	
heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml	1	
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml, 5000 unit/ml	1	
INDIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml	1	QL (24 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	1	QL (15 ml (30 syringes) per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fondaparinux sodium subcutaneous solution 5 mg/0.4ml	1	QL (12 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml	1	QL (18 ml (30 syringes) per prescription)
IRON PREPARATIONS - Vitamins and Minerals		
ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***)	3	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	3/4	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal oral tablet 27-1 mg	1	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals		
cyanocobalamin injection solution 1000 mcg/ml	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
cyanocobalamin nasal solution 500 mcg/0.1ml	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***)	3	
PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec adult low dose oral tablet delayed release 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
cilostazol oral tablet 100 mg, 50 mg	1	
clopidogrel bisulfate oral tablet 300 mg, 75 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
prasugrel hcl oral tablet 10 mg, 5 mg	1	
ticagrelor oral tablet 60 mg, 90 mg	1	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (***vorapaxar sulfate***)	3/4	QL (1 tablet per day.)
PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots		
anagrelide hcl oral capsule 0.5 mg, 1 mg	1	
THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec adult low dose oral tablet delayed release 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ft aspirin oral tablet chewable 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
VON WILLEBRAND FACTOR-RELATED ANTITHROMB - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***)	2	PA; QL (1 vial per day and 58 vials per 120 days.); SP; SMCS
CARDIOVASCULAR DRUGS		
BRADYKININ RECEPTORS ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
CARBONIC ANHYDRASE INHIBITORS (24:36)		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.)
methazolamide oral tablet 25 mg, 50 mg	1	
FACTOR XIIA INHIBITORS		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (***garadacimab-gxii***)	2	PA; QL (1 auto-injector per month.)
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
LOOP DIURETICS (24:36)		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (***bumetanide***)	3/4	PA; QL (12 nasal sprays per copay.)
ethacrynic acid oral tablet 25 mg	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (***furosemide***)	3/4	PA
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	3/4	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (24:36)		
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	
POTASSIUM-SPARING DIURETICS (24:36)		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
THIAZIDE DIURETICS (24:36)		
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***hydrochlorothiazide***)	3/4	PA
THIAZIDE-LIKE DIURETICS (24:36)		
chlorthalidone oral tablet 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ACL INHIBITORS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	1	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral solution 4 mg/ml	1	PA
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs for the Heart		
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
ARBLI ORAL SUSPENSION 10 MG/ML (***losartan potassium***)	3/4	PA
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
valsartan oral solution 4 mg/ml	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***)	3/4	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***)	3/4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
QBRELIS ORAL SOLUTION 1 MG/ML (***lisinopril***)	3/4	PA
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	1	
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	3/4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	3/4	PA; QL (60 capsules per month.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; QL (62 capsules per month.)
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
omega-3-acid ethyl esters oral capsule 1 gm	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 autoinjector (0.8 mL) per month.); SP; SMCS
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
BETA-ADRENERGIC BLOCKING AGENTS (24:20) - Drugs for High Blood Pressure		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	QL (5 ml per prescription.)
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	QL (5 ml per prescription.)
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
BILE ACID SEQUESTRANTS - Drugs for Cholesterol		
cholestyramine light oral packet 4 gm	1	
cholestyramine light oral powder 4 gm/dose	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	1	
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
COLESTID ORAL GRANULES 5 GM (***colestipol hcl***)	3	
COLESTID ORAL TABLET 1 GM (***colestipol hcl***)	3/4	
colestipol hcl oral granules 5 gm	1	
colestipol hcl oral packet 5 gm	1	
colestipol hcl oral tablet 1 gm	1	
prevalite oral packet 4 gm	1	
prevalite oral powder 4 gm/dose	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (***cholestyramine light***)	3/4	
QUESTRAN ORAL PACKET 4 GM (***cholestyramine***)	3/4	
QUESTRAN ORAL POWDER 4 GM/DOSE (***cholestyramine***)	3/4	
CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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(HYPOTEN) - Drugs for High Blood Pressure & Angina		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
methazolamide oral tablet 25 mg, 50 mg	1	
CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (***acoramidis hcl***)	2	PA; QL (124 tablets per month.)
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***mavacamten***)	3/4	PA; QL (1 capsule per day.)
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (2 tablets per day.)
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	1	
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
CARDIOTONIC AGENTS - Drugs for Angina		
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (2 tablets per day.)
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	3/4	
CENTRAL ALPHA-AGONISTS - Drugs for Abnormal Heart Rhythms		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
JAVADIN ORAL SOLUTION 0.02 MG/ML (***clonidine hcl***)	3/4	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CGMP SYNTHESIS AGENT - Drugs for High Blood Pressure & Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (***vericiguat***)	3/4	PA; QL (1 tablet per day.)
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
ezetimibe oral tablet 10 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
disopyramide phosphate oral capsule 100 mg, 150 mg	1	
NORPACE ORAL CAPSULE 100 MG, 150 MG (***disopyramide phosphate***)	3/4	
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
CLASS IB ANTIARRHYTHMICS - Drugs for Angina		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (***phenytoin***)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (***phenytoin sodium extended***)	3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (***phenytoin***)	3	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	1	
phenytek oral capsule 200 mg, 300 mg	1	
phenytoin infatabs oral tablet chewable 50 mg	1	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
CLASS IC ANTIARRHYTHMICS - Drugs for Angina		
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	1	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 II ANTIARRHYTHMICS - Drugs for Angina		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	QL (5 ml per prescription.)
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fenofibrate oral capsule 134 mg, 200 mg, 67 mg	1	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	1	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	1	
gemfibrozil oral tablet 600 mg	1	
LOPID ORAL TABLET 600 MG (***gemfibrozil***)	3/4	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (***atorvastatin calcium***)	3/4	PA
atorvastatin calcium oral tablet 10 mg, 20 mg	1	H-N
atorvastatin calcium oral tablet 40 mg, 80 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3/4	PA
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	1	
fluvastatin sodium oral capsule 20 mg, 40 mg	1	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	H
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	H-N
simvastatin oral tablet 80 mg	1	
LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ethacrynic acid oral tablet 25 mg	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	3/4	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (ALDOSTERONE) ANTAGNTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG (***finerenone***)	3/4	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (***finerenone***)	3/4	PA; QL (30 tablets per month.)
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 2 MG (***lomitapide mesylate***)	3/4	PA; QL (30 capsules per month.)
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	3/4	PA; QL (60 capsules per month.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; QL (62 capsules per month.)
NITRATES AND NITRITES - Drugs for High Blood Pressure & Angina		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nitro-bid transdermal ointment 2 %	1	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (***nitroglycerin***)	3	
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal ointment 2 %	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
NITRATES AND NITRITES - Drugs for the Heart		
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
nitro-bid transdermal ointment 2 %	1	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (***nitroglycerin***)	3	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal ointment 2 %	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
omega-3-acid ethyl esters oral capsule 1 gm	1	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***evolocumab***)	2	QL (2 pens per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
alyq oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (3 tablets per month.)
cilostazol oral tablet 100 mg, 50 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (3 tablets per month.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
tadalafil oral tablet 10 mg, 20 mg	1	QL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (3 tablets per month.)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (3 tablets per month.)
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	QL (4 films per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
alyq oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (3 tablets per month.)
cilostazol oral tablet 100 mg, 50 mg	1	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (3 tablets per month.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
tadalafil oral tablet 10 mg, 20 mg	1	QL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
vardenafil hcl oral tablet dispersible 10 mg	1	QL (3 tablets per month.)
POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
triamterene oral capsule 100 mg, 50 mg	1	
RENIN INHIBITORS - Drugs for the Heart		
aliskiren fumarate oral tablet 150 mg, 300 mg	1	
TEKTURNA ORAL TABLET 150 MG, 300 MG (***aliskiren fumarate***)	3	
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure & Angina		
chlorthalidone oral tablet 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina		
phenoxybenzamine hcl oral capsule 10 mg	1	
VECAMYL ORAL TABLET 2.5 MG (***mecamylamine hcl***)	3/4	PA
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
CAVERJECT IMPULSE(2 CARTRIDGE) INTRACAVERNOSAL CARTRIDGE KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month.)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month.)
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (2 tablets per day.)
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
EDEX (2 CARTRIDGE) INTRACAVERNOSAL CARTRIDGE KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month.)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL CARTRIDGE KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month.)
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (***vericiguat***)	3/4	PA; QL (1 tablet per day.)
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (***treprostinil sodium***)	2	PA; QL (140 capsules per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System		
ADAMANTANES (CNS) - Drugs for Parkinson		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	
amantadine hcl oral tablet 100 mg	1	
ADENOSINE A2A RECEPTOR ANTAGONISTS - Drugs for Parkinson		
NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***)	3	PA; QL (1 tablet per day.)
AMPHETAMINES - Drugs for the Nervous System		
amphetamine sulfate oral tablet 10 mg, 5 mg	1	
amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	1	QL (2 capsules per day.)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	QL (1 capsule per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	QL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	QL (10 capsules per day.)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	1	QL (2 capsules per day.)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	1	QL (1 capsule per day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	1	QL (2 tablets per day.)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	1	QL (1 tablet per day.)
methamphetamine hcl oral tablet 5 mg	1	
PROCENTRA ORAL SOLUTION 5 MG/5ML (***dextroamphetamine sulfate***)	3	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (***dextroamphetamine***)	3	PA; QL (1 patch per day.)
ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
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, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
JOURNAVX ORAL TABLET 50 MG (***suzetrigine***)	3/4	QL (30 tablets per 90 days.)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	PA
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System		
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.)
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (***setmelanotide acetate***)	3	PA; QL (9 mls per month.); SP; SMCS
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (2 pens (6 mL) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (3 pens (9 mL) per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (***eslicarbazepine acetate***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
brivaracetam oral solution 10 mg/ml	1	PA
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	1	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (***brivaracetam***)	3/4	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (***brivaracetam***)	3	PA
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KEPPRA ORAL SOLUTION 100 MG/ML (***levetiracetam***)	3/4	PA
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (***levetiracetam***)	3/4	PA
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (***levetiracetam***)	3/4	PA
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	PA
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3/4	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3/4	PA
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	PA
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	PA
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	PA
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	1	
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	PA
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (***lacosamide***)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	PA
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
perampanel oral suspension 0.5 mg/ml	1	PA
perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
roweepra oral tablet 500 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	3/4	PA
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
subvenite starter kit-blue oral kit 35 x 25 mg	1	
subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	PA
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	1	PA; QL (6 packets per day.)
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.)
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SP; SMCS
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SP; SMCS
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (***cenobamate***)	3	PA
XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (***cenobamate***)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	PA
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (***dextromethorphan-bupropion***)	3/4	QL (2 tablets per day.)
AUVELITY TITRATION PACK ORAL TABLET EXTENDED RELEASE THERAPY PACK 30-105 MG & 45-105 MG (***dextromethorphan-bupropion***)	3/4	QL (1 titration pack every 365 days.)
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	1	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	1	
bupropion hcl oral tablet 100 mg, 75 mg	1	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (12 devices (4 kits) per month.)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (***zuranolone***)	2	PA; QL (28 capsules per year.)
ZURZUVAE ORAL CAPSULE 30 MG (***zuranolone***)	2	PA; QL (14 capsules per year.)
ANTIMANIC AGENTS - Drugs for Personality Disorder		
aripiprazole oral solution 1 mg/ml	1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	3/4	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	PA
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3/4	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	PA
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	PA
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	PA
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium oral solution 8 meq/5ml	1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (***lithium carbonate***)	3/4	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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg	1	QL (1 capsule per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	3/4	PA
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
subvenite starter kit-blue oral kit 35 x 25 mg	1	
subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***)	3/4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec adult low dose oral tablet delayed release 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
butorphanol tartrate nasal solution 10 mg/ml	1	QL (7.5 ml (3 bottles) per prescription.)
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
caffeine citrate oral solution 60 mg/3ml	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	PA
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	QL (8 mL per prescription.)
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	3/4	QL (5 tablets per prescription.)
ergotamine-caffeine oral tablet 1-100 mg	1	
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
mm aspirin oral tablet delayed release 81 mg	E	H
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (1 starter pack per year.)
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	1	
pimozide oral tablet 1 mg, 2 mg	1	
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
meprobamate oral tablet 200 mg, 400 mg	1	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
aripiprazole oral solution 1 mg/ml	1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (***lumateperone tosylate***)	3/4	PA; QL (1 capsule per day.)
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	1	
CLOZARIL ORAL TABLET 100 MG, 25 MG (***clozapine***)	3/4	
FANAPT ORAL TABLET 1 MG (***iloperidone***)	3/4	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (***iloperidone***)	3/4	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (***iloperidone***)	3/4	QL (56 tablets per year.)
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG (***iloperidone***)	3	QL (8 tablets (1 pack) per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG (***iloperidone***)	3/4	QL (1 pack (12 tablets) per 365 days.)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (***iloperidone***)	3/4	QL (2 pack (8 tablets) per 365 days.)
lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg	1	QL (1 tablet per day.)
lurasidone hcl oral tablet 40 mg	1	QL (1 tablet per day)
lurasidone hcl oral tablet 80 mg	1	QL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (***pimavanserin tartrate***)	3/4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (***pimavanserin tartrate***)	3/4	PA; QL (31 tablets per month.)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	1	QL (1 tablet per day)
paliperidone er oral tablet extended release 24 hour 6 mg	1	QL (2 tablets per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	1	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	1	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (***brexpiprazole***)	3/4	QL (1 tablet per day.)
risperidone oral solution 1 mg/ml	1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
VRAYLAR ORAL CAPSULE 0.5 MG (***cariprazine hcl***)	3/4	QL (60 capsules per month.)
VRAYLAR ORAL CAPSULE 0.75 MG (***cariprazine hcl***)	3/4	QL (30 capsules per month.)
VRAYLAR ORAL CAPSULE 1.5 MG, 4.5 MG, 6 MG (***cariprazine hcl***)	3/4	QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VRAYLAR ORAL CAPSULE 3 MG (***cariprazine hcl***)	3/4	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures		
MYSOLINE ORAL TABLET 250 MG, 50 MG (***primidone***)	2	
phenobarbital oral elixir 20 mg/5ml	1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	
primidone oral tablet 125 mg, 250 mg, 50 mg	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
ascomp-codeine oral capsule 50-325-40-30 mg	1	
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
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, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
phenobarbital oral elixir 20 mg/5ml	1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	QL (1 box (2 doses/box) per prescription)
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
lorazepam intensol oral concentrate 2 mg/ml	1	
lorazepam oral concentrate 2 mg/ml	1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
midazolam hcl oral syrup 2 mg/ml	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA; QL (1 box per prescription.)
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	3/4	PA
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	3/4	PA
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (***temazepam***)	3/4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	3/4	PA
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
triazolam oral tablet 0.125 mg, 0.25 mg	1	
BUTYROPHENONES - Drugs for Depression & Psychosis		
haloperidol lactate oral concentrate 2 mg/ml	1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	
CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (***erenumab-aooe***)	2	PA; QL (1 pen per month.)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (***rimegepant sulfate***)	2	PA; QL (0.27 tablets per day. 8 tablets per prescription.)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (***atogepant***)	2	PA; QL (1 tablet per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG (***ubrogepant***)	2	PA; QL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (***zavegepant hcl***)	3/4	PA; QL (6 mg per prescription.)
CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson		
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	1	
entacapone oral tablet 200 mg	1	
tolcapone oral tablet 100 mg	1	
CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder		
acamprosate calcium oral tablet delayed release 333 mg	1	
ADDYI ORAL TABLET 100 MG (***flibanserin***)	3/4	PA; QL (1 tablet per day.)
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (***trofinetide***)	2	PA; QL (120 ml per day.)
DAYBUE STIX ORAL PACKET 5000 MG, 6000 MG, 8000 MG (***trofinetide***)	2	PA; QL (120 packets per month.)
dextromethorphan-quinidine oral capsule 20-10 mg	1	PA; QL (2 capsules per day.)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LYNKUET ORAL CAPSULE 60 MG (***elinzanetant***)	3/4	PA; QL (60 capsules per month.)
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	1	
memantine hcl oral solution 2 mg/ml	1	
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***)	3	PA; QL (1 tablet per day.)
NUEDEXTA ORAL CAPSULE 20-10 MG (***dextromethorphan-quinidine***)	2	PA; QL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
VEOZAH ORAL TABLET 45 MG (***fezolinetant***)	3/4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
bromocriptine mesylate oral tablet 2.5 mg	1	
cabergoline oral tablet 0.5 mg	1	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	PA
milnacipran hcl oral 12.5 & 25 & 50 mg	1	QL (1 pack per 365 days.)
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	QL (2 tablets per day)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	3/4	PA; QL (60 sublingual tablets per month.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	PA
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	PA
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HYDANTOINS - Drugs for Seizures		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (***phenytoin***)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (***phenytoin sodium extended***)	3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (***phenytoin***)	3	
phenytek oral capsule 200 mg, 300 mg	1	
phenytoin infatabs oral tablet chewable 50 mg	1	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
INHALATION ANESTHETICS - Anesthetics		
FORANE INHALATION SOLUTION (***isoflurane***)	2	
isoflurane inhalation solution	1	
sevoflurane inhalation solution	1	
terrell inhalation solution	1	
ULTANE INHALATION SOLUTION (***sevoflurane***)	3	
ION CHANNEL INHIBITION AGENTS - Drugs for Seizures		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (***eslicarbazepine acetate***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (***lacosamide***)	3	PA
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	PA
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (***cenobamate***)	3	PA
XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (***cenobamate***)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	PA
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
MELATONIN RECEPTOR AGONISTS - Drugs for Anxiety & Sleep Disorder		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***)	3	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	1	
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (***selegiline hcl***)	3	
MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (***rotigotine***)	3	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
NON-OPIOID ANALGESICS - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
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, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC - Drugs for Pain		
diclofenac potassium oral tablet 50 mg	1	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	1	
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	PA
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
mefenamic acid oral capsule 250 mg	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	PA
meloxicam oral tablet 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	QL (5 bottles per prescription.)
sulindac oral tablet 150 mg, 200 mg	1	
OPIOID AGONISTS (28:08) - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
ascomp-codeine oral capsule 50-325-40-30 mg	1	
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	1	NTT
diskets oral tablet soluble 40 mg	1	QL (1.5 tablets per day.)
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	PA; QL (0.34 patches per day.)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	1	PA; QL (15 patches per 31 days.)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	1	PA; QL (2 capsules per day.)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	1	PA; QL (0 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	1	PA; QL (1 tablet per day.)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	1	PA; QL (1 capsule per day.)
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	1	PA; QL (0 tablets per 100 days, diagnosis review required.)
morphine sulfate er oral tablet extended release 15 mg, 30 mg	1	PA; QL (93 tablets per 31 days.)
morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml	1	NTT
morphine sulfate oral tablet 15 mg, 30 mg	1	NTT
morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	1	NTT
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (***tapentadol hcl***)	3	PA; QL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (***tapentadol hcl***)	3	PA; QL (0 tablets per 100 days, diagnosis review required.)
opium oral tincture 10 mg/ml (1%)	1	
oxycodone hcl oral capsule 5 mg	1	NTT
oxycodone hcl oral concentrate 100 mg/5ml	1	NTT
oxycodone hcl oral solution 5 mg/5ml	1	NTT
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg	1	PA; QL (0 tablet per 100 days.)
oxymorphone hcl oral tablet 10 mg	1	QL (6 tablets per day.); NTT
oxymorphone hcl oral tablet 5 mg	1	NTT
tapentadol hcl oral tablet 100 mg, 50 mg, 75 mg	1	NTT
tramadol hcl (er biphasic) oral tablet extended release 24 hour 200 mg, 300 mg	1	QL (1 tablet per day)
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	1	QL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
REZENOPY NASAL LIQUID 10 MG/0.11ML (***naloxone hcl***)	3	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	1	SM
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (***nalmefene hcl***)	1	
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (***buprenorphine hcl***)	3	PA; QL (2 Films per day.)
BELBUCA BUCCAL FILM 750 MCG (***buprenorphine hcl***)	3	PA; QL (2 films per day.)
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	1	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	1	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	
buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr	1	PA; QL (4 patches per 28 days.)
buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr	1	PA; QL (4 patches per month.)
butorphanol tartrate nasal solution 10 mg/ml	1	QL (7.5 ml (3 bottles) per prescription.)
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PHENOTHIAZINES - Drugs for Depression & Psychosis		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	1	PA
chlorpromazine hcl oral tablet 10 mg, 25 mg	1	QL (6 tablets per day.)
chlorpromazine hcl oral tablet 100 mg, 50 mg	1	QL (4 tablets per day.)
chlorpromazine hcl oral tablet 200 mg	1	QL (2 tablets per day.)
COMPRO RECTAL SUPPOSITORY 25 MG (***prochlorperazine***)	3	
fluphenazine hcl oral concentrate 5 mg/ml	1	
fluphenazine hcl oral elixir 2.5 mg/5ml	1	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	1	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	1	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	1	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	1	
RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System		
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
ascomp-codeine oral capsule 50-325-40-30 mg	1	
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (***serdexmethylphen-dexmethylphen***)	3	QL (1 capsule per day.)
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	3/4	
caffeine citrate oral solution 60 mg/3ml	1	
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	1	QL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	1	QL (31 capsules per 31 days.)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
elixophyllin oral elixir 80 mg/15ml	3	
ergotamine-caffeine oral tablet 1-100 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (***dexmethylphenidate hcl***)	3/4	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (***methylphenidate hcl***)	3/4	QL (1 capsule per day.)
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (***methylphenidate hcl***)	3/4	
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg	1	QL (2 capsules per day.)
methylphenidate hcl er (cd) oral capsule extended release 60 mg	1	QL (31 capsules per 31 days.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg	1	QL (5capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	1	QL (3 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg	1	QL (2 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg	1	QL (31 capsules per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
salsalate oral tablet 500 mg, 750 mg	1	
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***)	3/4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***)	3/4	QL (1 capsule per day.)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (***levomilnacipran hcl***)	3/4	QL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (***levomilnacipran hcl***)	3/4	QL (28 capsules per year.)
milnacipran hcl oral 12.5 & 25 & 50 mg	1	QL (1 pack per 365 days.)
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	QL (2 tablets per day)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
SELECTIVE SEROTONIN AGONISTS - Migraine Treatment		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	1	QL (10 tablets per copay.)
eletriptan hydrobromide oral tablet 20 mg, 40 mg	1	QL (10 tablets per copay.)
frovatriptan succinate oral tablet 2.5 mg	1	QL (10 tablets per copay.)
naratriptan hcl oral tablet 1 mg, 2.5 mg	1	QL (10 per prescription.)
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	QL (10 tablets per copay.)
rizatriptan benzoate oral tablet dispersible 10 mg	1	QL (10 per prescription.)
rizatriptan benzoate oral tablet dispersible 5 mg	1	QL (10 tablets per copay.)
sumatriptan nasal solution 20 mg/act, 5 mg/act	1	QL (6 spray bottles per prescription)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	QL (10 tablets per prescription.)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	QL (2 kits per prescription)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	1	QL (2 kits per prescription)
zolmitriptan oral tablet 2.5 mg, 5 mg	1	QL (10 tablets per copay.)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	1	QL (10 tablets per copay.)
ZOMIG NASAL SOLUTION 2.5 MG (***zolmitriptan***)	3	QL (6 units per prescription.)
ZOMIG NASAL SOLUTION 5 MG (***zolmitriptan***)	1	QL (1 box per prescription)
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
citalopram hydrobromide oral solution 10 mg/5ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
escitalopram oxalate oral solution 5 mg/5ml	1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	1	QL (4 capsules per 28 days.)
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	1	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	1	
paroxetine hcl oral suspension 10 mg/5ml	1	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
sertraline hcl oral concentrate 20 mg/ml	1	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	1	
SEROTONIN MODULATORS - Drugs for Depression & Psychosis		
EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG (***gepirone hcl***)	3/4	QL (31 tablets per month.)
EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG (***gepirone hcl***)	3/4	QL (31 tablets per month.)
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	1	
RALDESY ORAL SOLUTION 10 MG/ML (***trazodone hcl***)	3/4	PA
trazodone hcl oral tablet 100 mg, 150 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (***vortioxetine hbr***)	3/4	QL (1 tablet per day.)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	1	
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (***methsuximide***)	3/4	
ethosuximide oral capsule 250 mg	1	
ethosuximide oral solution 250 mg/5ml	1	
methsuximide oral capsule 300 mg	1	
ZARONTIN ORAL CAPSULE 250 MG (***ethosuximide***)	3/4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (***ethosuximide***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (***deutetrabenazine***)	2	PA; QL (30 tablets per month.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (***deutetrabenazine***)	2	PA; QL (30 Tablets per month.)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (***deutetrabenazine***)	2	PA; QL (1 kit (28 tablets) per year.)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day.)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (30 capsules per month.)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (***valbenazine tosylate***)	2	PA; QL (1 kit (28 capsules) per year.)
tetrabenazine oral tablet 12.5 mg, 25 mg	1	PA
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
armodafinil oral tablet 150 mg, 250 mg	1	QL (1 tablet per day)
armodafinil oral tablet 200 mg	1	QL (1 tablet per day.)
armodafinil oral tablet 50 mg	1	QL (2 tablets per day.)
diclofenac sodium oral tablet delayed release 75 mg	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
modafinil oral tablet 100 mg, 200 mg	1	QL (3 tablets per day.)
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
SUNOSI ORAL TABLET 150 MG, 75 MG (***solriamfetol hcl***)	2	PA; QL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (***pitolisant hcl***)	3/4	PA; QL (2 tablets per day.)
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
FLUORIDEX DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PEN NEEDLE 32G X 5 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	QL (10 pen needles per day.)
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUTOKEEPER SAFETY PEN NEEDLE 30G X 5 MM , 30G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUTOLET LANCING DEVICE (***lancet devices***)	3	QL (1 device per prescription.)
AUTOLET LITE LANCING DEVICE (***lancet devices***)	3	QL (1 device per prescription.)
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD BLUNT FILL NEEDLE 18G X 1" (***needle (disp)***)	2	
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (***needle (disp)***)	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (***needle (disp)***)	2	
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD SAFETYGLIDE NEEDLE 23G X 1-1/2" (***needle (disp)***)	2	
BD SHARPS COLLECTOR (***sharps container***)	3	
BD ULTRA-FINE INSULIN SYRINGES 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
CLEVER CHOICE COMFORT EZ PLUS 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
COMFORT TOUCH TWIST LANCET 30G (***lancets***)	3	
CONTOUR CONTROL IN VITRO LIQUID HIGH (***blood glucose calibration***)	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (***blood glucose calibration***)	2	
CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (***blood glucose calibration***)	2	
CONTOUR NEXT EZ KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT EZ KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT GEN MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT ONE KIT (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT ONE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.); SM
CONTOUR PLUS BLUE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DEXCOM G6 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G6 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DEXCOM G6 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (1 transmitter per 3 months for Dexcom G6 Transmitter.); SM
DEXCOM G7 15 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
DEXCOM G7 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G7 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DIABETES MONITOR DIGIT ADD-ON KIT	3	QL (1 meter or meter kit per year.)
DIABETES MONITOR DIGIT SOLN KIT	3	QL (1 meter or meter kit per year.)
DROPLET MEDLANCE LANCET 30G (***lancets***)	3	
DROPLET MICRON 34G X 3.5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE ACTI-LANCE 23G (***lancets***)	3	
DROPSAFE ACTI-LANCE LANCET 17G (***lancets***)	3	
DROPSAFE ACTI-LANCE LANCET 23G (***lancets***)	3	
DROPSAFE ACTI-LANCE LANCET 28G (***lancets***)	3	
DROPSAFE AUTOPROTECT DUO 31G X 4 MM , 31G X 5 MM , 31G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE ERGOLANCE LANCET 21G (***lancets***)	3	
DROPSAFE ERGOLANCE LANCET 25G (***lancets***)	3	
DROPSAFE ERGOLANCE LANCET 30G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 1.5 (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 18G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 21G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 25G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 28G (***lancets***)	3	
DROPSAFE MEDISAFE LANCET 23G (***lancets***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DROPSAFE MEDISAFE LANCET 29G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 0.8MM (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 21G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 25G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 30G (***lancets***)	3	
DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
DROPSAFE SICURA 25G X 1" , 25G X 5/8" (***needle (disp)***)	2	
EASIVENT (***spacer/aero-holding chambers***)	2	SM
EASY COMFORT SHARPS CONTAINER	3	
EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (***blood glucose calibration***)	3	
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (***blood glucose calibration***)	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL (***blood glucose calibration***)	3	
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (***blood glucose calibration***)	3	
EMBECTA AUTOSHIELD DUO 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYR ULTRAFINE 29G X 1/2" 0.5 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 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBRACE WAVE GLUCOSE CONTROL IN VITRO LIQUID HIGH (***blood glucose calibration***)	2	
ENLITE GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; SM
FLEXICHAMBER ADULT MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/LARGE (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	QL (1 device per prescription.)
FONDCIRCLE SINGLE USE LANCETS	3	
FORA TEST N' GO ADVANCE DEVICE (***blood glucose/ketone monitor***)	3	
FREESTYLE LIBRE 14 DAY READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 14 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 2 PLUS SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 2 READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 receiver per 999 days.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INSPIREASE RESERVOIR BAGS (***spacer/aero-hold chamber bags***)	2	SM
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM , 34G X 3.5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
INSULIN PEN NEEDLES 29G X 4MM , 29G X 5MM , 30G X 5 MM , 30G X 8 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM	2	QL (10 pen needles per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)	2	QL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)	2	QL (10 syringes per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 1 ML, 31G X 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, 32G X 5/16" 1 ML (***insulin syringe-needle u-100***)	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	2	QL (10 syringes per day.)
INSUPEN32G EXTR3ME 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
KT TAPE CGM PATCH (***continuous glucose monitor sup***)	3	PA; SM
LANCETS (***lancets***)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (***lancets***)	3	
MICROLET NEXT LANCETS (***lancets***)	3	
MICROLET NEXT LANCING DEVICE (***lancet devices***)	3	QL (1 device per prescription.)
MINIMED INSTINCT GLUC SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MOBI CONNECT LANCING DEVICE (***lancet devices***)	3	QL (1 device per prescription.)
MOBI CONNECT TWIST LANCETS (***lancets***)	3	
MOBILE LANCETS 30G	3	
NORDIPEN 5 INJECTION DEVICE (***injection device***)	3	
NOVOFINE PEN NEEDLE 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
NOVOPEN ECHO DEVICE (***injection device for insulin***)	3	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 180 days.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (***insulin disposable pump***)	2	PA; QL (10 pods (2 boxes) per copay.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (***insulin disposable pump***)	2	PA; QL (10 pods per prescription.)
OMNIPOD 5 LIBRE INTRO KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 2 years.)
OMNIPOD 5 LIBRE PODS (***insulin disposable pump***)	2	PA; QL (10 pods (2 boxes) per copay.)
ONETOUCH DELICA PLUS LANCING (***lancet devices***)	1	QL (1 device per prescription.)
ONETOUCH DELICA SAFETY LANCING (***lancets***)	1	
ONETOUCH ULTRA IN VITRO LIQUID (***blood glucose calibration***)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (***blood glucose calibration***)	1	
PARI VORTEX ADULT MASK (***spacer/aero-hold chamber mask***)	2	SM
PARI VORTEX PEDIATRIC MASK (***spacer/aero-hold chamber mask***)	2	SM
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 METRIX LEVEL 3 IN VITRO SOLUTION HIGH (***blood glucose calibration***)	2	
TWIIST REFILL KIT KIT (***insulin disposable pump***)	2	PA; QL (1 kit per copay.)
TWIIST REFILL KIT/INFUSION SET KIT (***insulin disposable pump***)	2	PA; QL (1 kit per copay.)
TWIIST STARTER KIT KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 730 days.)
ULTRA-CARE SAFETY LANCETS 30G	3	
UNIFINE OTC PEN NEEDLES 31G X 5 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
UNISTRIP CONTROL IN VITRO SOLUTION LOW (***blood glucose calibration***)	3	
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 23G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 28G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 30G (***lancets***)	3	
VERIFINE SHARPS CONTAINER (***sharps container***)	3	
VERISAFE SAFETY INSULIN SYR 29G X 1/2" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (***needle (disp)***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***lancets***)	3	
VIVAGUARD LANCING DEVICE (***lancet devices***)	3	QL (1 device per prescription.)
VIVAGUARD SAFETY LANCETS 28G (***lancets***)	3	
VORTEX VALVE CHAMBER-PEDI MASK DEVICE (***spacer/aero-holding chambers***)	2	SM
VORTEX VALVED HOLDING CHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; SP; SMCS
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (***cosyntropin***)	3/4	
cosyntropin injection solution reconstituted 0.25 mg	1	
CARDIAC FUNCTION		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
DIABETES MELLITUS		
ACCU-CHEK GUIDE TEST IN VITRO STRIP (***glucose blood***)	2	QL (51 strips per prescription without history 204 strips per prescription with history.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 IN VITRO STRIP (***glucose blood***)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR NEXT TEST IN VITRO STRIP (***glucose blood***)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR PLUS TEST IN VITRO STRIP (***glucose blood***)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
FORA TEST N'GO ADV-VOICE-6 CON IN VITRO STRIP (***ketone blood test***)	3	
RELION GLUCOSE TEST STRIPS IN VITRO STRIP (***glucose blood***)	3/4	QL (51 strips per prescription without history 204 strips per prescription with history.)
KETONES		
CHEMSTRIP K IN VITRO STRIP (***acetone (urine) test***)	2	
KETOSTIX IN VITRO STRIP (***acetone (urine) test***)	2	
PHEOCHROMOCYTOMA		
metyrosine oral capsule 250 mg	1	PA
PITUITARY FUNCTION		
METOPIRONE ORAL CAPSULE 250 MG (***metyrapone***)	3	
SUGAR		
DIASTIX REAGENT IN VITRO STRIP (***glucose urine test-glucose ox***)	3	
URINE AND FECES CONTENTS		
CHEMSTRIP UGK IN VITRO STRIP (***urine glucose-ketones test***)	3	
KETO-DIASTIX IN VITRO STRIP (***urine glucose-ketones test***)	3	
KETONE CARE IN VITRO STRIP (***urine glucose-ketones test***)	2	
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
formaldehyde external solution 37 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
glutaraldehyde external solution 25 %	1	
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
ACIDIFYING AGENTS		
K-PHOS NO 2 ORAL TABLET 305-700 MG (***pot & sod ac phosphates***)	2	
ALKALINIZING AGENTS		
cytra k crystals oral packet 3300-1002 mg	1	
ORACIT ORAL SOLUTION 490-640 MG/5ML (***sod citrate-citric acid***)	2	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	1	
potassium citrate-citric acid oral solution 1100-334 mg/5ml	1	
sod citrate-citric acid oral solution 500-334 mg/5ml	1	
tricitrates oral solution 550-500-334 mg/5ml	1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (***potassium citrate***)	3/4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (***potassium citrate***)	3/4	
AMMONIA DETOXICANTS		
carglumic acid oral tablet soluble 200 mg	1	PA; SP; SMCS
constulose oral solution 10 gm/15ml	1	
enulose oral solution 10 gm/15ml	1	
generlac oral solution 10 gm/15ml	1	
glycerol phenylbutyrate oral liquid 1.1 gm/ml	1	PA; QL (17.5 ml per day.)
KRISTALOSE ORAL PACKET 10 GM, 20 GM (***lactulose***)	3	
lactulose encephalopathy oral solution 10 gm/15ml	1	
lactulose oral packet 20 gm	1	
lactulose oral solution 10 gm/15ml, 20 gm/30ml	1	
LITHOSTAT ORAL TABLET 250 MG (***acetohydroxamic acid***)	3	
sodium phenylbutyrate oral powder 3 gm/tsp	1	PA
sodium phenylbutyrate oral tablet 500 mg	1	PA
CALORIC AGENTS - Drugs for Nutrition		
DOJOLVI ORAL LIQUID 100 % (***triheptanoin***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CARBONIC ANHYDRASE INHIBITORS (40:28) - Drugs for Water Balance		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
DIURETICS, MISCELLANEOUS - Drugs for Water Balance		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
LOOP DIURETICS (40:28) - Drugs for Water Balance		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (***bumetanide***)	3/4	PA; QL (12 nasal sprays per copay.)
ethacrynic acid oral tablet 25 mg	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (***furosemide***)	3/4	PA
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	3/4	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (40:28) - Drugs for Water Balance		
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OTHER ION-REMOVING AGENTS		
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
PHOSPHATE-REMOVING AGENTS		
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
calcium acetate oral tablet 667 mg	1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
sevelamer carbonate oral tablet 800 mg	1	
VELPHORO ORAL TABLET CHEWABLE 500 MG (***sucroferric oxyhydroxide***)	3/4	
XPHOZAH ORAL TABLET 20 MG, 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-REMOVING AGENTS		
LOKELMA ORAL PACKET 10 GM (***sodium zirconium cyclosilicate***)	3	PA; QL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM (***sodium zirconium cyclosilicate***)	3	PA; QL (3 packets per day.)
sodium polystyrene sulfonate combination suspension 15 gm/60ml	1	
sodium polystyrene sulfonate oral powder	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (***sodium polystyrene sulfonate***)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (***sodium polystyrene sulfonate***)	3	
VELTASSA ORAL PACKET 1 GM (***patiromer sorbitex calcium***)	3	PA; QL (124 packets per month.)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (***patiromer sorbitex calcium***)	3	PA; QL (1 Packet per day.)
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance		
amiloride hcl oral tablet 5 mg	1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
REPLACEMENT PREPARATIONS		
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
calcium acetate oral tablet 667 mg	1	
EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (***potassium bicarb-citric acid***)	2	
effer-k oral tablet effervescent 25 meq	1	
GALZIN ORAL CAPSULE 25 MG, 50 MG (***zinc acetate (oral)***)	3	
klor-con 10 oral tablet extended release 10 meq	1	
klor-con m10 oral tablet extended release 10 meq	1	
klor-con m15 oral tablet extended release 15 meq	1	
klor-con m20 oral tablet extended release 20 meq	1	
klor-con oral packet 20 meq	1	
klor-con oral tablet extended release 8 meq	1	
K-PHOS ORAL TABLET 500 MG (***potassium phosphate monobasic***)	2	
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (***k phos mono-sod phos di & mono***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	SM
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (***k phos mono-sod phos di & mono***)	2	
phosphorous oral tablet 155-852-130 mg	1	
phospho-trin 250 neutral oral tablet 155-852-130 mg	1	
PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION 22-4-1 MEQ-MMOL/L	3	
PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5-1 MEQ-MMOL/L	3	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq	1	
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	1	
potassium chloride oral packet 20 meq	1	
potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)	1	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION 22-4 MEQ/L (***bicarb-dextrose-k (crrt)***)	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION 32-2.5 MEQ/L (***bicarb-dextrose-ca (crrt)***)	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION 32-2 MEQ/L (***bicarb-dextrose-k (crrt)***)	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION 32-2-3.5 MEQ/L (***bicarb-dextrose-k-ca (crrt)***)	3	
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION 32-4-1.2 MEQ/L (***bicarb-dextose-k-mg (crrt)***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5 MEQ/L (***bicarb-dextrose-k-ca (crrt)***)	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION 32-1.2 MEQ/L (***bicarb-mg (crrt)***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (***copper histidinate***)	3/4	PA; QL (30 single-dose vials per month.); SP; SMCS
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***hydrochlorothiazide***)	3/4	PA
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***)	3/4	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
THIAZIDE-LIKE DIURETICS (40:28) - Drugs for Water Balance		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
URICOSURIC AGENTS		
colchicine-probenecid oral tablet 0.5-500 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	QL (10 tablets per course of therapy.)
probenecid oral tablet 500 mg	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (***tolvaptan (hyponatremia)***)	3/4	PA; QL (90 tablets per 365 days.); SP; SMCS
SAMSCA ORAL TABLET 30 MG (***tolvaptan (hyponatremia)***)	3/4	PA; QL (60 tyablets per 365 days.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
tolvaptan (hyponatremia) oral tablet 15 mg	1	PA; QL (90 tablets per 365 days.)
tolvaptan (hyponatremia) oral tablet 30 mg	1	PA; QL (60 tablets per 365 days.)
tolvaptan oral tablet 15 mg, 30 mg	1	PA
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	1	PA; QL (2 tablets per day.)
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (***arimoclomol citrate***)	3/4	PA; QL (90 capsules per month.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day)
SEPHIENCE ORAL PACKET 1000 MG (***sepiapterin***)	3/4	PA; QL (186 packets per month.)
SEPHIENCE ORAL PACKET 250 MG (***sepiapterin***)	3/4	PA; QL (682 packets per month.)
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
HARLIKU ORAL TABLET 2 MG (***nitisinone (aku)***)	3/4	PA; QL (31 tablets per month.)
miglustat oral capsule 100 mg	1	
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; QL (7 mL per year.); SP; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; QL (6 syringes per 365 days.); SP; SMCS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (***pegvaliase-pqpz***)	3	PA; QL (1 ml per day.); SP; SMCS
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***dornase alfa***)	2	PA; QL (5 ml per day.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	QL (90 grams per prescription.)
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML (***asfotase alfa***)	2	PA; QL (12 vials per month.); SP; SMCS
SUCRAID ORAL SOLUTION 8500 UNIT/ML (***sacrosidase***)	2	PA; SP; SMCS
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***pancrelipase (lip-prot-amyl)***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (***brimonidine tartrate***)	1	QL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	3/4	QL (10 ml per prescription)
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate external gel 0.33 %	1	PA; QL (30 grams per prescription.)
brimonidine tartrate ophthalmic solution 0.15 %	1	QL (10 ml per prescription)
brimonidine tartrate ophthalmic solution 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	QL (5 ml per prescription)
IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***)	3	
ANTIALLERGIC AGENTS - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
epinastine hcl ophthalmic solution 0.05 %	1	QL (5 ml per prescription)
olopatadine hcl nasal solution 0.6 %	1	
ANTIBACTERIALS (52:04) - Drugs for Infections		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	QL (30 grams per prescription.)
AZASITE OPHTHALMIC SOLUTION 1 % (***azithromycin***)	3	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BESIFLOXACIN HCL OPHTHALMIC SUSPENSION 0.6 %	3	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (***besifloxacin hcl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CETRAXAL OTIC SOLUTION 0.2 % (***ciprofloxacin hcl***)	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (***ciprofloxacin hcl***)	3	
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	3/4	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
ciprofloxacin hcl otic solution 0.2 %	1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (***neomycin-colist-hc-thonzonium***)	3	
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin ophthalmic ointment 5 mg/gm	1	H-N
gatifloxacin ophthalmic solution 0.5 %	1	
gentamicin sulfate external cream 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate external ointment 0.1 %	1	QL (30 grams per prescription.)
gentamicin sulfate ophthalmic solution 0.3 %	1	QL (15 ml per prescription.)
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
MITOSOL OPHTHALMIC KIT 0.2 MG (***mitomycin***)	3	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin otic solution 0.3 %	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sulfacetamide sodium ophthalmic solution 10 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	QL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	QL (3.5 grams per prescription.)
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA; QL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (***loteprednol-tobramycin***)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (***natamycin***)	3	
ANTI-INFECTIVES, MISCELLANEOUS (52:04) - Drugs for Infections		
ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % (***silver nitrate-pot nitrate***)	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (***povidone-iodine***)	3	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (***pramoxine-chloroxylenol***)	3	
silver nitrate external solution 0.5 %	1	
XDEMVY OPHTHALMIC SOLUTION 0.25 % (***lotilaner***)	3/4	PA; QL (10 ml per 63 days.)
ANTI-INFLAMMATORY AGENTS (EENT) - Drugs for Inflammation		
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (***perfluorohexyloctane***)	3/4	PA; QL (1 bottle per month.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	3/4	PA; QL (60 vials per month.)
ANTIVIRALS (EENT) - Drugs for Infections		
trifluridine ophthalmic solution 1 %	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ASTRINGENTS (52:04) - Drugs for Infections		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye		
betaxolol hcl ophthalmic solution 0.5 %	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	QL (5 ml per prescription.)
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	QL (5 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	3/4	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	QL (5 ml per prescription.)
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
CARBONIC ANHYDRASE INHIBITORS (52:40) - Drugs for the Eye		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
brinzolamide ophthalmic suspension 1 %	1	QL (10 ml per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	3/4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
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
ALREX OPHTHALMIC SUSPENSION 0.2 % (***loteprednol etabonate***)	3/4	QL (5 ml per prescription)
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	3/4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (***neomycin-colist-hc-thonzonium***)	3	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	QL (118.28 ml per prescription.)
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	1	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	1	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (***loteprednol etabonate***)	3/4	QL (8.3 mL per prescription)
FLAREX OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone acetate***)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluocinolone acetonide body external oil 0.01 %	1	QL (118.28 ml per prescription.)
fluocinolone acetonide external cream 0.01 %	1	QL (15 grams per prescription.)
fluocinolone acetonide external cream 0.025 %	1	QL (120 grams per copay.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fluocinolone acetonide external ointment 0.025 %	1	QL (120 grams per copay.)
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (***fluorometholone***)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone***)	3/4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (***loteprednol etabonate***)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (***loteprednol etabonate***)	3	QL (5 grams per prescription.)
loteprednol etabonate ophthalmic suspension 0.2 %	1	QL (5 ml per prescription)
loteprednol etabonate ophthalmic suspension 0.5 %	1	QL (5 ml per prescription.)
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (***dexamethasone***)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	QL (34 grams (2 bottles) per copay.)
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 30 mg	1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (***dexamethasone***)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 % (***loteprednol-tobramycin***)	3	
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	3/4	PA; QL (60 vials per month.)
EENT DRUGS, MISCELLANEOUS		
acetic acid otic solution 2 %	1	
apraclonidine hcl ophthalmic solution 0.5 %	1	
AQUORAL MOUTH/THROAT SOLUTION (***artificial saliva***)	3	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (***sulfuric acid-sulf phenolics***)	2	
hydrocortisone-acetic acid otic solution 1-2 %	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***)	3	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (***perfluorohexyloctane***)	3/4	PA; QL (1 bottle per month.)
MUCOSITISRX MOUTH/THROAT PACKET (***artificial saliva***)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP; SMCS
TRYPTYR OPHTHALMIC SOLUTION 0.003 % (***acoltremon***)	3/4	PA; QL (60 vials per month.)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	3/4	PA; QL (0.28 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	3/4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	1	
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (***nepafenac***)	3/4	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	QL (5 bottles per prescription.)
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (***lidocaine hcl***)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (***proparacaine hcl***)	3	
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
lidocaine hcl mouth/throat solution 4 %	1	
lidocaine viscous hcl mouth/throat solution 2 %	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (***pramoxine-chloroxylenol***)	3	
proparacaine hcl ophthalmic solution 0.5 %	1	
tetracaine hcl ophthalmic solution 0.5 %	1	
MACULAR DEGENERATION AGENTS		
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	3/4	PA; QL (20 mL per 21 days); SP; SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SP; SMCS
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (***echothiophate iodide***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	3/4	
MYDRIATICS - Drugs for the Eye		
atropine sulfate ophthalmic solution 1 %	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (***cyclopentolate hcl***)	3/4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
cyclopentolate hcl ophthalmic solution 1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
OSMOTIC AGENTS - Drugs for the Eye		
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
bimatoprost ophthalmic solution 0.03 %	1	QL (2.5 ml per prescription.)
bimatoprost solution 0.01 % ophthalmic	1	QL (2.5 mL per copay.)
latanoprost ophthalmic solution 0.005 %	1	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	QL (2.5 mL per prescription.)
tafluprost (pf) ophthalmic solution 0.0015 %	1	QL (30 unit of use droppers per prescription.)
travoprost (bak free) ophthalmic solution 0.004 %	1	QL (2.5 ml per prescription)
XELPROS OPHTHALMIC EMULSION 0.005 % (***latanoprost***)	3	QL (2.5 ml per prescription.)
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (***tafluprost***)	3	QL (30 unit of use droppers per prescription.)
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***)	3	QL (2.5 ml per prescription.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	QL (2.5 mL per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
oxymetazoline hcl external cream 1 %	1	PA; QL (30 grams per prescription.)
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA; QL (30 grams per prescription.)
UPNEEQ OPHTHALMIC SOLUTION 0.1 % (***oxymetazoline hcl***)	3/4	PA; QL (30 single-use vials per prescription.)
GASTROINTESTINAL DRUGS		
CHLORIDE CHANNEL ACTIVATORS		
lubiprostone oral capsule 24 mcg, 8 mcg	1	PA; QL (2 capsules per day.)
GUANYLATE CYCLASE C (GCC) RECEPT AGONIST		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***)	2	PA; QL (1 capsule per day.)
IMMUNOMODULATORY AGENTS (56:44)		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 auto-injector) per month.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 prefilled syringe) per month.)
OPIOID ANTAGONISTS (56:18)		
alvimopan oral capsule 12 mg	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	PA; QL (0.6 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	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***)	3/4	QL (1 capsule per prescription.)
granisetron hcl oral tablet 1 mg	1	
GRANISOL ORAL SOLUTION 2 MG/10ML (***granisetron hcl***)	3	
ondansetron hcl oral solution 4 mg/5ml	1	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	
ondansetron odt oral tablet dispersible 4 mg, 8 mg	1	
ANTIDIARRHEA AGENTS - Drugs for Diarrhea		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***)	3/4	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (***crofelemer***)	3/4	PA; QL (2 tablets per day.)
opium oral tincture 10 mg/ml (1%)	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
XERMELO ORAL TABLET 250 MG (***telotristat etiprate***)	3	PA; QL (3 tablets per day.)
ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	PA; QL (4 ml per day.)
ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
COMPRO RECTAL SUPPOSITORY 25 MG (***prochlorperazine***)	3	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	
trimethobenzamide hcl oral capsule 300 mg	1	
ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation		
alosetron hcl oral tablet 0.5 mg, 1 mg	1	PA; QL (2 tablets per day)
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (***mesalamine***)	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
balsalazide disodium oral capsule 750 mg	1	
DIPENTUM ORAL CAPSULE 250 MG (***olsalazine sodium***)	3	
mesalamine oral capsule delayed release 400 mg	1	
mesalamine oral tablet delayed release 1.2 gm	1	
mesalamine rectal enema 4 gm	1	QL (28 bottles per month.)
mesalamine rectal suppository 1000 mg	1	QL (1 suppository per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
mesalamine-cleanser rectal kit 4 gm	1	QL (4 kits per month.)
ROWASA RECTAL KIT 4 GM (***mesalamine-cleanser***)	3/4	QL (4 kits per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
ANTIULCER AGENTS AND ACID SUPPRESSANTS - Drugs for Ulcers and Stomach Acid		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
CATHARTICS AND LAXATIVES - Drugs for Constipation		
bisacodyl ec oral tablet delayed release 5 mg	E	H
clearlax oral powder 17 gm/scoop	E	H
ft clearlax oral powder 17 gm/scoop	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ft laxative oral tablet delayed release 5 mg	E	H
ft magnesium citrate oral solution 1.745 gm/30ml	E	H
gavilax oral powder 17 gm/scoop	E	H
gavilyte-c oral solution reconstituted 240 gm	E	H
gavilyte-g oral solution reconstituted 236 gm	E	H
gavilyte-n with flavor pack oral solution reconstituted 420 gm	E	H
gentle laxative oral tablet delayed release 5 mg	E	H
glycolax oral powder 17 gm/scoop	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (***peg 3350-kcl-nabcb-nacl-nasulf***)	E	H
goodsense clearlax oral powder 17 gm/scoop	E	H
laxative osmotic oral powder 17 gm/scoop	E	H
magnesium citrate oral solution 1.745 gm/30ml	E	H
mm clearlax oral powder 17 gm/scoop	E	H
peg 3350 oral powder 17 gm/scoop	E	H
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	E	H
peg-3350/electrolytes oral solution reconstituted 236 gm	E	H
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
smooth lax oral powder 17 gm/scoop	E	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.)
CTEXLI ORAL TABLET 250 MG (***chenodiol (basds)***)	3/4	PA; QL (93 tablets per month.)
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	3/4	PA; QL (31 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LIVDELZI ORAL CAPSULE 10 MG (***seladelpar lysine***)	3/4	PA; QL (30 capsules per month.)
LIVMARLI ORAL SOLUTION 19 MG/ML (***maralixibat chloride***)	3/4	PA; QL (60 mL (1140 mg) per month.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	3/4	PA; QL (4 mL per day.)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (***maralixibat chloride***)	3/4	PA; QL (60 tablets per month.)
LIVMARLI ORAL TABLET 30 MG (***maralixibat chloride***)	3/4	PA; QL (30 tablets per month.)
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
DIGESTANTS - Drugs for the Stomach		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; QL (1 vial per day.); SP; SMCS
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
DOPAMINE RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
GI DRUGS, MISCELLANEOUS - Drugs for the Stomach		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
alvimopan oral capsule 12 mg	1	
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled cartridge (180 mg) every 8 weeks after induction.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled cartridge (360 mg) every 8 weeks after induction.)
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day.)
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	PA; QL (4 ml per day.)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	3/4	PA; QL (12 capsules per 365 days.)
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
scopolamine transdermal patch 72 hour 1 mg/3days	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	3/4	QL (1 capsule per prescription.)
aprepitant oral capsule 125 mg, 40 mg	1	QL (1 capsule per prescription)
aprepitant oral capsule 80 mg	1	QL (2 capsules per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aprepitant oral capsule therapy pack 80 & 125 mg	1	QL (3 capsules per prescription)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (***aprepitant***)	2	QL (3 pouches per prescription.)
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (60 tablets per month and 60 tablets per year.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
PROKINETIC AGENTS - Drugs for the Stomach		
metoclopramide hcl oral solution 5 mg/5ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
REGLAN ORAL TABLET 10 MG, 5 MG (***metoclopramide hcl***)	3/4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (***misoprostol***)	3/4	SM
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	1	
misoprostol oral tablet 100 mcg, 200 mcg	1	SM
PROTECTANTS - Drugs for Ulcers and Stomach Acid		
sucralfate oral suspension 1 gm/10ml	1	
sucralfate oral tablet 1 gm	1	
PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid		
esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg	1	PA; QL (1 packet per day.)
esomeprazole magnesium oral packet 40 mg	1	PA; QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (***lansoprazole***)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	1	PA; QL (1 tablet per day.)
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
rabeprazole sodium oral tablet delayed release 20 mg	1	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (60 tablets per month and 60 tablets per year.)
GOLD COMPOUNDS		
GOLD COMPOUNDS		
AURANOFIN ORAL CAPSULE 3 MG	3	
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	1	PA
deferiprone oral tablet 1000 mg, 500 mg	1	PA
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
FERRIPROX ORAL SOLUTION 100 MG/ML (***deferiprone***)	2	PA
FERRIPROX ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
penicillamine oral tablet 250 mg	1	
trientine hcl oral capsule 250 mg, 500 mg	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (***setmelanotide acetate***)	3	PA; QL (9 mls per month.); SP; SMCS
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	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
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
budesonide oral capsule delayed release particles 3 mg	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
EOHILIA ORAL SUSPENSION 2 MG/10ML (***budesonide***)	3/4	PA; QL (20 grams per day.)
fludrocortisone acetate oral tablet 0.1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	QL (60 ml per prescription.)
fluticasone propionate external ointment 0.005 %	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
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	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INTRAROSA VAGINAL INSERT 6.5 MG (***prasterone***)	3/4	PA; QL (1 insert per day.)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (***methylprednisolone***)	3/4	
MEDROL ORAL TABLET 2 MG (***methylprednisolone***)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (***methylprednisolone***)	3/4	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	QL (34 grams (2 bottles) per copay.)
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 30 mg	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	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
procto-med hc external cream 2.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROCTOSOL HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (***dexamethasone***)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***)	3	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (***budesonide***)	3/4	PA; QL (4 capsules per day.)
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (***budesonide***)	1	
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
ALPHA-GLUCOSIDASE INHIBITORS - Drugs for Diabetes		
acarbose oral tablet 100 mg, 25 mg, 50 mg	1	
miglitol oral tablet 100 mg, 25 mg, 50 mg	1	
ANDROGENS - Hormones		
COVARYX HS ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
COVARYX ORAL TABLET 1.25-2.5 MG (***est estrogens-methyltest***)	2	
danazol oral capsule 100 mg, 200 mg, 50 mg	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
EEMT HS ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
EEMT ORAL TABLET 1.25-2.5 MG (***est estrogens-methyltest***)	2	
est estrogens-methyltest ds oral tablet 1.25-2.5 mg	1	
est estrogens-methyltest hs oral tablet 0.625-1.25 mg	1	
est estrogens-methyltest oral tablet 1.25-2.5 mg	1	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	3/4	PA; QL (4 capsules per day.); SM
METHITEST ORAL TABLET 10 MG	2	SM
methyltestosterone oral capsule 10 mg	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone gel 20.25 mg/act (1.62%) transdermal	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
CYCLOSET ORAL TABLET 0.8 MG (***bromocriptine mesylate***)	3	
mifepristone oral tablet 300 mg	1	PA; QL (4 tablets per day.); SP; SMCS
ANTIESTROGENS - Drugs for Women		
anastrozole oral tablet 1 mg	1	H-N
exemestane oral tablet 25 mg	1	H-N
letrozole oral tablet 2.5 mg	1	H-N
ANTIGONADTROPINS - Hormones		
aftera oral tablet 1.5 mg	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (***cetrorelix acetate***)	3/4	PA; QL (14 cartons per 21 days.)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
econtra one-step oral tablet 1.5 mg	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***ganirelix acetate***)	3	QL (7 ml per 21 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml	1	QL (7 ml per 21 days.)
her style oral tablet 1.5 mg	1	H
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	3/4	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***)	3	PA; QL (1 tablet per day); CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
ORILISSA ORAL TABLET 150 MG (***elagolix sodium***)	2	PA; QL (1 tablet per day.)
ORILISSA ORAL TABLET 200 MG (***elagolix sodium***)	2	PA; QL (2 tablets per day.)
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
shewise oral tablet 1.5 mg	1	H
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
take action oral tablet 1.5 mg	1	H
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone gel 20.25 mg/act (1.62%) transdermal	1	PA; QL (150 grams (2 pumps) per month.); SM
your choice oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (***diazoxide***)	3/4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
calcitonin (salmon) injection solution 200 unit/ml	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg	1	
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***)	3	
ANTITHYROID AGENTS - Drugs for the Thyroid		
iodine strong oral solution 5 %	1	
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	1	
BIGUANIDES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	QL (3 tablets per day)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***)	2	QL (1 tablet per day.)
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	1	
metformin hcl oral solution 500 mg/5ml	1	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
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.)
CONTRACEPTIVES - Drugs for Women		
afirmelle oral tablet 0.1-20 mg-mcg	1	H
aftera oral tablet 1.5 mg	1	H
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (***segesterone-ethinyl estradiol***)	3	QL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 &0.01 mg	1	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	E	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	1	H
camrese oral tablet 0.15-0.03 &0.01 mg	1	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
cryselle oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 &0.01 mg	1	H
deblitane oral tablet 0.35 mg	1	H
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL per 365 days.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
econtra one-step oral tablet 1.5 mg	1	H
elinest oral tablet 0.3-30 mg-mcg	1	H
ELLA ORAL TABLET 30 MG (***ulipristal acetate***)	1	QL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
emzahh oral tablet 0.35 mg	1	H
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H
errin oral tablet 0.35 mg	1	H
estarylla oral tablet 0.25-35 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H
gemmily oral capsule 1-20 mg-mcg(24)	1	H
hailey 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey 24 fe oral tablet 1-20 mg-mcg(24)	1	H
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey fe 1/20 oral tablet 1-20 mg-mcg	1	H
heather oral tablet 0.35 mg	1	H
her style oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
luizza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
luizza 1/20 oral tablet 1-20 mg-mcg	1	H
lutera oral tablet 0.1-20 mg-mcg	1	H
lyleq oral tablet 0.35 mg	1	H
lyza oral tablet 0.35 mg	1	H
marlissa oral tablet 0.15-30 mg-mcg	1	H
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	1	QL (5 ml per year.); H; SM
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
meleya oral tablet 0.35 mg	1	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (***estradiol valerate-dienogest***)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEXTSTELLIS ORAL TABLET 3-14.2 MG (***drospirenone-estetrol***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg	1	H
norlyroc oral tablet 0.35 mg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
OPILL ORAL TABLET 0.075 MG (***norgestrel***)	1	H
option 2 oral tablet 1.5 mg	1	H
orquidea oral tablet 0.35 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	H
sharobel oral tablet 0.35 mg	1	H
shewise oral tablet 1.5 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	1	H
take action oral tablet 1.5 mg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (***levonorgestrel-eth estradiol***)	3/4	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
your choice oral tablet 1.5 mg	1	H
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	2	QL (1 tablet per day.)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BRYNOVIN ORAL SOLUTION 25 MG/ML (***sitagliptin hydrochloride***)	3/4	PA
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***)	2	QL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***)	2	QL (1 tablet per day.)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	1	QL (1 tablet per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
TRADJENTA ORAL TABLET 5 MG (***linagliptin***)	2	QL (1 tablet per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (2 tablets per day.)
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
clomid oral tablet 50 mg	1	
clomiphene citrate oral tablet 50 mg	1	
DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***)	3	QL (1 tablet per day.)
milophene oral tablet 50 mg	1	
OSPHENA ORAL TABLET 60 MG (***ospemifene***)	3	PA; QL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	1	H-N
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
toremifene citrate oral tablet 60 mg	1	CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ESTROGENS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***)	3	QL (8 patches (1 box) per 28 days.); SM
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (***drospirenone-estradiol***)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (***segesterone-ethinyl estradiol***)	3	QL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 &0.01 mg	1	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	E	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	1	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (***estrogens conjugated***)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (***estrogens, conjugated***)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (***conj estrog-medroxyprogest ace***)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (***conj estrog-medroxyprogest ace***)	3	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (***levonorgestrel-eth estradiol***)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
yuvafem vaginal tablet 10 mcg	1	
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
GLYCOGENOLYTIC AGENTS - Hormones		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	QL (2 intranasal devices per prescription.)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	QL (2 intranasal devices per prescription.)
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***)	2	QL (0.4 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***)	2	QL (0.4 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	QL (2 vials per copay.)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	QL (2 prefilled syringes per copay.)
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (***follitropin beta***)	2	PA; QL (5.4 mL (15 cartridges)per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML (***follitropin beta***)	2	PA; QL (8.64 mL(12 cartridges)per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 900 UNT/1.08ML (***follitropin beta***)	2	PA; QL (8.64 mL (8 cartridges)per 21 days.)
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***follitropin alfa***)	3/4	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (***follitropin alfa***)	3/4	PA
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; SM
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (***menotropins***)	3/4	PA; QL (6 vials per day.)
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***chorionic gonadotropin***)	3	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***choriogonadotropin alfa***)	3/4	
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (***chorionic gonadotropin***)	3	
SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***)	2	SM
INCRETIN MIMETICS - Drugs for Diabetes		
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (2 pens (6 mL) per month.)
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (3 pens (9 mL) per month.)
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide***)	2	PA; QL (0.08 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OZEMPIC ORAL TABLET 1.5 MG, 9 MG (***semaglutide***)	2	PA; QL (30 tablets per month.)
OZEMPIC ORAL TABLET 4 MG (***semaglutide***)	2	PA; QL (30 Tablets per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (***semaglutide***)	2	PA; QL (1 Pen-injector per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (***semaglutide***)	2	PA; QL (3 ml per month.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (***semaglutide***)	2	PA; QL (1 tablet per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 mL per month.)
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	QL (70 ml per prescription.); SM
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***)	2	QL (75 ml per prescription.); SM
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***)	1	QL (70 ml per prescription.); SM
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (***metreleptin***)	3	PA; QL (0.9 vial per day.); SP; SMCS
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***)	1	QL (75 ml per prescription.); SM
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***)	1	QL (70 ml per prescription.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	QL (75 ml per prescription.); SM
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	QL (37.5 ml per prescription.); SM
MEGLITINIDES - Drugs for Diabetes		
nateglinide oral tablet 120 mg, 60 mg	1	
repaglinide oral tablet 0.5 mg, 1 mg	1	QL (4 tablets per day)
repaglinide oral tablet 2 mg	1	QL (8 tablets per day)
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.12 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.96 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (2.8 mL) per 28 days.)
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP; SMCS
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP; SMCS
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP; SMCS
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP; SMCS
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	3/4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	
desmopressin acetate spray nasal solution 0.01 %	1	
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML (***somatrogon-ghla***)	3/4	PA; QL (0.172 ml per day.)
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 60 MG/1.2ML (***somatrogon-ghla***)	3/4	PA; QL (4.8 mL (4 Prefilled Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL (9 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL (6 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL (18 Pens) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 ml (9 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 ml (18 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial per day.)
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (***lonapegsomatropin-tcgd***)	3/4	PA; QL (4 single-dose prefilled cartridges per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (***lonapegsomatropin-tcgd***)	3/4	PA; QL (0.143 cartridge per day.)
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (***somapacitan-beco***)	3/4	PA; QL (0.215 ml per day.)
PROGESTINS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
aftera oral tablet 1.5 mg	1	H
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (***drospirenone-estradiol***)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (***segesterone-ethinyl estradiol***)	3	QL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 &0.01 mg	1	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	E	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (***estradiol-progesterone***)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	1	H
camrese oral tablet 0.15-0.03 &0.01 mg	1	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (***estradiol-levonorgestrel***)	3	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***)	3	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (***progesterone***)	3/4	
cryselle oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 &0.01 mg	1	H
deblitane oral tablet 0.35 mg	1	H
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
econtra one-step oral tablet 1.5 mg	1	H
elinest oral tablet 0.3-30 mg-mcg	1	H
ELLA ORAL TABLET 30 MG (***ulipristal acetate***)	1	QL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
emzahh oral tablet 0.35 mg	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (***progesterone***)	2	
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H
errin oral tablet 0.35 mg	1	H
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	1	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H
gallifrey oral tablet 5 mg	1	
gemmily oral capsule 1-20 mg-mcg(24)	1	H
hailey 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey 24 fe oral tablet 1-20 mg-mcg(24)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey fe 1/20 oral tablet 1-20 mg-mcg	1	H
heather oral tablet 0.35 mg	1	H
her style oral tablet 1.5 mg	1	H
iclevia oral tablet 0.15-0.03 mg	1	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	1	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 &0.01 mg	1	H
jasmiel oral tablet 3-0.02 mg	1	H
jencycla oral tablet 0.35 mg	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	1	H
juleber oral tablet 0.15-30 mg-mcg	1	H
junel 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel fe 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 24 oral tablet 1-20 mg-mcg(24)	1	H
kaitlib fe oral tablet chewable 0.8-25 mg-mcg	1	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
kelnor 1/35 oral tablet 1-35 mg-mcg	1	H
kurvelo oral tablet 0.15-30 mg-mcg	1	H
larin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin 1/20 oral tablet 1-20 mg-mcg	1	H
larin 24 fe oral tablet 1-20 mg-mcg(24)	1	H
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin fe 1/20 oral tablet 1-20 mg-mcg	1	H
lessina oral tablet 0.1-20 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	1	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	1	H
levonorgestrel oral tablet 1.5 mg	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	1	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
luizza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
luizza 1/20 oral tablet 1-20 mg-mcg	1	H
lutera oral tablet 0.1-20 mg-mcg	1	H
lyleq oral tablet 0.35 mg	1	H
lyza oral tablet 0.35 mg	1	H
marlissa oral tablet 0.15-30 mg-mcg	1	H
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	1	QL (5 ml per year.); H; SM
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	SM
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	1	
megestrol acetate oral tablet 20 mg, 40 mg	1	
meleya oral tablet 0.35 mg	1	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	1	
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (***relugolix-estradiol-norethind***)	2	PA; QL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (***estradiol valerate-dienogest***)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (***drospirenone-estetrol***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acetate oral tablet 5 mg	1	
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
OPILL ORAL TABLET 0.075 MG (***norgestrel***)	1	H
option 2 oral tablet 1.5 mg	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
orquidea oral tablet 0.35 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMPHASE ORAL TABLET 0.625-5 MG (***conj estrog-medroxyprogest ace***)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (***conj estrog-medroxyprogest ace***)	3	
progesterone intramuscular oil 50 mg/ml	1	SM
progesterone oral capsule 100 mg, 200 mg	1	SM
progesterone vaginal insert 100 mg	1	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (***medroxyprogesterone acetate***)	3/4	SM
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	H
sharobel oral tablet 0.35 mg	1	H
shewise oral tablet 1.5 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	1	H
take action oral tablet 1.5 mg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (***levonorgestrel-eth estradiol***)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
your choice oral tablet 1.5 mg	1	H
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
RAPID-ACTING INSULINS - Drugs for Diabetes		
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***)	2	QL (75 ml per prescription.); SM
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (***insulin lispro***)	2	QL (75 ml (25 pens) per prescription.); SM
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	QL (75 ml per prescription.); SM
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	1	QL (70 ml per prescription.); SM
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***)	2	QL (75 ml per prescription.); SM
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***)	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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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	1	QL (70 ml per prescription.); SM
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	QL (75 ml per prescription.); SM
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	QL (75 ml per prescription.); SM
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***)	2	QL (75 ml per prescription.); SM
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***)	1	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 (***insulin nph isophane & regular***)	2	QL (75 ml per prescription.); SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	QL (70 ml per prescription.); SM
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***)	2	QL (75 mL per prescription.); SM
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***)	1	QL (70 ml per prescription.); SM
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	SM
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (***bexagliflozin***)	3	QL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***)	2	QL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG (***empagliflozin***)	2	QL (30 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (***empagliflozin-metformin hcl***)	2	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (***empagliflozin-metformin hcl***)	2	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (***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, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (***pasireotide diaspartate***)	3/4	PA; QL (2 ampules per day.); SP; SMCS
SOMATOTROPIN AGONISTS - Hormones		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (***tesamorelin acetate***)	3/4	PA; QL (1 vial per day.); SP; SMCS
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (***tesamorelin acetate***)	3/4	PA; QL (4 vials per month.); SP; SMCS
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (***mecasermin***)	2	PA; QL (13 vials per month.); SP; SMCS
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL (9 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL (6 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL (18 Pens) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 ml (9 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 ml (18 cartridges) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial per day.)
SOMATOTROPIN ANTAGONISTS - Hormones		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (***pegvisomant***)	3/4	PA; QL (1 vial per day.); SP; SMCS
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***)	3	
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (***glipizide***)	3/4	
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	
THIAZOLIDINEDIONES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	QL (3 tablets per day)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***)	3	
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
THYROID AGENTS - Drugs for the Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (***thyroid***)	3	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (***resmetirom***)	3/4	PA; QL (1 Tablet per day.)
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (***levothyroxine sodium***)	2	PA
unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
IMMUNOMODULATORY AGENTS (90:00)		
AMINO ACID POLYMERS		
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
ANTIMETABOLITES		
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
mycophenolate mofetil oral capsule 250 mg	1	
APRIL OR BAFF INHIBITOR AGENTS		
VOYXACT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 400 MG/2ML (***sibeprenlimab-szsi***)	3/4	PA; QL (1 prefilled syringe per month.); SP; SMCS
CALCINEURIN INHIBITORS, MISC (90:28)		
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	QL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
COMPLEMENT INHIBITOR AGENTS (90:20)		
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
AURANOFIN ORAL CAPSULE 3 MG	3	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (4 ml (2 pens/1 box) per month.)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.)
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.)
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
IMMUNOMODULATORY AGENTS (90:00)		
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-hmny***)	2	PA; QL (1 single-dose vial every 3 months.)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-hmny***)	2	PA; QL (1 prefilled syringe every 3 months.)
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-stba***)	2	
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-stba***)	2	PA; QL (1 syringe every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-auub***)	2	PA; QL (1 single-dose vial every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-auub***)	2	PA; QL (1 syringe per 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-kfce***)	2	PA; QL (1 single-dose vial every 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-kfce***)	2	PA; QL (1 syringe every 3 months.)
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 LQ ORAL SOLUTION 1 MG/ML (***upadacitinib***)	2	PA; QL (360 mL (2 bottles) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)
tofacitinib citrate er oral tablet extended release 24 hour 11 mg, 22 mg	1	PA; QL (1 tablet per day.)
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.)
tofacitinib citrate oral tablet 10 mg, 5 mg	1	PA; QL (2 tablets per day.)
MONOCARBOXYLIC ACID AMIDE AGENTS		
leflunomide oral tablet 10 mg, 20 mg	1	
MONOCLONAL ANTIBODIES (90:04)		
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; QL (0.02 ml per day.)
MONOCLONAL ANTIBODIES (90:10)		
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (***lecanemab-irmb***)	3/4	PA; QL (7.2 mL (4 autoinjectors) per month.)
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
NEONATAL FC RECEPTOR BLOCKERS		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (***efgartigimod alfa-hyalur-qvfc***)	3/4	PA; QL (4 syringes every 50 days.)
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***apremilast***)	2	PA; QL (30 tablets per month.)
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (***apremilast***)	2	PA; QL (1 starter pack (41 tablets) per 365 days.)
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.)
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	3/4	PA; QL (1 capsule per day.)
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.)
T-CELL BLOCKERS (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
tetracaine hcl ophthalmic solution 0.5 %	1	
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
dutasteride oral capsule 0.5 mg	1	
finasteride oral tablet 5 mg	1	
5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence		
disulfiram oral tablet 250 mg, 500 mg	1	
dutasteride oral capsule 0.5 mg	1	
finasteride oral tablet 5 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTES (92:12) - Drugs for Overdose or Poisoning		
acetylcysteine inhalation solution 10 %, 20 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	QL (2 intranasal devices per prescription.)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	QL (2 intranasal devices per prescription.)
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***)	2	QL (0.4 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (***glucagon***)	2	QL (0.2 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (***glucagon***)	2	QL (0.4 ml per prescription.)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	QL (2 vials per copay.)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	QL (2 prefilled syringes per copay.)
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
lederle leucovorin oral tablet 5 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
phytonadione oral tablet 5 mg	1	QL (5 tablets per prescription.)
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
sevelamer carbonate oral tablet 800 mg	1	
sodium polystyrene sulfonate combination suspension 15 gm/60ml	1	
sodium polystyrene sulfonate oral powder	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (***sodium polystyrene sulfonate***)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (***sodium polystyrene sulfonate***)	3	
VISTOGARD ORAL PACKET 10 GM (***uridine triacetate***)	2	QL (20 packets per prescription.)
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 mg, 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
colchicine oral capsule 0.6 mg	1	
colchicine oral tablet 0.6 mg	1	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	1	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (***colchicine***)	3/4	PA
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	PA
MITIGARE ORAL CAPSULE 0.6 MG (***colchicine***)	2	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	QL (10 tablets per course of therapy.)
probenecid oral tablet 500 mg	1	
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 autoinjector (0.8 mL) per month.); SP; SMCS
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP; SMCS
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (***eplontersen sodium***)	2	PA; QL (0.029 ml per day.)
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
BONE RESORPTION INHIBITORS - Drugs for Bone Loss		
alendronate sodium oral solution 70 mg/75ml	1	
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	1	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***)	3	QL (8 patches (1 box) per 28 days.); SM
calcitonin (salmon) injection solution 200 unit/ml	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (***estradiol valerate***)	3/4	SM
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	SM
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (***estradiol***)	3	SM
dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.); SM
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (***estradiol***)	3	SM
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm	1	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (37.5 grams (1 box) per month.); SM
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.); SM
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 patches (1 carton) per 28 days.); SM
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
ESTRING VAGINAL RING 7.5 MCG/24HR (***estradiol***)	2	QL (1 ring per 90 days.)
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	1	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***)	2	SM
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (***estradiol acetate***)	3	QL (1 ring per 3 months.)
FOSAMAX ORAL TABLET 70 MG (***alendronate sodium***)	3/4	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***)	3	
ibandronate sodium oral tablet 150 mg	1	
lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.); SM
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***)	3	QL (4 patches (1 carton) per 28 days.); SM
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***)	3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (***estrogens conjugated***)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (***estrogens, conjugated***)	3	
raloxifene hcl oral tablet 60 mg	1	H-N
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	1	
yuvafem vaginal tablet 10 mcg	1	
BRADYKININ RECEPTOR ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
CARBONIC ANHYDRASE INHIBITORS (92:26)		
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.)
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
FLUORIDEX DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
COMPLEMENT INHIBITORS		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP; SMCS
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP; SMCS
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (16 vials per month.); SP; SMCS
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
VOYDEYA ORAL TABLET 100 MG (***danicopan***)	2	PA; QL (6 tablets per day.)
VOYDEYA ORAL TABLET THERAPY PACK 50 & 100 MG (***danicopan***)	2	PA; QL (180 tablets per month.)
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP; SMCS
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP; SMCS
COMPLEMENT INHIBITORS (92:32)		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP; SMCS
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP; SMCS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP; SMCS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (16 vials per month.); SP; SMCS
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 auto injector per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 prefilled syringes per month.)
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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***)	2	PA; QL (1 tablet per day.); CM
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
gengraf oral capsule 100 mg, 25 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
leflunomide oral tablet 10 mg, 20 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; QL (1 tablet per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
penicillamine oral tablet 250 mg	1	
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***)	2	QL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***)	2	QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***)	2	QL (1.4 ml (4 auto-injectors) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***)	2	QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***)	2	QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***)	2	QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***)	2	QL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
tofacitinib citrate er oral tablet extended release 24 hour 11 mg, 22 mg	1	PA; QL (1 tablet per day.)
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.)
tofacitinib citrate oral tablet 10 mg, 5 mg	1	PA; QL (2 tablets per day.)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)		
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 prefilled syringes per month.)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (***interferon gamma-1b***)	2	PA; QL (8.5 mls per month.); SP; SMCS
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 syringes (1 box) per month.)
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM; SMCS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM; SMCS
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; QL (15 vials per month.)
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.)
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP; SMCS
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.)
gengraf oral capsule 100 mg, 25 mg	1	
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	3/4	PA; QL (1 capsule per day.)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
JOENJA ORAL TABLET 40 MG, 50 MG (***leniolisib phosphate***)	2	
JOENJA ORAL TABLET 70 MG (***leniolisib phosphate***)	2	PA; QL (2 tablets per day.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; QL (0.02 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP; SMCS
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); CM
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.)
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; QL (28 capsules per prescription.); CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
ZENBEXUS ORAL CAPSULE 0.75 MG, 1 MG (***iberdomide hydrochloride***)	3/4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (***ozanimod hcl***)	3	PA; QL (7 capsules per year.)
ZEPOSIA ORAL CAPSULE 0.92 MG (***ozanimod hcl***)	3	PA; QL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (***ozanimod hcl***)	3	PA
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
leflunomide oral tablet 10 mg, 20 mg	1	
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	3/4	PA; QL (6 capsules per day.); SP; SMCS
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
mycophenolate mofetil oral capsule 250 mg	1	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	1	
mycophenolate mofetil oral tablet 500 mg	1	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	1	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	1	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (***mycophenolate mofetil***)	1	
pimecrolimus external cream 1 %	1	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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	QL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP; SMCS
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP; SMCS
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (***levacetylleucine***)	3/4	PA; QL (112 packets per month.)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP; SMCS
betaine oral powder	1	
CARNITOR ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CARNITOR ORAL TABLET 330 MG (***levocarnitine***)	3/4	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
CYSTADANE ORAL POWDER (***betaine***)	3/4	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (***cysteamine bitartrate***)	2	
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day)
DIABETES MONITOR DIGIT ADD-ON KIT	3	QL (1 meter or meter kit per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DIABETES MONITOR DIGIT SOLN KIT	3	QL (1 meter or meter kit per year.)
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (***givinostat hcl***)	3/4	PA; QL (420 mL per month.)
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (***prasterone (dhea)***)	3	
ELMIRON ORAL CAPSULE 100 MG (***pentosan polysulfate sodium***)	3/4	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	PA; QL (6 packets per day.)
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (***risdiplam***)	2	PA; QL (6.7 ml per day, 1280 ml per 180 days.); SP; SMCS
EVRYSDI ORAL TABLET 5 MG (***risdiplam***)	2	PA; QL (30 tablets per month.); SP; SMCS
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.)
FORZINITY SUBCUTANEOUS SOLUTION 280 MG/3.5ML (***elamipretide hcl***)	3/4	PA; QL (4 vials (14 ml) per month.); SP; SMCS
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)
KYGEVVI ORAL PACKET 2-2 GM (***doxecitine-doxribtimine***)	3/4	PA; QL (558 packets per month.); SP; SMCS
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine oral tablet 330 mg	1	
levocarnitine sf oral solution 1 gm/10ml	1	
l-glutamine oral packet 5 gm	1	PA; QL (6 packets per day.)
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
metyrosine oral capsule 250 mg	1	PA
miglustat oral capsule 100 mg	1	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (***cysteamine bitartrate***)	3/4	PA; SP; SMCS
PROCYSBI ORAL PACKET 300 MG, 75 MG (***cysteamine bitartrate***)	3/4	SP; SMCS
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (***belumosudil mesylate***)	3/4	PA; QL (1 tablet per day.); SP; SMCS
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (***nedosiran sodium***)	3/4	PA; QL (0.03 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day)
SKYCLARYS ORAL CAPSULE 50 MG (***omaveloxolone***)	2	PA; QL (3 capsules per day.)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (***palovarotene***)	3/4	PA; QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
tiopronin oral tablet 100 mg	1	CM
tiopronin oral tablet delayed release 100 mg, 300 mg	1	CM
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***)	2	
VIJOICE ORAL PACKET 50 MG (***alpelisib***)	3/4	PA; QL (28 packets (1 carton) per month.)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (***alpelisib***)	3/4	PA; QL (28 tablets (1 blister pack) per month.)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (***alpelisib***)	3/4	PA; QL (56 tablets (2 blister packs) per month.)
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	3/4	PA; QL (12 capsules per 365 days.)
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (***vosoritide***)	3/4	PA; QL (1 vial per day.); SP; SMCS
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
YUVIWEL SUBCUTANEOUS SOLUTION RECONSTITUTED 1.3 MG, 2.8 MG, 5.5 MG (***navepegritide***)	3/4	PA; QL (4 vials per month.); SP; SMCS
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
PROTECTIVE AGENTS		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	QL (45 grams per prescription)
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day)
mesna oral tablet 400 mg	1	CM
MESNEX ORAL TABLET 400 MG (***mesna***)	3/4	CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (***diaphragm arc-spring***)	3	H
CONDOMS	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN DEVICE (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
DUREX TROPICAL (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (***nonoxynol-9***)	E	H
FC2 FEMALE CONDOM (***condoms - female***)	3	QL (12 condoms per month.); H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (***cervical caps***)	3	H
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (***diaphragms***)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (***nonoxynol-9***)	E	H
PHEXX VAGINAL GEL 1.8-1-0.4 % (***lactic ac-citric ac-pot bitart***)	3/4	H
TODAY SPONGE VAGINAL 1000 MG (***nonoxynol-9***)	E	H
TRUE COVER DEVICE	3	QL (12 condoms per month.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (***transdermal base***)	3	
RESPIRATORY TRACT AGENTS		
DUAL PHOSPHODIESTERASE INHIBITOR (48:34)		
OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (***ensifentrine***)	3/4	PA; QL (150 mL per month.); SM
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (***epinephrine***)	2	QL (2 pens per prescription.); SM
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	QL (2 injections per prescription.); SM
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml	1	QL (2 injections per prescription.); SM
epinephrine injection solution auto-injector 0.15 mg/0.3ml	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		
atropine sulfate ophthalmic solution 1 %	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	3	QL (0.28 grams per day.); SM
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	1	QL (0.87 grams per day.); SM
ipratropium bromide inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	3/4	PA; QL (60 tablets per month.)
nintedanib esylate oral capsule 100 mg, 150 mg	1	PA; QL (2 capsules per day.)
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	3	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	QL (10.7 grams per prescription.); SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	QL (0.04 mcg per day.); SM
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	QL (34 grams (2 bottles) per copay.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 tablets per month.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (***lumacaftor-ivacaftor***)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KALYDECO ORAL PACKET 13.4 MG (***ivacaftor***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (***ivacaftor***)	2	PA; QL (728 packets per 356 days.)
KALYDECO ORAL PACKET 5.8 MG (***ivacaftor***)	2	PA; QL (2 packets per day and 728 packets per 365 days.)
KALYDECO ORAL TABLET 150 MG (***ivacaftor***)	2	PA; QL (780 tablets per 356 days.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (***lumacaftor-ivacaftor***)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TRYVIO ORAL TABLET 12.5 MG (***aprocitentan***)	3/4	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
EXPECTORANTS - Drugs for the Lungs		
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml	1	
iodine strong oral solution 5 %	1	
maxi-tuss ac oral solution 100-10 mg/5ml	1	
potassium iodide (expectorant) oral solution 1 gm/ml	1	
SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***)	3	
FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy		
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP; SMCS
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (***benralizumab***)	3/4	PA; QL (1 pen every 2 months.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg	1	QL (0.5 tablet per day.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
tadalafil oral tablet 10 mg, 20 mg	1	QL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	1	QL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	QL (4 films per month.)
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (***treprostinil sodium***)	2	PA; QL (140 capsules per month.)
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; QL (20 capsules per day.); CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; QL (20 capsules per day.); CM
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (***sotatercept-csrk***)	3/4	PA; QL (1 kit every 3 weeks.); SP; SMCS
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 (***albuterol-budesonide***)	3	QL (10.7 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (1 inhaler per copay.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (1 inhaler per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (18 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (6.7 grams per prescription.); SM
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	QL (8.5 grams per prescription.); SM
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	PA
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	1	QL (90 ml per prescription.); SM
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	1	QL (30 vials per prescription); SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	QL (15 grams per prescription.); SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	QL (15 grams per prescription.); SM
VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***)	2	PA; QL (3 tablets per day.)
alyq oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 20 mg, 25 mg, 50 mg	1	QL (0.5 tablet per day.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (0.5 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP; SMCS
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 tablets per year.)
VASODILATING AGENTS, MISC (48:48) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***)	2	PA; QL (3 tablets per day.)
UPTRAVI ORAL TABLET 100 MCG, 150 MCG (***selexipag***)	3/4	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 tablets per year.)
XANTHINE DERIVATIVES - Drugs for Asthma/COPD		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
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 %	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
mupirocin calcium external cream 2 %	1	QL (15 grams per prescription)
mupirocin external ointment 2 %	1	QL (22 grams per prescription.)
neomycin sulfate oral tablet 500 mg	1	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sodium sulfacetamide external shampoo 10 %	1	
sodium sulfacetamide wash external liquid 10 %	1	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium (acne) external lotion 10 %	1	
sulfacetamide sodium (cleans) external gel 10 %	1	
sulfacetamide sodium external liquid 10 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	QL (1 gel tube (8 grams) per prescription.)
XEPI EXTERNAL CREAM 1 % (***ozenoxacin***)	3	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA; QL (30 grams per prescription.)
ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin		
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	QL (60 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA; QL (60 grams per prescription.)
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
doxepin hcl external cream 5 %	1	PA; QL (45 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral concentrate 10 mg/ml	1	
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
glydo external prefilled syringe 2 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
lidocaine external ointment 5 %	1	QL (1.19 grams per day.)
lidocaine external patch 5 %	1	PA
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external gel 2 %	1	
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	1	
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
PYRIDIUM ORAL TABLET 100 MG, 200 MG (***phenazopyridine hcl***)	3	
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GYNAZOLE-1 VAGINAL CREAM 2 % (***butoconazole nitrate (1 dose)***)	3	
JUBLIA EXTERNAL SOLUTION 10 % (***efinaconazole***)	3/4	PA; QL (4 ml per month.)
ketoconazole external cream 2 %	1	QL (30 grams per prescription.)
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	1	
miconazole 3 vaginal suppository 200 mg	1	
ORAVIG BUCCAL TABLET 50 MG (***miconazole***)	3	
oxiconazole nitrate external cream 1 %	1	QL (30 grams per prescription.)
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
BASIC LOTIONS AND LINIMENTS - Drugs for the Skin		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***)	2	
methyl salicylate external liquid	1	
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (***salicylic acid-urea in lactac***)	3	
turpentine external spirit	1	
VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID	3	
XIRUN EXTERNAL GEL 40-10 %	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***)	3	
BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin		
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
attero external suspension 0.005-0.064 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
attero external suspension 0.005-0.064 %	1	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
budesonide rectal foam 2 mg, 2 mg/act	1	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	1	
clobetasol prop emollient base external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate e external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external cream 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external gel 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external liquid 0.05 %	1	QL (59 ml per prescription)
clobetasol propionate external ointment 0.05 %	1	QL (30 grams per prescription.)
clobetasol propionate external solution 0.05 %	1	QL (25 ml per prescription.)
clocortolone pivalate external cream 0.1 %	1	QL (75 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***)	3	QL (1 packet per prescription.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	QL (118.28 ml per prescription.)
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
desonide external cream 0.05 %	1	QL (15 grams per prescription.)
desonide external gel 0.05 %	1	QL (60 grams per prescription)
desonide external lotion 0.05 %	1	QL (60 ml per prescription.)
desonide external ointment 0.05 %	1	QL (15 grams per prescription.)
desoximetasone external cream 0.05 %	1	QL (60 gm per prescription.)
desoximetasone external cream 0.25 %	1	QL (15 grams per prescription.)
desoximetasone external gel 0.05 %	1	QL (15 grams per prescription.)
desoximetasone external ointment 0.05 %	1	QL (60 grams per prescription.)
desoximetasone external ointment 0.25 %	1	QL (15 grams per prescription.)
diflorasone diacetate external cream 0.05 %	1	QL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	QL (60 grams per prescription.)
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
fluocinolone acetonide body external oil 0.01 %	1	QL (118.28 ml per prescription.)
fluocinolone acetonide external cream 0.01 %	1	QL (15 grams per prescription.)
fluocinolone acetonide external cream 0.025 %	1	QL (120 grams per copay.)
fluocinolone acetonide external ointment 0.025 %	1	QL (120 grams per copay.)
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
flurandrenolide external lotion 0.05 %	1	QL (120 ml per prescription.)
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	QL (60 ml per prescription.)
fluticasone propionate external ointment 0.005 %	1	
halcinonide external cream 0.1 %	1	QL (30 grams per prescription.)
halobetasol propionate external cream 0.05 %	1	QL (15 grams per prescription.)
halobetasol propionate external ointment 0.05 %	1	QL (15 grams per prescription.)
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	1	QL (15 grams per prescription.)
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
KOURZEQ MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
ORALONE MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 OINTMENT 1-2.5 % (***pramoxine-hc***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOPICORT EXTERNAL OINTMENT 0.05 % (***desoximetasone***)	3/4	QL (60 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.25 % (***desoximetasone***)	3/4	QL (15 grams per prescription.)
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	QL (63 grams per prescription.)
triamcinolone acetonide external cream 0.025 %, 0.1 %	1	
triamcinolone acetonide external cream 0.5 %	1	QL (15 grams per prescription.)
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide mouth/throat paste 0.1 %	1	
triderm external cream 0.5 %	1	QL (15 grams per prescription.)
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ciclodan external solution 8 %	1	
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	1	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ciclopirox olamine external suspension 0.77 %	1	
IMMUNOMODULATORY AGENTS (84:06) - Drugs for the Skin		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***tralokinumab-ldrm***)	2	PA; QL (2 auto-injectors per month.)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (1 pen (2 ml) per month.)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (1 pen (2 ml) per month.)
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
ICOTYDE ORAL TABLET 200 MG (***icotrokinra hcl***)	2	PA; QL (30 tablets per month.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (***nemolizumab-ilto***)	2	PA; QL (2 pens every 4 weeks.)
pimecrolimus external cream 1 %	1	QL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA
RHAPSIDO ORAL TABLET 25 MG (***remibrutinib***)	2	PA; QL (60 tablets per month.)
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 55 MG/0.37ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (55 mg/0.37ml) every 12 weeks.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***spesolimab-sbzo***)	3/4	PA; QL (2 Prefilled syringes per month.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***spesolimab-sbzo***)	3/4	PA; QL (1 prefilled syringe per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	QL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 syringe) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (4 ml (2 pens/1 box) per month.)
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
ANZUPGO EXTERNAL CREAM 20 MG/GM (***delgocitinib***)	3/4	PA; QL (60 Grams per Month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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***)	2	PA; QL (1 tablet per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; CM
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per prescription.)
KERATOLYTIC AGENTS - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	QL (45 grams per prescription)
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA; QL (45 grams per prescription.)
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	3/4	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***sulfacetamide sodium-sulfur***)	3	
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
bp 10-1 external emulsion 10-1 %	1	
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***)	2	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
SALICATE EXTERNAL LIQUID 10 % (***salicylic acid***)	3	
salicylic acid external solution 26 %	1	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (***salicylic acid-urea in lactac***)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tazarotene external cream 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA; QL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA; QL (30 grams per prescription.)
urea external cream 20 %, 40 %	1	
urea external lotion 40 %	1	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	QL (30 grams per prescription.)
XIRUN EXTERNAL GEL 40-10 %	3	
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
KERATOPLASTIC AGENTS - Drugs for the Skin		
coal tar external solution 20 %	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	QL (45 grams per prescription)
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	QL (23.3 grams per prescription.)
benzoyl peroxide-erythromycin external gel 5-3 %	1	QL (23.3 grams per prescription.)
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (***sulfuric acid-sulf phenolics***)	2	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	3/4	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	3/4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***)	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
diclofenac sodium external gel 3 %	1	PA; QL (100 grams per prescription.)
OXABOROLES - Drugs for the Skin		
tavaborole external solution 5 %	1	PA; QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	QL (60 grams per prescription.)
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	3/4	PA; QL (60 tablets per month.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.05 % (***roflumilast***)	3/4	PA; QL (60 Grams per prescription.)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA; QL (60 grams per copay.)
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	QL (45 grams per prescription)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA; QL (45 grams per prescription.)
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
attero external suspension 0.005-0.064 %	1	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	QL (30 grams per prescription.)
B & C EXTERNAL OINTMENT	3	
balsam peru-castor oil external ointment	1	
bexarotene external gel 1 %	1	QL (60 grams per prescription.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
brimonidine tartrate external gel 0.33 %	1	PA; QL (30 grams per prescription.)
calcipotriene external cream 0.005 %	1	QL (60 grams per prescription)
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	QL (60 mL per prescription)
calcipotriene-betameth diprop external suspension 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
calcitriol external ointment 3 mcg/gm	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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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***)	2	PA; QL (1 tablet per day.); CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
dapsone external gel 5 %, 7.5 %	1	QL (60 grams per prescription.)
dapsone oral tablet 100 mg, 25 mg	1	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	PA; QL (6 packets per day.)
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	QL (60 grams per prescription.)
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	3/4	
FILSUVEZ EXTERNAL GEL 10 % (***birch triterpenes***)	3/4	PA; QL (14.4 grams per day.)
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	3/4	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HALUCORT EXTERNAL GEL (***dermatological products, misc.***)	3	PA
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
imiquimod external cream 5 %	1	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	QL (5 units per prescription)
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	QL (5 units per prescription)
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
l-glutamine oral packet 5 gm	1	PA; QL (6 packets per day.)
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
oxymetazoline hcl external cream 1 %	1	PA; QL (30 grams per prescription.)
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
pimecrolimus external cream 1 %	1	QL (30 grams per prescription.)
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA; QL (30 grams per prescription.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	QL (90 grams per prescription.)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
tacrolimus external ointment 0.03 %, 0.1 %	1	QL (30 grams per prescription.)
tazarotene external cream 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA; QL (30 grams per prescription.)
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA; QL (30 grams per prescription.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 syringe) every 8 weeks.)
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA; QL (120 grams per prescription.)
VENELEX EXTERNAL OINTMENT (***balsam peru-castor oil***)	3	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	QL (30 grams per prescription.)
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA; QL (60 grams per prescription.)
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	3/4	QL (31 grams (1 box) per copay)
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (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 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per prescription.)
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles		
ANTIMUSCARINICS - Drugs for the Urinary System		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (1 starter pack per year.)
flavoxate hcl oral tablet 100 mg	1	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 2.5 mg, 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	
tolterodine tartrate oral tablet 1 mg, 2 mg	1	
trospium chloride oral tablet 20 mg	1	
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
elixophyllin oral elixir 80 mg/15ml	3	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	1	
VITAMINS		
MULTIVITAMIN PREPARATIONS		
ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***)	3	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal oral tablet 27-1 mg	1	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN A		
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAMIN B COMPLEX		
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
cyanocobalamin injection solution 1000 mcg/ml	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
cyanocobalamin nasal solution 500 mcg/0.1ml	1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***)	3	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
folic acid oral tablet 400 mcg, 800 mcg	E	H
folic acid tablet 1 mg oral (rx)	1	
ft folic acid oral tablet 400 mcg, 800 mcg	E	H
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	3/4	
lederle leucovorin oral tablet 5 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***)	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***)	3	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal oral tablet 27-1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN C		
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAMIN D		
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	
calcitriol oral solution 1 mcg/ml	1	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	1	
ergocalciferol oral capsule 1.25 mg (50000 ut)	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***)	3	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	1	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (***paricalcitol***)	3/4	
VITAMIN E		
wheat germ oil oral oil	1	
VITAMIN K ACTIVITY		
phytonadione oral tablet 5 mg	1	QL (5 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

abacavir sulfate 33
abacavir sulfate-lamivudine ... 33
abigale 226, 239
abigale lo 226, 239
abiraterone acetate 44
abirtega 44
ABRYSVO 58
acamprosate calcium 15, 134
acarbose 213
ACCU-CHEK AVIVA 160
ACCU-CHEK FASTCLIX LANCET KIT 160
ACCU-CHEK GUIDE 160
ACCU-CHEK GUIDE CONTROL 160
ACCU-CHEK GUIDE ME 160
ACCU-CHEK GUIDE TEST 173
ACCU-CHEK SMARTVIEW CONTROL 160
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT 161
accutane 316, 320
ACD-A NOCLOT-50 75
acebutolol hcl 73, 93, 98, 101, 107
acetaminophen-codeine 116, 142, 144
acetazolamide 87, 98, 118, 176, 188
acetazolamide er 87, 98, 118, 176, 188
acetic acid 194
acetylcysteine 15, 261, 293
acitretin 316, 320
ACTEMRA 256, 269, 273
ACTEMRA ACTPEN 256, 268, 273
ACTHAR 173, 237
ACTHAR GEL 173, 237
ACTHIB 58
ACTIMMUNE 273
ACTIVELLA 226, 239
ACTOPLUS MET 216, 250
ACULAR 151, 195
ACULAR LS 151, 195
acyclovir 37, 305
ADACEL 58, 59
ADALIMUMAB-AATY (1 PEN) 203, 259, 269, 273
ADALIMUMAB-AATY (2 PEN) 203, 259, 269, 273
ADALIMUMAB-AATY (2 SYRINGE) 203, 259, 269, 273
ADALIMUMAB-AATY CD/UC/HS START 203, 259, 269, 273
ADALIMUMAB-ADAZ 203, 259, 260, 269, 273
adapalene-benzoyl peroxide 284, 316, 318, 321
ADBRY 314, 321
ADDYI 134
adefovir dipivoxil 37
ADEMPAS 298, 299
ADRENALIN 63, 197, 286
ADVAIR HFA 71, 189, 208, 289
ADVANTAGE SAFETY LANCETS 28G 161
ADVATE 79
ADVOCATE SAFETY LANCETS 21G 161
ADVOCATE SAFETY LANCETS 23G 161
ADVOCATE SAFETY LANCETS 28G 161
ADYNOVATE 79
AEROCHAMBER HOLDING CHAMBER 161
AEROCHAMBER PLS FLOVU MTHPIECE 161
AEROCHAMBER PLUS FLO-VU INTERM 161
AEROCHAMBER PLUS FLO-VU LARGE 161
AEROCHAMBER PLUS FLO-VU MEDIUM 161
AEROCHAMBER PLUS FLO-VU SMALL 161
AEROCHAMBER2GO ANTI-STATIC 161
afirmelle 217, 226, 239
AFSTYLA 79
aftera 214, 217, 239
AIMOVIG 134
AIRSUPRA 71, 189, 208, 289, 294, 297
AKEEGA 44
AKLIEF 316, 321
AKTEN 195
AKYNZEO 198, 205
albendazole 23
albuterol sulfate 72, 297
ALBUTEROL SULFATE ... 72, 297
albuterol sulfate hfa .. 71, 72, 297
ALCAINE 195
alclometasone dipropionate 308
ALCOHOL PREP PADS 161
ALECENSA 44
alendronate sodium 264
alfuzosin hcl er 71
aliskiren fumarate 111
allopurinol 262
almotriptan malate 154
ALOGLIPTIN BENZOATE 224
ALOGLIPTIN-METFORMIN HCL 216, 224
ALOGLIPTIN-PIOGLITAZONE 224, 250
ALORA 226, 264
alosetron hcl 199
ALPHAGAN P 184, 300
ALPHANATE 79
ALPHANINE SD 79
alprazolam 132
alprazolam er 132
alprazolam intensol 132
alprazolam xr 133
ALPROLIX 79
ALREX 189
ALTACAINE 195, 261
altavera 217, 226, 239
ALTUVIIIO 79
ALUNBRIG 44
ALVAIZ 77
alvimopan 197, 203
alyacen 1/35 ..... 217, 226, 239
alyacen 7/7/7 ..... 217, 226, 239
ALYFTREK 290
alyq 110, 294, 298
amantadine hcl 21, 115
ambrisentan 112, 291, 298
amcinonide 308
AMELUZ 300, 321
amethyst 217, 226, 239
amiloride hcl 88, 111, 178
amiloride-hydrochlorothiazide 178, 180
aminocaproic acid 79
amiodarone hcl 102
amitriptyline hcl 156
AMJEVITA 203, 260, 269, 273
AMJEVITA-PED 15KG TO <30KG 203, 260, 269, 274

amlodipine besylate 103, 104, 112
amlodipine besylate-benazepril hcl 91, 103
amlodipine besylate-valsartan 90, 103
amlodipine-olmesartan ...90, 103
amnesteem 316, 321
amoxapine 156
amoxicillin 22, 200
amoxicillin trihydrate 22, 200
amoxicillin-potassium clavulanate 22
amphetamine sulfate 115
amphetamine-dextroamphetamine 115
amphetamine-dextroamphetamine er 115
amphet-dextroamphet 3-bead er 115
ampicillin 22
AMZEEQ 24, 42, 184, 301
anagrelide hcl 86
ANALPRAM HC 189, 208, 304, 309
anastrozole 44, 214
ANCOBON 40
ANDEMBRY 87
ANGELIQ 226, 239
ANNOVERA 217, 226, 239
ANORO ELLIPTA 64, 72
ANTICOAGULANT SODIUM CITRATE 75
ANUCORT-HC 189, 208, 309
ANUSOL-HC 189, 208, 309
ANZUPGO 315
apap-caff-dihydrocodeine 116, 142, 144, 149
APOKYN 141
apomorphine hcl 141
apraclonidine hcl 184, 194
aprepitant 205, 206
apri 217, 226, 239
APRISO 199
APTIOM 118, 139
APTIVUS 34
AQ INSULIN SYRINGE 161
AQINJECT PEN NEEDLE 161
AQNEURSA 280
AQUORAL 194
AQVESME 75
ARAKODA 24
aranelle 217, 226, 239
ARANESP (ALBUMIN FREE) 74, 77
ARBLI 90
ARCALYST 280, 292
AREXVY 59
arformoterol tartrate 72, 297
ARIKAYCE 21
aripiprazole 123, 129
armodafinil 157
ARMOUR THYROID 251
ARNUITY ELLIPTA 189, 208, 289, 294
ARTISS 307, 321
ARZOL SILVER NIT APPLICATORS 187
ascomp-codeine 131, 144, 149, 152
asenapine maleate 123, 129
ashlyna 217, 226, 239
aspirin 85, 86, 126, 153
aspirin 81 ..... 85, 86, 126, 152
aspirin adult low dose 85, 86, 126, 152
aspirin adult low strength 85, 86, 126, 152
aspirin childrens 85, 86, 126, 152
aspirin ec adult low dose 85, 86, 126, 152
aspirin ec low dose 85, 86, 126, 152
aspirin ec low strength 85, 86, 126, 152
aspirin low dose 85, 86, 126, 152, 153
aspirin regimen . 85, 86, 126, 153
aspirin-dipyridamole er 86, 110, 153, 173
ASSURE CONTROL SOLUTION 2/3 161
ASSURE ID DUO PRO PEN NEEDLES 161
ASSURE ID PRO PEN NEEDLES 161
ASTRINGYN 79
atazanavir sulfate 34
atenolol 73, 93, 98, 101, 107
atenolol-chlorthalidone 93, 98, 181
ATMEKSI 68
atomoxetine hcl 134, 135, 149
ATORVALIQ 106
atorvastatin calcium 106
atovaquone 25
atovaquone-proguanil hcl 24
atropine sulfate . 15, 64, 196, 286
attero 307, 309, 321
ATTRUBY 98
aubra eq 217, 226, 239
AUGTYRO 44
AUM INSULIN SAFETY PEN NEEDLE 161
AUM MINI INSULIN PEN NEEDLE 161
AUM PEN NEEDLE 162
AUM READYGARD DUO PEN NEEDLE 162
AUM SAFETY PEN NEEDLE . 162
AURANOFIN ... 207, 253, 269, 274
aurovela 1.5/30 ..... 217, 226, 239
aurovela 1/20 ..... 217, 226, 239
aurovela 24 fe 218, 226, 239
aurovela fe 1.5/30 .. 218, 226, 239
aurovela fe 1/20 ..... 218, 226, 239
AUSTEDO 156
AUSTEDO XR 157
AUSTEDO XR PATIENT TITRATION 157
AUTOKEEPER SAFETY PEN NEEDLE 162
AUTOLET LANCING DEVICE 162
AUTOLET LITE LANCING DEVICE 162
AUVELITY 123
AUVELITY TITRATION PACK 123
AUVI-Q 63, 286
avanafil 110
AVAR CLEANSER 301, 316
AVAR-E EMOLLIENT 301, 316
aviane 218, 226, 239
AVIDOXY 24, 42, 301
AVIDOXY DK 42, 316, 325
AVMAPKI FAKZYNJA CO-PACK 44
AVONEX PEN 256, 274
AVONEX PREFILLED 256, 274
AVTOZMA 256
ayuna 218, 226, 239
AYVAKIT 44
AZASAN 252, 269, 274, 278
AZASITE 184
azathioprine ... 252, 269, 274, 278
azelaic acid 301, 321
azelastine hcl 184, 296
AZELEX 301, 321
azithromycin 38, 39
AZSTARYS 149

AZULFIDINE 41, 199, 253, 269, 274
AZULFIDINE EN-TABS 41, 199, 253, 269, 274
azurette 218, 226, 239
B & C 321
bac (butalbital-acetamin-caff) 116, 131, 142, 149
bacitracin-polymyxin b 28, 184, 301
bacitra-neomycin-polymyxin-hc ... 28, 184, 189, 301
baclofen 68
BACTRIM 25, 42, 43
BACTRIM DS 25, 41, 43
BAFIERTAM 255, 274
BALCOLTRA 218, 226, 240
balsalazide disodium 199
balsam peru-castor oil 321
BALVERSA 44
balziva 218, 226, 240
BANZEL 118, 139
BAQSIMI ONE PACK 15, 234, 261
BAQSIMI TWO PACK 15, 234, 261
BARACLUDE 38
BAXDELA 41
BD AUTOSHIELD DUO PEN NEEDLES 162
BD BLUNT FILL NEEDLE 162
BD ECLIPSE LUER-LOK NEEDLE 162
BD ECLIPSE NEEDLE 162
BD PEN NEEDLE MICRO ULTRAFINE 162
BD PEN NEEDLE MINI ULTRAFINE 162
BD PEN NEEDLE NANO ULTRAFINE 162
BD PEN NEEDLE ORIG ULTRAFINE 162
BD PEN NEEDLE SHORT ULTRAFINE 162
BD SAFETYGLIDE NEEDLE .. 162
BD SHARPS COLLECTOR 162
BD ULTRA-FINE INSULIN SYRINGES 162
BD ULTRA-FINE PEN NEEDLES 163
BD VEO INSULIN SYR ULTRAFINE 163
BELBUCA 148
belladonna alkaloids-opium 64, 144
BELSOMRA 128, 148
benazepril hcl 91
benazepril-hydrochlorothiazide 91, 180
BENEFIX 79
BENLYSTA 255, 278
benzalkonium chloride . 306, 318
BENZAMYCIN 301, 318
BENZNIDAZOLE 25, 37
benzoin 308
benzonatate 288
benzoyl peroxide-erythromycin 301, 318
benztropine mesylate 66, 118
BEQALZI 44
BEQALZI STARTER PACK 44
BERINERT 267, 268
BESIFLOXACIN HCL 184
BESIVANCE 184
BESREMI 35, 45, 274
BESREMI PEN 35, 45, 274
BETADINE OPHTHALMIC PREP 187
betaine 280
betamethasone dipropionate 208, 309
betamethasone dipropionate aug 208, 309
betamethasone valerate 208, 309
BETAPACE AF 69, 93, 98, 101, 102, 107
BETASERON 256, 274
betaxolol hcl 73, 93, 98, 101, 107, 188
bethanechol chloride 70
BETIMOL 69, 93, 101, 188
BEVESPI AEROSPHERE 64, 72, 306
bexarotene 45, 300, 321
BEXSERO 59
BEYAZ 218, 226, 240, 327
BEYFORTUS 36
bicalutamide 45
BIGFOOT UNITY PROGRAM 163
BIJUVA 227, 240
BIKTARVY 31, 32, 33
BILTRICIDE 23
bimatoprost 196
BIMZELX 314, 321
bis subcit-metronid-tetracyc 23, 25, 42, 198, 200
bisacodyl ec 200
bismuth/metronidaz/tetracyc lin 23, 25, 42, 198, 200
bisoprolol fumarate 74, 93, 99, 101, 108
bisoprolol-hydrochlorothiazide .. 93, 99, 180
BIXLENVO 31
blisovi 24 fe 218, 227, 240
blisovi fe 1.5/30 ..... 218, 227, 240
blisovi fe 1/20 ..... 218, 227, 240
BLUJEPA 43
BONSITY 237, 263
BOOSTRIX 58, 59
bosentan 112, 291, 298
BOSULIF 45
bosutinib 45
bp 10-1 ..... 301, 316
BRAFTOVI 45
BREATHE COMFORT CHAMBER/ADULT 163
BREATHE COMFORT CHAMBER/CHILD 163
BRENZAVVY 248
BREO ELLIPTA 72, 189, 209, 289
BREZTRI AEROSPHERE 64, 72, 209
briellyn 218, 227, 240
brimonidine tartrate 184, 300, 321
BRINSUPRI 288, 293
brinzolamide 188
brivaracetam 118
BRIVIACT 118
bromfenac sodium (once-daily) 195
bromocriptine mesylate 136, 137
BRONCHITOL 296
BRONCHITOL TOLERANCE TEST 296
BRUKINSA 45
BRYNOVIN 225
budesonide 209, 289, 294, 309
bumetanide 87, 106, 176
BUMEX 87, 106, 176
buprenorphine 148
buprenorphine hcl 148
buprenorphine hcl-naloxone hcl 147, 148
bupropion hcl 123

bupropion hcl er (smoking det) 62, 123
bupropion hcl er (sr) 123
bupropion hcl er (xl) 123
buspirone hcl 128, 141
butalbital-acetaminophen 116, 131, 142
butalbital-apap-caff-cod 116, 131, 142, 144, 149
butalbital-apap-caffeine 116, 131, 142, 149, 150
BUTALBITAL-APAP-CAFFEINE 116, 131, 142, 149
butalbital-asa-caff-codeine 131, 144, 150, 153
butalbital-aspirin-caffeine 131, 150, 153
butorphanol tartrate 126, 148
BYLVAY 201, 203
BYLVAY (PELLETS) 201, 203
cabergoline 137
CABLIVI 75, 87
CABOMETYX 45
CAFERGOT 70, 126, 150
caffeine citrate 127, 150
CALCIFOL 178, 327, 329
calcipotriene 308, 321
calcipotriene-betameth diprop 308, 309, 321
calcitonin (salmon) 216, 264
CALCITRENE 308, 321
calcitriol 321, 329
calcium acetate 177, 178
calcium acetate (phos binder) 177, 178
CALQUENCE 45
camila 218, 240
camrese 218, 227, 240
camrese lo 218, 227, 240
CAMZYOS 98
candesartan cilexetil 89, 90
candesartan cilexetil-hctz 90, 180
capecitabine 45
CAPLYTA 129
CAPRELSA 45
captopril 91
captopril-hydrochlorothiazide 91, 180
CAPVAXIVE 59
carbamazepine 119, 124
carbamazepine er 118, 123, 124
CARBATROL 119, 124
carbidopa 136
carbidopa-levodopa 136
carbidopa-levodopa er 136
carbidopa-levodopa-entacapone 134, 136
carbinoxamine maleate 17, 18, 292
CARBZAH 17, 18, 292
CARDAMYST 96, 102
CARDURA 70, 89, 93
CARDURA XL 70, 89, 93
CAREPOINT POLY HUB NEEDLE 163
CAREPOINT PRECISION POLY HUB 163
CAREPOINT SAFETY 1ST NEEDLE 163
CARESENS CONTROL SOLUTION A/B 163
CARESENS LANCETS 30G 163
CARESENS S CONTROL SOLN A/B 163
CARETOUCH CONTROL SOL LEVEL 2 163
CARETOUCH HYPODERMIC NEEDLE 163
CARETOUCH LANCING/EJECTOR 163
carglumic acid 175
carisoprodol 68
CARNITOR 280
CARNITOR SF 280
CAROSPIR 88, 107, 111, 178
carteolol hcl 188
cartia xt 95, 96, 97, 102, 112
carvedilol 69, 71, 89, 93, 99, 101, 108
CAVERJECT 105, 112
CAVERJECT IMPULSE(2 CARTRIDGE) 105, 112
CAYA 284
CAYSTON 36
cefaclor 20
cefaclor er 20
cefadroxil 20
cefdinir 20
cefixime 20
CEFIXIME 20
cefpodoxime proxetil 21
cefprozil 20
cefuroxime axetil 20
celecoxib 136
CELONTIN 155
cephalexin 20
CEQUR SIMPLICITY 1U EXTND WEAR 163
CEQUR SIMPLICITY 2U 163
CEQUR SIMPLICITY 2U EXTND WEAR 163
CERDELGA 182, 280
CERVIDIL 285
CETRAXAL 185
CETROTIDE 214
cevimeline hcl 70
CHANTIX 62, 67
CHANTIX CONTINUING MONTH PAK 62, 67
CHANTIX STARTING MONTH PAK 62, 67
charlotte 24 fe 218, 227, 240
chateal eq 218, 227, 240
CHEMET 15, 207, 261
CHEMSTRIP BG LOG BOOK 164
CHEMSTRIP K 174
CHEMSTRIP UGK 174
chlordiazepoxide hcl 133
chlordiazepoxide-amitriptyline 133, 156
chlordiazepoxide-clidinium 64, 133
chlorhexidine gluconate 21, 187, 188, 306, 318
chloroquine phosphate 24
chlorpromazine hcl 149
chlorthalidone 88, 112, 181
chlorzoxazone 68
CHOLBAM 201, 204
cholestyramine 95
cholestyramine light 94
CHORIONIC GONADOTROPIN 235
CHOSEN LANCETS 30G 164
CHOSEN LANCING DEVICE 164
CHOSEN SAFETY LANCETS 28G 164
CIBINQO 257, 270, 316, 322
ciclodan 313
ciclopirox 313
ciclopirox olamine 313, 314
cilostazol 86, 110
CILOXAN 185
CIMDUO 33
cimetidine 19, 205
cimetidine hcl 19, 205

CIMZIA (1 SYRINGE) 204, 253, 260, 270, 274
CIMZIA (2 SYRINGE) 204, 254, 260, 270, 274
CIMZIA-STARTER 204, 254, 260, 270, 274
cinacalcet hcl 216
CIPRO 26, 41
CIPRO HC 185, 189
ciprofloxacin hcl 26, 41, 185
ciprofloxacin-dexamethasone 185, 189
ciprofloxacin-hydrocortisone 185, 189
citalopram hydrobromide 154
cladribine (10 tabs) 45, 252, 274, 278
cladribine (4 tabs) 45, 252, 274, 278
cladribine (5 tabs) 46, 252, 274, 278
cladribine (6 tabs) 46, 252, 274, 278
cladribine (7 tabs) 46, 252, 275, 278
cladribine (8 tabs) 46, 252, 275, 278
cladribine (9 tabs) 46, 252, 275, 279
claravis 316, 322
clarithromycin 26, 39, 200
clarithromycin er 26, 39, 200
clearlax 200
clemastine fumarate 18, 292
CLEMSZA 18, 292
CLEOCIN 35, 301
CLEOCIN-T 35, 301
CLEVER CHOICE COMFORT EZ 164
CLEVER CHOICE COMFORT EZ PLUS 164
CLIMARA PRO 227, 240
clindacin 35, 301
clindacin etz 35, 301
clindacin-p 36, 301
clindamycin hcl 36, 301
clindamycin palmitate hcl 36, 302
clindamycin phos (twice-daily) 36, 302
clindamycin phos-benzoyl perox 36, 302, 318
clindamycin phosphate 36, 302
CLINDESSE 36, 302
CLINPRO 5000 ..... 158, 265
clobazam 131, 133
clobetasol prop emollient base 309
clobetasol propionate 309
clobetasol propionate e 309
clocortolone pivalate 309
clomid 225
clomiphene citrate 225
clomipramine hcl 156
clonazepam 131, 132, 133
clonidine 64, 99, 105
clonidine hcl 64, 99, 105
clonidine hcl er 64, 105
clopidogrel bisulfate 86
clorazepate dipotassium 132, 133
clotrimazole 306
clotrimazole-betamethasone 306, 310
clozapine 129
CLOZARIL 129
COAGADEX 79
coal tar 318
COARTEM 24
COBENFY 128, 325
COBENFY STARTER PACK 128, 325
codeine sulfate 144, 288
colchicine 263
colchicine-probenecid 181, 263
colesevelam hcl 95, 214
COLESTID 95
colestipol hcl 95
colistimethate sodium (cba) 40
COLY-MYCIN M 40
COMBIGAN 184, 188, 300
COMBIPATCH 227, 240
COMBIVENT RESPIMAT 64, 72, 286
COMETRIQ 46
COMFORT EZ PRO PEN NEEDLES 164
COMFORT TOUCH TWIST LANCET 30G 164
COMIRNATY 59
COMIRNATY 5-11 YEARS 59
COMPLERA 32, 33, 38
COMPRO 149, 199
CONDOMS 284
CONDYLOX 316, 322
constulose 175
CONTOUR CONTROL 164
CONTOUR NEXT 174
CONTOUR NEXT CONTROL 164
CONTOUR NEXT EZ 164
CONTOUR NEXT GEN MONITOR 164
CONTOUR NEXT MONITOR 164
CONTOUR NEXT ONE 164
CONTOUR NEXT TEST 174
CONTOUR PLUS BLUE 164
CONTOUR PLUS CONTROL SOLUTION 164
CONTOUR PLUS TEST 174
COPIKTRA 46
CORDRAN 310
CORIFACT 80
CORLANOR 98, 112
CORTANE-B 190, 209, 304, 310, 318
CORTEF 190, 209, 310
CORTENEMA 190, 209, 310
CORTIFOAM 190, 209, 310
CORTISPORIN-TC 185, 190
CORTROPHIN 173, 238
CORTROPHIN GEL 173, 237
CORTROSYN 173
COSENTYX (300 MG DOSE) 256, 270, 322
COSENTYX 150 MG/ML 257, 270, 322
COSENTYX SENSOREADY (300 MG) 257, 270, 322
COSENTYX SENSOREADY PEN 257, 270, 322
COSENTYX UNOREADY 257, 270, 322
COSOPT 188, 189
cosyntropin 173
COTELLIC 46
COVARYX 213, 227
COVARYX HS 213, 227
CRENESSITY 80, 238
CREON 183, 202
CRESEMBA 27
CREXONT 136
CRINONE 240
cromolyn sodium 184, 194, 293
CROTAN 320
cryselle 218, 227, 240
CTEXLI 201
CUVPOSA 65, 306
cyanocobalamin 85, 327
CYANOCOBALAMIN 85, 327

cyclobenzaprine hcl 68
CYCLOGYL 196
CYCLOMYDRIL 196, 197
cyclopentolate hcl 196
cyclophosphamide . 46, 255, 279
CYCLOPHOSPHAMIDE
..... 46, 255, 279
cycloserine 26
CYCLOSET 214
cyclosporine
..... 187, 252, 270, 275, 279
cyclosporine modified
..... 187, 252, 270, 275, 279
cyproheptadine hcl 18, 292
cyred eq 218, 227, 240
CYSTADANE 280
CYSTADROPS 194, 195
CYSTAGON 280
CYSTARAN 194, 195
CYTOTEC 206
cytra k crystals 175
dabigatran etexilate mesylate 77
dalfampridine er 280, 284
danazol 213
DANTRIUM 68
dantrolene sodium 68
dapsone 23, 25, 302, 322
DAPTACEL 58, 59
DARAPRIM 24
darunavir 34
dasatinib 46
dasetta 1/35 (28) 218, 227, 240
dasetta 7/7/7 ..... 218, 227, 240
DAURISMO 46
DAYBUE 135
DAYBUE STIX 135
daysee 218, 227, 240
DEBACTEROL 194, 318
deblitane 218, 240
deferasirox 207
deferasirox granules 207
deferiprone 207
DELESTROGEN 227, 264
DELSTRIGO 32, 33
delyla 218, 227, 240
demeclocycline hcl 42
DENGVAXIA 59
DENTA 5000 PLUS 157, 158, 265
DENTA 5000 PLUS
SENSITIVE 159, 266
DENTAGEL 157, 159, 266
DEPAKOTE 119, 124, 127, 137
DEPAKOTE ER
..... 119, 124, 127, 137
DEPAKOTE SPRINKLES
..... 119, 124, 127
DEPEN TITRATABS . 15, 207, 270
DEPO-ESTRADIOL 227, 264
DEPO-PROVERA 218, 240
DEPO-SUBQ PROVERA 104
..... 219, 241
DEPO-TESTOSTERONE 213, 214
DERMA-SMOOTHE/FS BODY
..... 190, 310
DERMA-SMOOTHE/FS
SCALP 190, 310
DERMOTIC 190, 310
DESCOVY 33, 38
desipramine hcl 156
DESMODA 80, 238
desmopressin ace spray refrig 80, 238
desmopressin acetate 80, 238
DESMOPRESSIN ACETATE
..... 80, 238
desmopressin acetate pf 80, 238
desmopressin acetate spray
..... 80, 238
desonide 310
desoximetasone 310
desvenlafaxine succinate er 153
dexamethasone 190, 209
dexamethasone intensol
..... 190, 209
dexamethasone sodium phosphate 190
DEXCOM G6 RECEIVER 165
DEXCOM G6 SENSOR 165
DEXCOM G6 TRANSMITTER 165
DEXCOM G7 15 DAY
SENSOR 165
DEXCOM G7 RECEIVER 165
DEXCOM G7 SENSOR 165
dexmethylphenidate hcl 150
dexmethylphenidate hcl er ... 150
dextroamphetamine sulfate . 115
dextroamphetamine sulfate er 115
dextromethorphan-quinidine
..... 135
DIABECIN HR 304, 318
DIABETES MONITOR DIGIT
ADD-ON 165, 280
DIABETES MONITOR DIGIT
SOLN 165, 281
DIACOMIT 119, 137
DIASTIX REAGENT 174
diazepam 132, 133
diazepam intensol 132, 133
diazoxide 216
dichlorphenamide 87, 265
diclofenac potassium 143
diclofenac sodium
..... 143, 151, 157, 195, 319
diclofenac sodium er 143
diclofenac-misoprostol 143, 206
dicloxacillin sodium 40
dicyclomine hcl 65
DIFICID 39
diflorasone diacetate 310
diflunisal 143, 151
difluprednate 190
digoxin 92, 98
dihydroergotamine mesylate
..... 70, 127
DILANTIN 100, 139
DILANTIN INFATABS 100, 139
DILANTIN-125 ..... 100, 139
diltiazem hcl 95, 96, 97, 103, 113
diltiazem hcl er
..... 95, 96, 97, 102, 103, 112, 113
diltiazem hcl er beads
..... 95, 96, 97, 102, 112
diltiazem hcl er coated beads 95, 96, 97, 102, 112
dilt-xr 95, 96, 97, 103, 113
dimethyl fumarate 255, 275
dimethyl fumarate starter pack 255, 275
DIPENTUM 199
diphenhydramine hcl
..... 18, 66, 118, 128, 288, 292
diphenoxylate-atropine .. 65, 198
DIPROLENE 209, 311
dipyridamole 86, 110, 113, 173
diskets 144
disopyramide phosphate 100
disulfiram 15, 261
divalproex sodium
..... 119, 124, 127, 137
divalproex sodium er
..... 119, 124, 127, 137
DIVIGEL 227, 264
dofetilide 102
DOJOLVI 175
dolishale 219, 227, 241
donepezil hcl 70
DOPTELET 78

DOPTELET SPRINKLE 78
DORZOLAMIDE HCL 189
dorzolamide hcl 189
dorzolamide hcl-timolol mal 188, 189
dotti 228, 264
DOVATO 31, 33
doxazosin mesylate 70, 89, 93
doxepin hcl 156, 304, 305
doxercalciferol 329
doxycycline hyclate .. 24, 42, 302
doxycycline monohydrate 24, 42, 302
DRIZALMA SPRINKLE 153
dronabinol 198, 204
DROPLET MEDLANCE LANCET 30G 165
DROPLET MICRON 165
DROPSAFE ACTI-LANCE 23G 165
DROPSAFE ACTI-LANCE LANCET 17G 165
DROPSAFE ACTI-LANCE LANCET 23G 165
DROPSAFE ACTI-LANCE LANCET 28G 165
DROPSAFE AUTOPROTECT DUO 165
DROPSAFE ERGOLANCE LANCET 21G 165
DROPSAFE ERGOLANCE LANCET 25G 165
DROPSAFE ERGOLANCE LANCET 30G 165
DROPSAFE HAEMOLANCE LANCET 1.5 165
DROPSAFE HAEMOLANCE LANCET 18G 165
DROPSAFE HAEMOLANCE LANCET 21G 165
DROPSAFE HAEMOLANCE LANCET 25G 165
DROPSAFE HAEMOLANCE LANCET 28G 165
DROPSAFE MEDISAFE LANCET 23G 165
DROPSAFE MEDISAFE LANCET 29G 166
DROPSAFE MEDLANCE LANCET 0.8MM 166
DROPSAFE MEDLANCE LANCET 21G 166
DROPSAFE MEDLANCE LANCET 25G 166
DROPSAFE MEDLANCE LANCET 30G 166
DROPSAFE SAFETY SYRINGE/NEEDLE 166
DROPSAFE SICURA 166
drospiren-eth estrad-levomefol 219, 228, 241, 327
drospirenone-ethinyl estradiol 219, 228, 241
DROXIA 46
droxidopa 63
DRYSOL 306
DUAVEE 225, 228
DUETACT 250
duloxetine hcl 137, 153
DUOPA 136
DUPIXENT 292, 314, 322
DUREX EXTRA SENSITIVE THIN 284
DUREX TROPICAL 284
dutasteride 261
DUVYZAT 281
E.E.S. GRANULES 29
EASIVENT 166
EASY COMFORT SHARPS CONTAINER 166
EASY TOUCH HEALTHPRO HIGH/LOW 166
EASYGEL 157, 159, 266
EASYMAX 15 LEVEL 2-3 CONTROL 166
EASYMAX CONTROL 166
EASYMAX CONTROL NORMAL/HIGH 166
EBGLYSS 314
econazole nitrate 306
econtra one-step ... 214, 219, 241
EC-RX DHEA 281
EDEX (2 CARTRIDGE) ... 105, 113
EDEX (6 CARTRIDGE) ... 105, 113
EDURANT PED 32
EEMT 213, 228
EEMT HS 213, 228
efavirenz 32
efavirenz-emtricitab-tenofo df 32, 33
efavirenz-lamivudine-tenofovir 32, 33
EFFER-K 178
effer-k 178
EGATEN 23
EGRIFTA SV 249
EGRIFTA WR 249
ELESTRIN 228, 264
eletriptan hydrobromide 154
elinest 219, 228, 241
ELIQUIS 76
ELIQUIS (1.5 MG PACK) 76
ELIQUIS (2 MG PACK) 76
ELIQUIS DVT/PE STARTER PACK 76
ELITE-OB 84, 326, 328
elixophyllin 105, 150, 176, 299, 325
ELLA 219, 241
ELMIRON 281
ELOCTATE 80
eltrombopag olamine 78
eluryng 219, 228, 241
EMBECTA AUTOSHIELD DUO 166
EMBECTA INS SYR U/F 1/2 UNIT 166
EMBECTA INSULIN SYR ULTRAFINE 166
EMBECTA INSULIN SYRINGE 166
EMBECTA INSULIN SYRINGE U-100 166
EMBECTA INSULIN SYRINGE U-500 167
EMBECTA PEN NEEDLE NANO 167
EMBECTA PEN NEEDLE NANO 2 GEN 167
EMBECTA PEN NEEDLE ULTRAFINE 167
EMBRACE PEN NEEDLES 167
EMBRACE WAVE GLUCOSE CONTROL 167
EMEND 206
EMGALITY 134
EMPAVELI 267, 268
EMSAM 140
emtricitabine 33
emtricitabine-tenofovir df .33, 38
emtricitab-rilpivir-tenofov df 32, 33, 38
EMTRIVA 33
EMVERM 23
emzahh 219, 241
enalapril maleate 91
enalapril-hydrochlorothiazide 91, 180

ENBRACE HR .. 84, 281, 326, 328
ENBREL 260, 270, 275
ENBREL MINI 260, 270, 275
ENBREL SURECLICK
..... 260, 270, 275
ENBUMYST 87, 176
ENCARE 284
ENDARI 281, 322
endocet 116, 142, 144
ENDOMETRIN 241
ENFLONSIA 36
ENGERIX-B 59
enilloring 219, 228, 241
ENLITE GLUCOSE SENSOR . 167
enoxaparin sodium 82, 83
ENSACOVE 46
enskyce 219, 228, 241
ENSPRYNG 258, 275
ENSTILAR 308, 311, 322
entacapone 134
entecavir 38
ENTRESTO 89, 90, 111
ENTYVIO PEN 197, 204, 253
enulose 175
EOHILIA 209
EPIDIOLEX 119
EPIFOAM 305, 311
epinastine hcl 20, 184
epinephrine 63, 286
EPINEPHRINE 63, 286
EPIVIR 33
eplerenone 88, 107, 111, 178
EQUETRO 119, 124
ergocalciferol 329
ERGOMAR 70, 127
ergotamine-caffeine 70, 127, 150
ERIVEDGE 46
ERLEADA 46, 47
erlotinib hcl 47
errin 219, 241
ERY 29, 185, 302
ERYPED 400 29
erythromycin 29, 185, 302
erythromycin base 29
erythromycin ethylsuccinate . 29
escitalopram oxalate 154
eslicarbazepine acetate 119, 139
esomeprazole magnesium ... 206
est estrogens-methyltest
..... 213, 228
est estrogens-methyltest ds
..... 213, 228
est estrogens-methyltest hs
..... 213, 228
estarylla 219, 228, 241
estazolam 133
estradiol 228, 264
estradiol valerate 229, 265
estradiol-norethindrone acet
..... 229, 241
ESTRATEST H.S. 213, 229
ESTRING 229, 265
estrogens conjugated ... 229, 265
eszopiclone 128, 141
ETCAMAH 47
ethacrynic acid 87, 106, 176
ethambutol hcl 26
ethosuximide 155
etodolac 143, 151
etodolac er 143, 151
etonogestrel-ethinyl
estradiol 219, 229, 241
etoposide 47
etravirine 32
EUCRISA 304, 319
EURAX 320
EVAMIST 229, 265
everolimus 47, 255, 279
EVEXITHROID 251
EVOTAZ 34, 281
EVRYSDI 281
EXELDERM 306
exemestane 47, 214
EXODERM 17, 304, 317
EXXUA 155
EXXUA TITRATION PACK 155
EYSUVIS 190
ezetimibe 100
ezetimibe-simvastatin ... 100, 106
FABHALTA 253, 267
falmina 219, 229, 241
famciclovir 38
famotidine 19, 205
FANAPT 129
FANAPT TITRATION PACK A 129
FANAPT TITRATION PACK B 130
FANAPT TITRATION PACK C 130
FASENRA PEN 292
FC2 FEMALE CONDOM 284
febuxostat 263
FEIBA 80
feirza 1.5/30 ..... 219, 229, 241
feirza 1/20 ..... 219, 229, 241
felbamate 119
FELBATOL 119
felodipine er 103, 104
FEM PH 318, 322
FEMCAP 284
FEMLYV 219, 229, 241
FEMRING 229, 265
fenofibrate 106
fenofibrate micronized 105
fenofibric acid 106
fentanyl 144
FERRIPROX 207
FERRIPROX TWICE-A-DAY .. 207
FETZIMA 153
FETZIMA TITRATION 153
fidaxomicin 39
FILSPARI 111, 272, 281, 291
FILSUVEZ 322
FINACEA 302, 322
finasteride 261, 308
fingolimod hcl 259, 275
FINTEPLA 119
finzala 219, 229, 241
FIORICET 116, 131, 142, 150
FIRDAPSE 70, 281
FIRMAGON 47, 214
FIRMAGON (240 MG DOSE)
..... 47, 214
FIRST-LANSOPRAZOLE 206
FIRVANQ 29
FLAREX 190
flavoxate hcl 325
flecainide acetate 100
FLEXICHAMBER 167
FLEXICHAMBER ADULT
MASK/SMALL 167
FLEXICHAMBER CHILD
MASK/LARGE 167
FLEXICHAMBER CHILD
MASK/SMALL 167
FLOLIPID 106
FLORIVA 158, 159, 266, 329
FLOTREX 158, 159, 266, 326
FLUAD 59
FLUARIX 59
FLUCELVAX 59
fluconazole 27
flucytosine 41
fludrocortisone acetate 209
FLULAVAL 59
FLUMIST 59
flunisolide 190, 210, 289, 293
fluocinolone acetonide
..... 190, 191, 311

fluocinolone acetonide body 190, 311
fluocinolone acetonide scalp 191, 311
fluocinonide 311
fluocinonide emulsified base 311
FLUORIDEX 159, 266
FLUORIDEX DAILY RENEWAL 158, 159, 266
FLUORIDEX ENHANCED WHITENING 159, 266
FLUORIMAX 5000 ..... 159, 266
FLUORIMAX 5000 SENSITIVE 159, 266
fluorometholone 191
fluorouracil 47, 300, 322
fluoxetine hcl 154
fluphenazine hcl 149
flurandrenolide 311
flurazepam hcl 133
flurbiprofen 143, 151, 195
flurbiprofen sodium 151, 195
fluticasone propionate 191, 210, 289, 293, 311
fluticasone-salmeterol 72, 191, 210, 289
FLUTICASONE-SALMETEROL ..72, 191, 210, 289
fluvastatin sodium 106
fluvastatin sodium er 106
fluvoxamine maleate 155
fluvoxamine maleate er 154
FLUZONE 60
FLUZONE HIGH-DOSE 59
FML FORTE 191
FML LIQUIFILM 191
FOCALIN 150
folic acid 328
FOLLISTIM AQ 235
fondaparinux sodium . 75, 83, 84
FONDCIRCLE CONTROL SOLUTION 167
FONDCIRCLE LANCING DEVICE 167
FONDCIRCLE SINGLE USE LANCETS 167
FORA TEST N' GO ADVANCE 167
FORA TEST N'GO ADV-VOICE-6 CON 174
FORANE 139
formaldehyde 174
formoterol fumarate 73, 297
FORZINITY 281
FOSAMAX 265
FOSAMAX PLUS D 265, 330
fosamprenavir calcium 34
fosfomycin tromethamine 43
fosinopril sodium 91
fosinopril sodium-hctz ... 92, 180
FOSRENOL 177, 261
FOTIVDA 47
FRAGMIN 83
FREESTYLE LIBRE 14 DAY READER 167
FREESTYLE LIBRE 14 DAY SENSOR 167
FREESTYLE LIBRE 2 PLUS SENSOR 167
FREESTYLE LIBRE 2 READER 167
FREESTYLE LIBRE 2 SENSOR 168
FREESTYLE LIBRE 3 PLUS SENSOR 168
FREESTYLE LIBRE 3 READER 168
FREESTYLE LIBRE 3 SENSOR 168
frovatriptan succinate 154
FRUZAQLA 47
ft aspirin 86, 87, 127, 153
ft aspirin adult low dose 86, 127, 153
ft aspirin low dose .. 86, 127, 153
ft clearlax 200
ft folic acid 328
ft laxative 201
ft magnesium citrate 201
ft naloxone hcl 15, 147
ft nicotine 62, 67
ft nicotine mini 62, 67
furosemide 87, 88, 106, 176
fyavolv 229, 241
FYCOMPA 119
FYREMADEL 214
gabapentin 116, 119, 137, 138
GALAFOLD 182, 281
galantamine hydrobromide 70
galantamine hydrobromide er 70
galbriela 219, 229, 241
gallifrey 241
GALZIN 178
ganirelix acetate 215
GARDASIL 9 60
gatifloxacin 185
GATTEX 202, 204
gavilax 201
gavilyte-c 201
gavilyte-g 201
gavilyte-n with flavor pack ... 201
GAVRETO 47
gefitinib 47
GELFILM 80
gemfibrozil 106
gemmily 219, 229, 241
generlac 175
gengraf ...187, 252, 270, 275, 279
gentamicin sulfate .. 21, 185, 302
gentle laxative 201
GENVOYA 31, 33
GILENYA 259, 275
GILOTRIF 47
glatiramer acetate 251, 275
glatopa 251, 252, 275
GLEOSTINE 48
glimepiride 250
glipizide 250
glipizide er 250
glipizide-metformin hcl .216, 250
GLOPERBA 263
glucagon emergency kit 15, 234, 261
GLUCAGON EMERGENCY KIT 15, 234, 261
GLUCOTROL XL 250
glutaraldehyde 175
glyburide 250
glyburide-metformin 216, 250
glycerol phenylbutyrate 175
glycolax 201
glycopyrrolate 65, 306
glydo 305
GLYXAMBI 225, 248
GOLYTELY 201
GOMEKLI 48
GONAL-F 235
GONAL-F RFF REDIJECT 235
goodsense aspirin low dose 86, 87, 127, 153
goodsense clearlax 201
goodsense nicotine 62, 67
goodsense nicotine policrilex 62, 67
GORDOFILM 307, 317
granisetron hcl 198
GRANISOL 198

GRASTEK 57
griseofulvin microsize 23
griseofulvin ultramicrosize 23
guaifenesin-codeine 288, 292
guanfacine hcl 99, 105, 135
guanfacine hcl er 135
GUARDIAN 4 GLUCOSE SENSOR 168
GUARDIAN 4 TRANSMITTER 168
GUARDIAN REAL-TIME CHARGER 168
GUARDIAN REAL-TIME TEST PLUG 168
GUARDIAN SENSOR 3 168
GVOKE HYPOPEN 1-PACK 15, 234, 261
GVOKE HYPOPEN 2-PACK 15, 234, 262
GVOKE KIT 15, 235, 262
GVOKE PFS 15, 235, 262
GYNAZOLE-1 307
habitrol 62, 67
HAEGARDA 267, 268
hailey 1.5/30 ..... 219, 229, 241
hailey 24 fe 219, 229, 241
hailey fe 1.5/30 ..... 219, 229, 242
hailey fe 1/20 ..... 219, 229, 242
halcinonide 311
halobetasol propionate 311
haloperidol 134
haloperidol lactate 134
HALUCORT 323
HAN-EASE 168
HARLIKU 182
HAVRIX 60
heather 219, 242
HEMANGEOL 69, 93, 99, 101, 108, 127
HEMATINIC/FOLIC ACID . 84, 328
HEMLIBRA 80
HEMMOREX-HC 191, 210, 311
HEMOFIL M 80
heparin na (pork) lock flsh pf . 83
heparin sod (pork) lock flush . 83
heparin sodium (porcine) 83
heparin sodium (porcine) +rfid 83
heparin sodium (porcine) pf .. 83
HEPCLUDEX 29
HEPLISAV-B 60
HEPZATO W/50MM CATHETER 48
HEPZATO W/62MM CATHETER 48
her style 215, 219, 242
HERNEXEOS 48
HETLIOZ 128, 140
HETLIOZ LQ 128, 140
HIBERIX 60
HUMALOG 247
HUMALOG KWIKPEN 247
HUMALOG MIX 50/50 KWIKPEN 247
HUMALOG MIX 75/25 KWIKPEN 247
HUMALOG MIX 75/25 VIAL 247
HUMALOG U-100 JUNIOR KWIKPEN 247
HUMATE-P 80
HUMATIN 21
HUMULIN 70/30 KWIKPEN 236, 248
HUMULIN 70/30 VIAL 236, 248
HUMULIN N KWIKPEN 236
HUMULIN N VIAL 236
HUMULIN R U-500 KWIKPEN 248
HUMULIN R VIAL 248
HYCAMTIN 48
hydralazine hcl 105
HYDRO 40 ..... 88, 176, 196, 317
hydrochlorothiazide 88, 112, 180
hydrocod poli-chlorphe poli er 18, 19, 288
hydrocodone bitartrate er 144
hydrocodone bit-homatrop mbr 65, 288
hydrocodone-acetaminophen 117, 142, 144, 145
hydrocodone-ibuprofen 143, 145, 151
hydrocortisone 191, 210, 312
hydrocortisone (perianal) 191, 210, 311
hydrocortisone ace-pramoxine 191, 210, 305, 311
hydrocortisone acetate 191, 210, 312
hydrocortisone butyrate 191, 210, 312
hydrocortisone valerate 191, 210, 312
hydrocortisone-acetic acid 191, 194, 210, 312
hydrocort-pramoxine (perianal) 192, 210, 305, 312
hydromorphone hcl 145
hydromorphone hcl er 145
hydroxychloroquine sulfate 24, 254, 270, 275
hydroxyurea 48
hydroxyzine hcl 18, 19, 128
hydroxyzine pamoate 18, 19, 129
HYFTOR 258, 279, 314, 323
HYMPAVZI 80
hyoscyamine sulfate . 16, 65, 286
hyoscyamine sulfate er 15, 65, 286
hyoscyamine sulfate sl 16, 65, 286
hyosyne 16, 65, 287
HYPERSAL 293
HYRNUO 48
ibandronate sodium 265
IBRANCE 48
IBTROZI 48
ibuprofen 127, 143, 152
icatibant acetate 87, 265, 268
iclevia 220, 229, 242
ICLUSIG 48
ICOTYDE 314
IDELVION 81
IDHIFA 48
IDVYNSO 32, 33
IHEALTH CONTROL SOLUTION 168
IHEALTH LANCING DEVICE . 168
imatinib mesylate 48
IMBRUVICA 48, 49
IMCIVREE 117, 208
imipramine hcl 156
imipramine pamoate 156
imiquimod 300, 323
IMKELDI 49
IMPAVIDO 25, 37
IMVEXXY MAINTENANCE PACK 229
IMVEXXY STARTER PACK ... 229
INBRIJA 136
incassia 220, 242
INCRELEX 249
indapamide 88, 112, 181
indomethacin 143, 152, 263
indomethacin er 143, 152, 263
INFANRIX 58, 60
INGREZZA 157
INLURIYO 49

INLYTA 49
INPEN 100-BLUE-LILLY-HUMALOG 168
INPEN 100-BLUE-NOVOLOG-FIASP 168
INPEN 100-GREY-LILLY-HUMALOG 168
INPEN 100-GREY-NOVOLOG-FIASP 168
INPEN 100-PINK-LILLY-HUMALOG 168
INPEN 100-PINK-NOVOLOG-FIASP 168
INQOVI 49
INSPIREASE RESERVOIR BAGS 169
INSULIN LISPRO 248
INSULIN LISPRO (1 UNIT DIAL) 248
INSULIN LISPRO JUNIOR KWIKPEN 248
INSULIN LISPRO PROT & LISPRO 248
INSULIN PEN NEEDLES 169, 170, 171
INSULIN SYRINGES 169
INSUPEN32G EXTR3ME 169
INTELENCE 32
INTRAROSA 210
introvale 220, 230, 242
INVELTYS 192
INZIRQO 88, 180
iodine strong 16, 23, 216, 292, 306
iodine tincture 306, 318
IOPIDINE 184, 194
IPOL 60
ipratropium bromide 65, 287
ipratropium bromide hfa 65, 287
ipratropium-albuterol 65, 73, 287
IQIRVO 201, 204
irbesartan 89, 90
irbesartan-hydrochlorothiazide 90, 180
IRESSA 49
ISENTRESS 31
ISENTRESS HD 31
isibloom 220, 230, 242
isoflurane 139
isoniazid 26, 27
isosorb dinitrate-hydralazine 105, 108, 109
isosorbide dinitrate 108, 109
isosorbide mononitrate 108, 109
isosorbide mononitrate er 108, 109
isotretinoin 317, 323
isradipine 103, 104
ISTALOL 69, 93, 101, 188
ISTURISA 210, 281
ITOVEBI 49
itraconazole 28
ivabradine hcl 98, 113
ivermectin 23
IWILFIN 49
jaimiess 220, 230, 242
JAKAFI 49, 316
JAKAFI XR 49, 316
JARDIANCE 248
JASCAYD 287, 294, 319
jasmiel 220, 230, 242
JAVADIN 64, 99
JAYPIRCA 49
jencycla 220, 242
JENTADUETO 216, 225
JENTADUETO XR 216, 225
jinteli 230, 242
JOENJA 276
jolessa 220, 230, 242
JORNAY PM 150
JOURNAVX 117
joyeaux 220, 230, 242
JUBLIA 307
juleber 220, 230, 242
JULUCA 31, 32
junel 1.5/30 ..... 220, 230, 242
junel 1/20 ..... 220, 230, 242
junel fe 1.5/30 ..... 220, 230, 242
junel fe 1/20 ..... 220, 230, 242
junel fe 24 ..... 220, 230, 242
JUST RIGHT 5000 ..... 159, 266
JUXTAPID 92, 107
JYLAMVO . 49, 254, 271, 276, 279
kaitlib fe 220, 230, 242
KALETRA 34, 35
kalliga 220, 230, 242
KALYDECO 291
KAPSPARGO SPRINKLE 74, 93, 99, 101, 108
kariva 220, 230, 242
kelnor 1/35 ..... 220, 230, 242
KEPPRA 120
KEPPRA XR 120
KERENDIA 107
KESIMPTA 258, 276
ketoconazole 28, 307
ketodan 28, 307
KETO-DIASTIX 174
KETONE CARE 174
ketorolac tromethamine 143, 152, 195
KETOSTIX 174
KEVZARA 257, 271
KHINDIVI 192, 211, 312
KINERET 257, 271, 276
KISQALI (200 MG DOSE) 49
KISQALI (400 MG DOSE) 49
KISQALI (600 MG DOSE) 50
KLARON 302
klayesta 40, 320
KLISYRI (250 MG) 300, 323
KLISYRI (350 MG) 300, 323
klor-con 178
klor-con 10 178
klor-con m10 178
klor-con m15 178
klor-con m20 178
KLOXXADO 16, 147
KOATE 81
KOATE-DVI 81
KOMZIFTI 50
KOSELUGO 50
KOURZEQ 312
KOVALTRY 81
K-PHOS 178
K-PHOS NO 2 175
K-PHOS-NEUTRAL 178
KRAZATI 50
KRINTAFEL 24
KRISTALOSE 175
KT TAPE CGM PATCH 169
kurvelo 220, 230, 242
KYGEVVI 281
KYZATREX 213, 215
labetalol hcl 69, 71, 89, 93, 99, 101, 108
lacosamide 120, 139
lactulose 175
lactulose encephalopathy 175
LAGEVRIO 38
LAMICTAL 120, 124
LAMICTAL ODT 120, 124
LAMICTAL STARTER 120, 124
LAMICTAL XR 120, 124
lamivudine 33, 34
lamivudine-zidovudine 34
lamotrigine 120, 125
lamotrigine er 120, 125
lamotrigine odt 120, 125

lamotrigine starter kit-blue 120, 125
lamotrigine starter kit-green 120, 125
lamotrigine starter kit-orange 121, 125
LAMPIT 25
LANCETS 169
LANCETS 28G THIN 169
LANCETS SUPER THIN 169
LANOXIN 92, 98
lansoprazole 207
lanthanum carbonate 177, 262
LANTUS SOLOSTAR 236
LANTUS U-100 VIAL 236
lapatinib ditosylate 50
larin 1.5/30 ..... 220, 230, 242
larin 1/20 ..... 220, 230, 242
larin 24 fe 220, 230, 242
larin fe 1.5/30 ..... 220, 230, 242
larin fe 1/20 ..... 220, 230, 242
LASIX 88, 106, 176
LASIX ONYU 88, 176
latanoprost 196
laxative osmotic 201
LAZCLUZE 50
lederle leucovorin 17, 262, 328
LEDIPASVIR-SOFOSBUVIR 30
leflunomide 258, 271, 276, 279
lenalidomide 50, 276
LENVIMA 50
LEQEMBI IQLIK 258
lessina 220, 230, 242
letrozole 50, 214
leucovorin calcium 17, 262, 328
LEUKERAN 50
LEUKINE 78
leuprolide acetate 50, 235
levalbuterol hcl 73, 297
LEVALBUTEROL HFA 73, 297
LEVBID 16, 65, 287
levetiracetam 121
levetiracetam er 121
levobunolol hcl 188
levocarnitine 281
levocarnitine sf 281
levocetirizine dihydrochloride 20
levofloxacin 27, 41, 185, 303
levonest 220, 230, 243
levonorgest-eth estrad 91-day 220, 230, 243
levonorgest-eth estradiol-iron 220, 230, 243
levonorgestrel 215, 220, 243
levonorgestrel-ethinyl estrad 220, 230, 243
levonorg-eth estrad triphasic 221, 230, 243
levorphanol tartrate 145
levothyroxine sodium 251
levoxyl 251
LEVSIN 16, 65, 287
LEVSIN/SL 16, 65, 287
LEVULAN KERASTICK 300, 323
l-glutamine 281, 323
lidocaine 305
lidocaine hcl 195, 305
lidocaine hcl urethral/mucosal 305
lidocaine viscous hcl 195
lidocaine-prilocaine 305
LIFYORLI (125 MG DOSE) 50, 51
LIFYORLI (150 MG DOSE) 51
LIKMEZ 21, 25, 37, 200, 303
linezolid 40
LINZESS 197, 204
liomny 251
liothyronine sodium 251
liraglutide 117, 118, 235
lisdexamfetamine dimesylate 116
lisinopril 91, 92
lisinopril-hydrochlorothiazide 92, 180
LITFULO 316, 323
lithium 125
lithium carbonate 125
lithium carbonate er 125
LITHOBID 125
LITHOSTAT 175
LIVDELZI 202
LIVMARLI 202, 204
LIVTENCITY 27
LO LOESTRIN FE 221, 231, 243
LODOCO 75, 281
lofexidine hcl 64
lojaimiess 221, 231, 243
LOKELMA 177
LOMOTIL 66, 198
lomustine 51
LONSURF 51
LOPID 106
lopinavir-ritonavir 35
LOPRESSOR 74, 94, 101
lorazepam 132, 133
lorazepam intensol 132, 133
LORBRENA 51
loryna 221, 231, 243
losartan potassium 89, 90
losartan potassium-hctz 90, 181
LOTEMAX 192
LOTEMAX SM 192
LOTENSIN 91, 92
LOTENSIN HCT 92, 181
loteprednol etabonate 192
loteprednol-tobramycin 185, 192
lovastatin 106
low-ogestrel 221, 231, 243
loxapine succinate 128, 136
lo-zumandimine 221, 231, 243
lubiprostone 197, 204
LUGOLS STRONG IODINE 306, 318
luizza 1.5/30 ..... 221, 231, 243
luizza 1/20 ..... 221, 231, 243
LUMAKRAS 51
LUMRYZ 135, 157, 263
LUMRYZ STARTER PACK 157, 263
LUPKYNIS 259, 279
lurasidone hcl 130
LURBIRO 143, 152, 195
lutera 221, 231, 243
lyleq 221, 243
lyllana 231, 265
LYNKUET 135
LYNPARZA 51
LYRICA 121, 137, 138
LYSODREN 51
LYTGOBI (12 MG DAILY DOSE) 51
LYTGOBI (16 MG DAILY DOSE) 51
LYTGOBI (20 MG DAILY DOSE) 51
LYUMJEV KWIKPEN 248
LYUMJEV VIAL 248
lyza 221, 243
macitentan 113, 291, 298
MACROBID 43
magnesium citrate 201
MALARONE 24
malathion 320
maraviroc 31
marlissa 221, 231, 243
MARPLAN 141
MATULANE 51

matzim la.....95, 96, 97, 103, 113
MAVYRET.....30
MAXIDEX.....192
MAXITROL.....185, 192
maxi-tuss ac..... 288, 292
MAYZENT.....259, 276
MAYZENT STARTER PACK
..... 259, 276
me/naphos/mb/hyo1. 43, 66, 281
meclofenamate sodium 143, 152
MEDROL.....211
medroxyprogesterone acetate.....221, 243
mefenamic acid..... 143, 152
mefloquine hcl.....24
megestrol acetate..... 51, 243
MEKINIST.....52
MEKTOVI.....52
meleya.....221, 243
MELOXICAM..... 143, 152
meloxicam..... 143, 152
memantine hcl.....135
memantine hcl er..... 135
MENOPUR.....235
MENOSTAR.....231, 265
MENQUADFI..... 60
MENVEO..... 60
meperidine hcl.....145
meprobamate..... 129, 141
mercaptopurine.....52, 255, 279
mesalamine..... 199
mesalamine-cleanser.....200
mesna.....284
MESNEX.....284
MESTINON..... 71
metaxalone..... 68
metformin hcl..... 216
metformin hcl er.....216
methadone hcl.....145
methadone hcl intensol.....145
METHADOSE..... 145
methadose.....145
METHADOSE SUGAR-FREE.145
methamphetamine hcl..... 116
methazolamide.....87, 98, 189
methenamine hippurate..... 43
methenamine mandelate..... 43
METHERGINE.....285
methimazole..... 216
METHITEST.....213
methocarbamol..... 32, 68
methotrexate sodium
..... 52, 254, 271, 276, 279
methotrexate sodium (pf)
..... 52, 254, 271, 276, 279
methoxsalen rapid..... 320
methscopolamine bromide.... 66
methsuximide.....155
methyl salicylate..... 307
methyldopa.....64, 99, 105
methylergonovine maleate...285
METHYLIN.....150
methylphenidate hcl..... 151
methylphenidate hcl er.....151
methylphenidate hcl er (cd). 150
methylphenidate hcl er (la).. 150
methylprednisolone.....211
methyltestosterone.....213
metoclopramide hcl..... 206
metolazone..... 88, 112, 181
METOPIRONE.....174
metoprolol succinate er
..... 74, 94, 99, 101, 108
metoprolol tartrate
..... 74, 94, 99, 101, 108
metoprolol-hydrochlorothiazide..94, 99, 181
metronidazole
..... 21, 25, 37, 200, 303
metyrosine.....174, 282
mexiletine hcl..... 100
MIACALCIN..... 216, 265
mibelas 24 fe..... 221, 231, 243
miconazole 3..... 307
microgestin 1.5/30.221, 231, 243
microgestin 1/20....221, 231, 243
microgestin fe 1.5/30
..... 221, 231, 243
microgestin fe 1/20221, 231, 244
MICROLET NEXT LANCETS. 169
MICROLET NEXT LANCING DEVICE.....169
midazolam hcl..... 133
midodrine hcl..... 64
MIEBO..... 187, 194
MIFEPREX.....285
mifepristone..... 214, 285
MIGERGOT..... 70, 127, 151
miglitol..... 213
miglustat.....182, 282
mili.....221, 231, 244
milnacipran hcl.....137, 153
milophene..... 225
mimvey.....231, 244
MINIMED INSTINCT GLUC SENSOR.....169
minocycline hcl. 24, 42, 185, 303
minocycline hcl er
..... 24, 42, 185, 303, 323
minoxidil..... 105, 308
minzoya.....221, 231, 244
MIPLYFFA..... 182
mirabegron er.....326
mirtazapine.....123, 155
misoprostol..... 206
MITIGARE.....263
MITOSOL.....185
mm aspirin.....86, 87, 127, 153
mm clearlax..... 201
M-M-R II..... 60
M-NATAL PLUS.....84, 326, 328
MNEXSPIKE..... 60
MOBI CONNECT LANCING DEVICE.....170
MOBI CONNECT TWIST LANCETS..... 170
MOBILE LANCETS 30G.....170
modafinil.....157
MODEYSO.....52
moexipril hcl.....91, 92
molindone hcl.....128, 136
mometasone furoate
..... 192, 211, 289, 293, 312
mono-linyah.....221, 231, 244
MONSELS FERRIC SUBSULFATE..... 81
montelukast sodium.....293
morphine sulfate.....146
morphine sulfate (concentrate)..... 145
morphine sulfate er.....146
morphine sulfate er beads
..... 145, 146
MOTPOLY XR..... 121, 139
MOUNJARO..... 235
moxifloxacin hcl 27, 41, 185, 303
moxifloxacin hcl (2x day)41, 185
MOZOBIL.....78
MUCOSITISRX.....194
MULPLETA..... 78
MULTAQ.....102
multivitamin w/fluoride
..... 158, 159, 266, 326
multivitamin/fluoride
..... 158, 159, 266, 326, 328

multi-vitamin/fluoride/iron 84, 266, 326
mupirocin 303
mupirocin calcium 303
my choice 215, 221, 244
my way 215, 221, 244
MYALEPT 236
mycophenolate mofetil .252, 279
mycophenolate sodium 279
mycophenolic acid 279
MYFEMBREE..... 215, 231, 244
MYHIBBIN 279
MYLERAN 52
MYSOLINE 131
MYTESI 198
MYXREDLIN 179, 248
nabumetone 143, 152
nadolol 69, 74, 89, 94, 99, 101, 108
naloxone hcl 16, 17, 147, 262
naltrexone hcl 15, 17, 62, 147, 261, 262
naproxen 127, 143, 144, 152, 263
naproxen dr ... 127, 143, 152, 263
naproxen sodium 127, 144, 152, 263
naratriptan hcl 154
NARCAN 16, 147
NARDIL 141
NASCOBAL 85, 328
NATACYN 187
NATAZIA 221, 231, 244
nateglinide 237
NAYZILAM 132, 133
nebivolol hcl 69, 94, 99, 101
NEBUPENT 25
NEBUSAL 293
necon 0.5/35 (28) ... 221, 231, 244
nefazodone hcl 155
NEFFY 64
NEMLUVIO 314
neomycin sulfate 22, 186, 303
neomycin-bacitracin zn-polymyx 186
neomycin-polymyxin-dexameth 186, 192
neomycin-polymyxin-gramicidin 186
neomycin-polymyxin-hc 186, 192
NEONATAL COMPLETE 84, 326, 328
NEONATAL PLUS 84, 326, 328
NEOTUSS PLUS .. 18, 19, 64, 288
NERLYNX 52
NESTABS 84, 326, 328
NESTABS ONE 84, 282, 326, 328
neuac 36, 303, 319
NEULASTA 78
NEUPRO 142
NEURONTIN 117, 121, 138
NEVANAC 195
nevirapine 32
nevirapine er 32
new day 215, 221, 244
NEXLETOL 88, 92
NEXLIZET 88, 93, 100
NEXTSTELLIS..... 222, 231, 244
NGENLA 238
niacin er (antihyperlipidemic) 93, 328
nicardipine hcl 103, 104, 113
NICORETTE 62, 67
NICORETTE MINI 62, 67
nicotine 63, 67
nicotine mini 62, 67
nicotine polacrilex 63, 67
nicotine polacrilex mini 62, 67
nicotine step 1 .....63, 67
nicotine step 2 .....63, 67
nicotine step 3 .....63, 67
NICOTROL NS 63, 67
nifedipine 104, 113
nifedipine er 103, 104, 113
nifedipine er osmotic release 104, 113
nikki 222, 231, 244
nilotinib hcl 52
nimodipine 104, 113
NIMODIPINE 104, 113
NINLARO 52
nintedanib esylate 287
nisoldipine er 104
nitazoxanide 25, 26
nitro-bid 108, 109
NITRO-DUR 108, 109
nitrofurantoin 43
nitrofurantoin macrocrystal ... 43
nitrofurantoin monohydrate macrocrystals 43
nitroglycerin .. 108, 109, 308, 323
NITROSTAT 108, 109
NITRO-TIME 108, 109
NIVA THYROID 251
NIVESTYM 78
nora-be 222, 244
NORDIPEN 5 INJECTION DEVICE 170
NORDITROPIN FLEXPRO 238, 249
norelgestromin-eth estradiol 222, 231, 244
norethin ace-eth estrad-fe 222, 232, 244
norethindrone 222, 244
norethindrone acetate 244
norethindrone acet-ethinyl est 222, 232, 244
norethindrone-eth estradiol 232, 244
norgestimate-eth estradiol 222, 232, 244
norgestimate-ethinyl estradiol triphasic . 222, 232, 244
NORLIQVA 104, 113
norlyroc 222, 244
NORPACE 100
NORPRAMIN 156
nortrel 0.5/35 (28) .. 222, 232, 244
nortrel 1/35 (21) 222, 232, 244
nortrel 1/35 (28) 222, 232, 245
nortrel 7/7/7 .....222, 232, 245
nortriptyline hcl 156
NORVIR 35
NOURIANZ 115, 135
NOVAREL 235
NOVOEIGHT 81
NOVOFINE PEN NEEDLE 170
NOVOFINE PLUS PEN NEEDLE 170
NOVOPEN ECHO 170
NOVOSEVEN RT 81
NOXAFIL 28
np thyroid 251
NUBEQA 52
NUCALA 288
NUCORT 192, 211, 312
NUCYNTA ER 146
NUEDEXTA 135
NULEV 16, 66, 287
NUPLAZID 130
NURTEC 134
NUWIQ 81
NUZYRA 22
nylia 1/35 .....222, 232, 245
nylia 7/7/7 .....222, 232, 245
NYMALIZE 104, 113
nystatin 40, 320

nystatin-triamcinolone 40, 312, 320
nystop 40, 320
OBIZUR 81
octreotide acetate 204, 249
OCUFLOX 41, 186
ODACTRA 57
ODEFSEY 32, 34, 38
ODOMZO 52
ofloxacin 41, 186
OGSIVEO 52
OHTUVAYRE 286
OJEMDA 52
OJJAARA 53
olanzapine 125, 130, 199
olanzapine-fluoxetine hcl 125, 130, 155, 199
olmesartan medoxomil 90
olmesartan medoxomil-hctz 90, 181
olopatadine hcl 19, 184
OLUMIANT 257, 271
omega-3-acid ethyl esters 93, 109
omeprazole 207
OMNIFLEX DIAPHRAGM 284
OMNIPOD 5 DEXG7G6 INTRO GEN 5 170
OMNIPOD 5 DEXG7G6 PODS GEN 5 170
OMNIPOD 5 LIBRE INTRO 170
OMNIPOD 5 LIBRE PODS 170
OMNITROPE 238, 249, 250
OMVOH 197
OMVOH (300 MG DOSE) 197
ondansetron hcl 198
ondansetron odt 198
ONE VITE WOMENS PLUS 84, 326, 328
ONENATAL RX 84, 179, 326, 328
ONETOUCH DELICA PLUS LANCING 170
ONETOUCH DELICA SAFETY LANCING 170
ONETOUCH ULTRA 170
ONETOUCH VERIO 170
ONFI 132, 133
ONTRALFY 68
ONUREG 53
ONYDA XR 64
opcicon one-step 215, 222, 245
OPFOLDA 182, 282
OPILL 222, 245
opium 146, 198
option 2 ..... 215, 222, 245
OPTIONS GYNOL II CONTRACEPTIVE 284
OPVEE 147
OPZELURA 53, 316, 323
ORACIT 175
ORALAIR 58
ORALAIR ADULT STARTER PACK 57
ORALAIR CHILDRENS STARTER PACK 57
ORALONE 312
ORAPRED ODT 192, 211
ORAVIG 307
ORENCIA 253, 271, 276
ORENCIA CLICKJECT 253, 271, 276
ORENITRAM 114, 295, 298
ORENITRAM MONTH 1 ..... 113, 295, 298
ORENITRAM MONTH 2 ..... 113, 295, 298
ORENITRAM MONTH 3 ..... 114, 295, 298
ORFADIN 182, 282
ORGOVYX 53, 215
ORIAHNN 215, 232, 245
ORILISSA 215
ORKAMBI 290, 291
ORLYNVAH 43, 181, 263
orphenadrine citrate er 68, 74, 118
orquidea 222, 245
ORSERDU 53
OSCIMIN 16, 66, 287
oseltamivir phosphate 37
OSPHENA 225
OTEZLA 258, 259, 271, 276, 277, 323
OTEZLA XR 259
OTEZLA/OTEZLA XR INITIATION PK 259
OVIDE 320
OVIDREL 235
oxaprozin 144, 152
oxazepam 133
oxcarbazepine 121, 139
OXERVATE 187, 194
oxiconazole nitrate 307
oxybutynin chloride 325
oxybutynin chloride er 325
oxycodone hcl 146
oxycodone-acetaminophen 117, 142, 146
oxymetazoline hcl 197, 300, 323
oxymorphone hcl 146
oxymorphone hcl er 146
OZEMPIC 236
PACERONE 102
paliperidone er 130
PALYNZIQ 183
PANCREAZE 183, 202
PANRETIN 300, 323
pantoprazole sodium 207
PARI VORTEX ADULT MASK 170
PARI VORTEX PEDIATRIC MASK 170
paricalcitol 330
PARNATE 141
paroxetine hcl 155
paroxetine hcl er 155
PAXLOVID (150/100) 27, 28
PAXLOVID (300/100 & 150/100) 27, 28
PAXLOVID (300/100) 27, 28
pazopanib hcl 53
PEDIARIX 58, 60
PEDVAXHIB 60
peg 3350 201
peg 3350-kcl-na bicarb-nacl 201
peg-3350/electrolytes 201
PEGASYS 35, 53, 256, 277
PEMAZYRE 53
PEN NEEDLE/5-BEVEL TIP 170
PENBRAYA 60
penicillamine 16, 207, 271
penicillin v potassium 36
PENMENVY 61
PENTACEL 58, 61
pentamidine isethionate 26
pentazocine-naloxone hcl 147, 148
pentoxifylline er 79
perampanel 121
PERFECT POINT SAFETY LANCETS 171
PERFECT POINT SAFETY NEEDLE 171
PERFOROMIST 73, 297
PERIDEX 21, 187, 188, 306, 319
perindopril erbumine 91, 92
periogard 21, 187, 188, 306, 319
permethrin 320
perphenazine 149

perphenazine-amitriptyline 149, 156
PERTZYE 183, 202
phenazopyridine hcl 305
phenelzine sulfate 141
phenobarbital 131
phenoxybenzamine hcl .. 70, 112
phenylephrine hcl 196, 197
phenytek 100, 139
phenytoin 100, 139
phenytoin infatabs 100, 139
phenytoin sodium extended 100, 139
PHEXX 284
philith 222, 232, 245
PHOSPHA 250 NEUTRAL 179
PHOSPHOLINE IODIDE 195
phosphorous 179
phospho-trin 250 neutral 179
PHOXILLUM B22K4/0 179
PHOXILLUM BK4/2.5 179
phytonadione 16, 262, 330
PIFELTRO 32
pilocarpine hcl 71, 196
pimecrolimus 279, 314, 323
pimozide 128, 136
pimtrea 222, 232, 245
pindolol 69, 94, 99, 101, 108
pioglitazone hcl 250
pioglitazone hcl-glimepiride 250
pioglitazone hcl-metformin hcl 217, 250
PIP GLUCOSE CONTROL SOLUTION 171
PIQRAY 53
pirfenidone 287, 296
piroxicam 144, 152
PIVOT SUPPLY KIT 171
PIVYA 22
PLAN B ONE-STEP 215, 222, 245
PLEGRIDY 277
PLEGRIDY STARTER PACK . 277
plerixafor 78
PNEUMOVAX 23 61
pnv 27-ca/fe/fa 84, 326, 328
PODOCON-25 ..... 317, 323
podofilox 317, 323
polyethylene glycol 3350 201
polymyxin b-trimethoprim 40, 186, 303
POLY-VI-FLOR/IRON 84, 266, 326
pomalidomide 53, 277
portia-28 ..... 222, 232, 245
posaconazole 28
potassium chloride 179
potassium chloride crys er .. 179
potassium chloride er 179
potassium citrate er 175
potassium citrate-citric acid 175
potassium iodide (expectorant) 292
PRADAXA 77
pramipexole dihydrochloride 142
PRAMOSONE 305, 312, 313
PRAMOTIC 187, 195
prasugrel hcl 86
pravastatin sodium 106
praziquantel 23
prazosin hcl 70, 89, 94
PRED MILD 193, 211
prednisolone 193, 211
prednisolone acetate 193, 211
prednisolone sodium phosphate 193, 211
prednisone 211
prednisone intensol 211
pregabalin 121, 137, 138
PREGNYL 235
PREMARIN 232, 265
PREMESISRX 179, 282, 326, 328
PREMPHASE 232, 245
PREMPRO 232, 245
PRENACORE 84, 327, 328
prenatal 84, 327, 328
PRENATE ENHANCE 84, 179, 282, 327, 329
PREPIDIL 285
PRETOMANID 27
prevalite 95
PREVIDENT ... 158, 159, 160, 267
PREVIDENT 5000 BOOSTER PLUS 159, 266
PREVIDENT 5000 DRY MOUTH 158, 159, 266
PREVIDENT 5000 ENAMEL PROTECT 159, 266
PREVIDENT 5000 KIDS . 159, 266
PREVIDENT 5000 ORTHO DEFENSE 159, 266
PREVIDENT 5000 PLUS 158, 159, 267
PREVIDENT 5000 SENSITIVE 159, 267
PREVNAR 20 61
PREVYMIS 27
PREZCOBIX 35, 282
PREZISTA 35
PRIFTIN 27, 41
primaquine phosphate 24
primidone 131
PRIORIX 61
PRISMASOL B22GK 4/0 179
PRISMASOL BGK 0/2.5 179
PRISMASOL BGK 2/0 179
PRISMASOL BGK 2/3.5 179
PRISMASOL BGK 4/0/1.2 179
PRISMASOL BGK 4/2.5 180
PRISMASOL BK 0/0/1.2 180
probenecid 181, 263
PROCENTRA 116
prochlorperazine 149, 199
prochlorperazine maleate 149, 199
PROCTOFOAM HC 193, 211, 305, 313
procto-med hc 193, 211, 313
PROCTOSOL HC ... 193, 212, 313
PROCTOZONE-HC 193, 212, 313
PROCYSBI 282
PROFILNINE 81
progesterone 245
PROGLYCEM 216
PROGRAF 252, 280, 314, 315
PROMACTA 78
promethazine hcl 17, 18, 19, 129, 199, 202, 292
promethazine-codeine 18, 19, 288
promethazine-dm 18, 19, 288
promethazine-phenylephrine 18, 19, 64
PROMETHEGAN 18, 19, 129, 199, 203, 292
PRONAL 307, 317
propafenone hcl 100
propafenone hcl er 100
proparacaine hcl 195
propranolol hcl 69, 94, 99, 101, 109, 128
propranolol hcl er 69, 94, 99, 101, 108, 128
propylthiouracil 216
PROQUAD 61
protriptyline hcl 156
PROVERA 245
prucalopride succinate 204
PRURADIK 320

pseudoephedrine-bromphen-dm 19, 64, 288
PULMOSAL 293
PULMOZYME 183, 293
PURE COMFORT SAFETY LANCET 30G 171
PURE COMFORT SAFETY PEN NEEDLE 171
PURIXAN 53, 255, 280
PYLERA 23, 26, 42, 198, 200
pyrazinamide 27
PYRIDIUM 305
pyridostigmine bromide 71
pyridostigmine bromide er 71
PYRIDOSTIGMINE BROMIDE ER 71
pyrimethamine 24
PYROGALLIC ACID 285, 317, 323
PYRUKYND 75
PYRUKYND TAPER PACK 76
QBRELIS 92
QFITLIA 81
QINLOCK 53
QUADRACEL 58, 61
QUESTRAN 95
QUESTRAN LIGHT 95
quetiapine fumarate 125, 130
quetiapine fumarate er . 125, 130
QUICK TOUCH INSULIN PEN NEEDLE 171
quinapril hcl 91, 92
quinapril-hydrochlorothiazide 92, 181
quinidine gluconate er 24, 100
quinidine sulfate 24, 100
quinine sulfate 24
QULIPTA 134
QVAR REDIHALER 212, 289, 290, 294
rabeprazole sodium 207
RADICAVA ORS 115, 135
RADICAVA ORS STARTER KIT 115, 135
RADIOGARDASE 17, 177, 262
RAGWITEK 58
RALDESY 155
raloxifene hcl 225, 265
ramelteon 129, 140
ramipril 91, 92
ranolazine er 98
rasagiline mesylate 140, 141
RASONQUE 53
RASUVO 254, 271, 272
RAYA SURE PEN NEEDLE ... 171
reclipsen 222, 232, 245
RECOMBINATE 81
RECOMBIVAX HB 61
RECOTHROM 81
RECOTHROM SPRAY KIT 82
RECTIV 109, 308, 324
REGLAN 206
RELENZA DISKHALER 37
RELION GLUCOSE TEST STRIPS 174
RELISTOR 147, 197, 198, 204
RELNATE DHA . 84, 282, 327, 329
RENTHYROID 251
repaglinide 237
REPATHA SURECLICK 109
RESTASIS 187, 194, 253
RESTORIL 133
RETACRIT 75, 78
RETEVMO 53, 54
RETROVIR 34
REVUFORJ 54
REXTOVY 16, 147
REXULTI 130
REYATAZ 35
REZDIFFRA 204, 251
REZENOPY 16, 148
REZLIDHIA 54
REZUROCK 282
RHAPSIDO 277, 315
RHOFADE 197, 300, 324
RHOPRESSA 196
ribavirin 38
RIDAURA 207, 254, 272, 277
rifabutin 27, 41
rifampin 27, 41
rifapentine 27, 41
rilpivirine hcl 32
riluzole 115, 135
rimantadine hcl 21
RINVOQ 258, 272
RINVOQ LQ 258
risedronate sodium 265
risperidone 125, 126, 130
ritonavir 35
rivaroxaban 76
rivastigmine 71
rivastigmine tartrate 71
rivelsa 222, 232, 245
RIVFLOZA 282
RIVIVE 16, 148
RIXUBIS 82
rizatriptan benzoate 154
ROCKLATAN 196
roflumilast 294, 316, 319
ROMVIMZA 54
ropinirole hcl 142
ropinirole hcl er 142
rosuvastatin calcium 106
rosyrah 222, 232, 245
ROTARIX 61
ROTATEQ 61
ROWASA 200
roweepra 121
ROZLYTREK 54
RUBRACA 54
RUCONEST 268
rufinamide 121, 139
RUKOBIA 31
RYBELSUS 236
RYDAPT 54
sacubitril-valsartan ... 89, 90, 111
SAFETY PEN NEEDLES 171
SAFYRAL 223, 232, 245, 329
SALAGEN 71, 196
SALICATE 317
salicylic acid 317
salsalate 153
SALVAX DUO PLUS 307, 317
SAMSCA 181
SANTYL 183, 308, 324
sapropterin dihydrochloride 182, 282
SAVAYSA 76
saxagliptin hcl 225
saxagliptin-metformin er 217, 225
SCALACORT DK 313, 317
SCEMBLIX 54
scopolamine 66, 199, 205
SELECT-OB 84, 327, 329
selegiline hcl 140, 141
selenium sulfide 306, 319
SELZENTRY 31
SENSILANCE SAFETY LANCETS 21G 171
SENSILANCE SAFETY LANCETS 26G 171
SENSILANCE SAFETY LANCETS 28G 171
SEPHIENCE 182
SEREVENT DISKUS 73, 297
SEROSTIM 238, 250
sertraline hcl 155
setlakin 223, 232, 245

sevelamer carbonate 17, 177, 262
sevoflurane 139
sf 158, 160, 267
sf 5000 plus 158, 160, 267
sharobel 223, 245
SHARPS COLLECTOR 171
SHARPS CONTAINER 171
shewise 215, 223, 245
SIGNIFOR 249
sildenafil citrate 110, 295, 298, 325
silodosin 71
SILVADENE 306, 319
silver nitrate 187
silver sulfadiazine 306, 319
simliya 223, 233, 245
simpesse 223, 233, 245
SIMPLERA SYNC SENSOR ... 171
SIMPONI . 205, 260, 261, 272, 277
simvastatin 106
SINEMET 136
SINGULAIR 293
sirolimus 258, 280, 315
SIRTURO 27
SIVEXTRO 40
SKYCLARYS 282
SKYRIZI 205, 315, 324
SKYRIZI PEN 315, 324
SKYTROFA 238, 239
SLYND 215, 223, 246
smooth lax 201
sod citrate-citric acid 175
sod fluoride-potassium nitrate 160, 267
sodium chloride 293
sodium fluoride 158, 160, 267
sodium fluoride 5000 enamel 160, 267
sodium fluoride 5000 plus 158, 160, 267
sodium fluoride 5000 ppm 158, 160, 267
sodium fluoride 5000 sensitive 160, 267
sodium oxybate 135, 157, 263
sodium phenylbutyrate 175
sodium polystyrene sulfonate 17, 177, 262
sodium sulfacetamide 303
sodium sulfacetamide wash 303
SOFOSBUVIR-VELPATASVIR . 30
SOGROYA 239
SOHONOS 282
solifenacin succinate 325
SOLIQUA 236, 237
SOLOSEC 26
SOMAVERT 250
SOOLANTRA 320
sorafenib tosylate 54
sotalol hcl 69, 94, 99, 101, 102, 109
sotalol hcl (af) 69, 94, 99, 101, 102, 109
SOTYLIZE 69, 94, 99, 101, 102, 109
SOVALDI 30
SPEVIGO 315
SPIKEVAX 61
SPIKEVAX 6M-11Y 61
spinosad 320
SPIRIVA HANDIHALER 66, 287
SPIRIVA RESPIMAT 66, 287
spironolactone 88, 107, 111, 178
spironolactone-hctz 88, 107, 111, 178, 181
SPORANOX 28
SPRAVATO (56 MG DOSE) 123, 141
SPRAVATO (84 MG DOSE) 123, 141
sprintec 28 ..... 223, 233, 246
SPRIX 144, 152, 195
SPS (SODIUM POLYSTYRENE SULF) 17, 177, 262
ssd 306, 319
SSKI 292
sss 10-5 ..... 303, 317
STARJEMZA 257
STENDRA 110
STEQEYMA 257
STIOLTO RESPIMAT 66, 73
STIVARGA 54
STRENSIQ 183
STRIBILD 31, 34, 283
STRIVERDI RESPIMAT ... 73, 298
STROMECTOL 23
SUBOXONE 148
SUBVENITE 121, 126
subvenite 121, 126
subvenite starter kit-blue 121, 126
subvenite starter kit-green 121, 126
subvenite starter kit-orange 121, 126
SUCRAID 183
sucralfate 206
SULAR 104
SULCONAZOLE NITRATE 307
sulfacetamide sodium .. 186, 303
sulfacetamide sodium (acne) 303
sulfacetamide sodium (cleans) 303
sulfacetamide sodium-sulfur 303, 317
sulfacetamide sod-sulfur wash 304, 317
sulfacetamide-prednisolone 186, 193
sulfacetamide-sulfur in urea 304, 317
sulfadiazine 42
sulfamethoxazole-trimethoprim 26, 42, 43
SULFAMYLON 304, 319
sulfasalazine 42, 200, 254, 272, 277
sulfatrim pediatric 26, 42, 43
sulfurated lime 320
sulindac 144, 152
sumatriptan 154
sumatriptan succinate 154
SUMAXIN 304, 317
sunitinib malate 54
SUNLENCA 26, 31
SUNOSI 157
syeda 223, 233, 246
SYMBICORT 73, 212
SYMDEKO 290, 291
SYMFI 32, 34
SYMPAZAN 132, 133
SYMPROIC 198, 205
SYNAREL 235
SYNDROS 199, 205
SYNJARDY 217, 248
SYNJARDY XR 217, 248, 249
TABLOID 54
TABRECTA 54
tacrolimus 253, 280, 315, 324
tadalafil 110, 295
tadalafil (pah) 110, 295, 298
TADLIQ 110, 295, 298
TAFINLAR 54, 55
tafluprost (pf) 196
TAGRISSO 55

take action 215, 223, 246
TAKHZYRO 87, 280
TALZENNA 55
tamoxifen citrate 55, 225
tamsulosin hcl 71
tapentadol hcl 146
TAPERDEX 12-DAY 193, 212
TAPERDEX 6-DAY 193, 212
TAPERDEX 7-DAY 193, 212
tarina 24 fe 223, 233, 246
tarina fe 1/20 eq 223, 233, 246
TARPEYO 212
tasimelteon 129, 140
tavaborole 319
TAVALISSE 76
TAVNEOS 253, 268
taysofy 223, 233, 246
TAYTULLA 223, 233, 246
tazarotene 317, 324
TAZORAC 317, 318, 324
TECHLITE LANCETS 26G 171
TECHLITE PLUS PEN NEEDLES 171
TEGLUTIK 115, 135
TEGRETOL 121, 122, 126
TEGRETOL-XR 122, 126
TEKTURNA 111
telmisartan 90
telmisartan-hctz 90, 181
temazepam 133
TEMBEXA 38
temozolomide 55
TENCON 117, 131, 142
TENIVAC 58
tenofovir disoproxil fumarate 34
TEPMETKO 55
terazosin hcl 70, 89, 94
terbinafine hcl 21
terbutaline sulfate 73, 298
terconazole 307
teriflunomide 252, 278
TERIPARATIDE 237, 264
terrell 139
TESTIM 214, 215
testosterone 214, 215
testosterone cypionate 214, 215
testosterone enanthate 214, 215
tetrabenazine 157
tetracaine hcl 195, 261
tetracycline hcl 24, 42, 200, 304
TEXACORT 193, 212, 313
TEZRULY 70, 89
TEZSPIRE 292, 296
THALOMID 55, 278
THEO-24 ..... 105, 151, 176, 299, 325
theophylline 105, 151, 176, 299, 300, 325
theophylline er 105, 151, 176, 299, 325
thioridazine hcl 149
thiothixene 156
THROMBIN-JMI 82
THROMBIN-JMI EPISTAXIS 82
THROMBOGEN 82
thyroid 251
tiadylt er 96, 97, 103, 114
tiagabine hcl 122, 138
TIAZAC 96, 97, 103, 114
TIBSOVO 55
ticagrelor 86
TIGLUTIK 115, 135
TIKOSYN 102
tilia fe 223, 233, 246
timolol hemihydrate 69, 94, 102, 188
timolol maleate 69, 94, 99, 102, 109, 128, 188
timolol maleate (once-daily) 69, 94, 102, 188
timolol maleate ocudose 69, 94, 102, 188
timolol maleate pf 69, 94, 102, 188
TIMOPTIC OCUDOSE 69, 94, 102, 188
tinidazole 26
tiopronin 283
TIROSINT-SOL 251
TISSEEL 308, 324
TIVICAY 31
TIVICAY PD 31
tizanidine hcl 68
TOBI NEBULIZER 22, 186
TOBI PODHALER 22, 186
TOBRADEX 22, 186, 193
tobramycin 22, 186
tobramycin-dexamethasone 22, 186, 193
TOBREX 22, 186
TODAY SPONGE 284
tofacitinib citrate 258, 272
tofacitinib citrate er 258, 272
tolcapone 134
tolterodine tartrate 325
tolvaptan 182
tolvaptan (hyponatremia) 182
TONMYA 68, 137
TOPAMAX 122, 128
TOPAMAX SPRINKLE 122, 128
TOPFINE INSULIN PEN NEEDLE 171
TOPICORT 313
topiramate 122, 128
toremifene citrate 55, 225
torpenz 55, 255
torsemide 88, 106, 176
TOUJEO MAX SOLOSTAR 237
TOUJEO SOLOSTAR 237
TPOXX 27
TRACLEER 114, 291, 298
TRADJENTA 225
tramadol hcl 147
tramadol hcl (er biphasic) 146
tramadol hcl er 146
tramadol-acetaminophen 117, 142, 147
trandolapril 91, 92
trandolapril-verapamil hcl er 92, 97
tranexamic acid 82
tranylcypromine sulfate 141
travoprost (bak free) 196
trazodone hcl 155
TRELEGY ELLIPTA 66, 73, 193, 212, 290
TREMFYA 254, 315, 324
TREMFYA ONE-PRESS 254, 315, 324
TREMFYA PEN 254, 315
TREMFYA-CD/UC INDUCTION 254, 315
tretinoin 55, 308
TRETTEN 82
TREXALL 55, 254, 272, 278, 280
TREZIX 117, 143, 147, 151
triamcinolone acetonide 212, 313
triamterene 88, 111, 178
triamterene-hctz 178, 181
triazolam 134
TRICITRASOL 75
tricitrates 175
triderm 212, 313
trientine hcl 207
tri-estarylla 223, 233, 246
trifluoperazine hcl 149
trifluridine 187
trihexyphenidyl hcl 66, 118
TRIJARDY XR 217, 225, 249

TRIKAFTA.....290, 291
tri-legest fe.....223, 233, 246
TRILEPTAL.....122, 140
tri-linyah.....223, 233, 246
tri-lo-estarylla..... 223, 233, 246
tri-lo-marzia..... 223, 233, 246
tri-lo-mili.....223, 233, 246
tri-lo-sprintec.....223, 233, 246
trimethobenzamide hcl.....199
trimethoprim.....43
tri-mili.....223, 233, 246
trimipramine maleate.....156
TRINATE.....85, 327, 329
TRINTELLIX.....155
tri-sprintec..... 223, 233, 246
TRISTART DHA
..... 85, 180, 283, 327, 329
TRIUMEQ..... 32, 34
TRIUMEQ PD..... 32, 34
TRI-VI-FLORO
..... 158, 160, 267, 327, 329, 330
tri-vite/fluoride
..... 158, 160, 267, 327, 329, 330
tri-vylibra.....223, 233, 246
tri-vylibra lo..... 223, 233, 246
trospium chloride.....325
TRUE COMFORT SAFETY
PEN NEEDLE..... 171
TRUE COVER..... 284
TRUE FOLIC ACID.....329
TRUE METRIX LEVEL 1..... 171
TRUE METRIX LEVEL 2..... 171
TRUE METRIX LEVEL 3..... 172
TRULICITY..... 236
TRUMENBA.....61
TRUQAP..... 55
TRUVADA.....34, 38
TRYNGOLZA..... 93, 213, 263
TRYPTYR..... 194
TRYVIO.....291
TUKYSA.....55
TURALIO..... 56
turpentine..... 307
turqoz.....223, 233, 246
TUXARIN ER..... 19, 288
TWIIST REFILL KIT.....172
TWIIST REFILL
KIT/INFUSION SET..... 172
TWIIST STARTER KIT..... 172
TWINRIX.....61
TWIRLA..... 223, 233, 246
TYBLUME.....224, 233, 246
tydemy..... 224, 233, 246, 329
TYMLOS..... 237, 264
TYRVAYA..... 63, 194
TYVASO..... 114, 295, 299
TYVASO DPI MAINTENANCE
KIT..... 114, 295, 298
TYVASO DPI TITRATION KIT
..... 114, 295, 299
TYVASO REFILL KIT
..... 114, 295, 299
TYVASO STARTER KIT
..... 114, 296, 299
UBRELVY..... 134
UCERIS..... 213
UDENYCA..... 78
ULTANE.....139
ULTRA-CARE SAFETY
LANCETS 30G.....172
UNIFINE OTC PEN NEEDLES
..... 172
UNIFINE PROTECT PEN
NEEDLE.....172
UNISTRIP CONTROL.....172
unithroid..... 251
UPNEEQ.....197
UPTRAVI..... 299
UPTRAVI TITRATION..... 299
urea..... 88, 176, 196, 318
URELLE.....43, 66, 117, 283
uretron d/s..... 43, 66, 117, 283
UROCIT-K 10.....175
UROCIT-K 15.....175
UROGESIC-BLUE..... 43, 66, 283
ursodiol.....202
VAFSEO..... 78
valacyclovir hcl..... 38
VALCHLOR.....300, 324
valganciclovir hcl.....38
valproic acid..122, 126, 128, 138
valsartan..... 90, 91
valsartan-
hydrochlorothiazide.....91, 181
VALTOCO 10 MG DOSE.....132
VALTOCO 15 MG DOSE.....132
VALTOCO 20 MG DOSE.....132
VALTOCO 5 MG DOSE.....132
valtya 1/35.....224, 233, 246
valtya 1/50.....224, 233, 246
VANCOCIN.....29
vancomycin hcl.....29
VANDAZOLE..... 21, 37, 304
VANFLYTA..... 56
VANRAFIA.....273, 292
VAQTA.....61
vardenafil hcl.....110, 111
varenicline tartrate.....63, 68
varenicline tartrate (starter)
..... 63, 68
varenicline tartrate(continue)
..... 63, 68
VARIVAX..... 62
VAXELIS.....58, 62
VAXNEUVANCE.....62
VCF VAGINAL
CONTRACEPTIVE..... 285
VECAMYL.....112
velivet.....224, 233, 246
VELPHORO.....177
VELTASSA..... 177
VENCLEXTA.....56
VENCLEXTA STARTING
PACK..... 56
VENELEX..... 324
venlafaxine hcl..... 154
venlafaxine hcl er.....153
VEOZAH..... 135
verapamil hcl..... 96, 97, 103, 114
verapamil hcl er.96, 97, 103, 114
VEREGEN..... 318, 324
VERIFINE INSULIN PEN
NEEDLE.....172
VERIFINE INSULIN SYRINGE
..... 172
VERIFINE PLUS PEN
NEEDLE.....172
VERIFINE SAFE LANCET
MINI 21G.....172
VERIFINE SAFE LANCET
MINI 23G.....172
VERIFINE SAFE LANCET
MINI 28G.....172
VERIFINE SAFE LANCET
MINI 30G.....172
VERIFINE SHARPS
CONTAINER.....172
VERISAFE SAFETY INSULIN
SYR.....172
VERISAFE SAFETY STERILE
NEEDLE.....172
VERKAZIA..... 187, 194, 253
VERQUVO..... 100, 114
VERSAPENN (AG)
ANHYDROUS.....285
VERSAPENN (AL) ANHYD
LIPID.....286
VERZENIO.....56
vestura..... 224, 233, 246

VFEND 28
VIBERZI 198, 205
vienva 224, 233, 246
vigabatrin 122, 138
VIGADRONE 122, 138
VIGAFYDE 138
VIJOICE 283
vilazodone hcl 155
VILEVEV MB 44, 66, 117, 283
VIMPAT 122, 140
VIOKACE 183, 202
viorele 224, 234, 247
VIRACEPT 35
VIREAD 34
VISTOGARD 17, 262
VITAFOL FE+ 85, 180, 283, 327, 329
VITAFOL-OB+DHA 85, 180, 283, 327, 329
VITAMIN C BRIGHTENING SERUM 307
vitamin d (ergocalciferol) 330
VITATHELY WITH GINGER 85, 327, 329
VITRAKVI 56
VIVAGUARD INO CONTROL SOLUTION 172
VIVAGUARD LANCETS 30G . 173
VIVAGUARD LANCING DEVICE 173
VIVAGUARD SAFETY LANCETS 28G 173
VIVJOA 28
VOCABRIA 32
volnea 224, 234, 247
VONVENDI 82
VOQUEZNA 206, 207
VOQUEZNA DUAL PAK ... 23, 206
VOQUEZNA TRIPLE PAK 23, 39, 206
VORANIGO 56
voriconazole 28
VORTEX VALVE CHAMBER-PEDI MASK 173
VORTEX VALVED HOLDING CHAMBER 173
VOSEVI 30
VOWST 205, 283
VOXZOGO 283
VOYDEYA 268
VOYXACT 252
VRAYLAR 130, 131
VTAMA 304, 308, 324
VYBRIQUE 110, 295
vyfemla 224, 234, 247
VYKAT XR 117, 118
VYLEESI 135, 208
vylibra 224, 234, 247
VYNDAMAX 98, 135, 283
VYSCOXA 136
VYVGART HYTRULO 258
WAINUA 263
WAKIX 157
warfarin sodium 76
WAYRILZ 76
WELIREG 56
wera 224, 234, 247
WESCAP-PN DHA 85, 180, 283, 327, 329
WESNATE DHA 85, 283, 327, 329
WESTGEL DHA 85, 180, 283, 327, 329
WEZLANA 257
wheat germ oil 330
WIDE-SEAL DIAPHRAGM 60 285
WIDE-SEAL DIAPHRAGM 65 285
WIDE-SEAL DIAPHRAGM 70 285
WIDE-SEAL DIAPHRAGM 75 285
WIDE-SEAL DIAPHRAGM 80 285
WIDE-SEAL DIAPHRAGM 85 285
WIDE-SEAL DIAPHRAGM 90 285
WIDE-SEAL DIAPHRAGM 95 285
WILATE 82
WINREVAIR 296
wixela inhub 73, 193, 213, 290
wymzya fe 224, 234, 247
XACIATO 36, 304
xarah fe 224, 234, 247
XARELTO 76, 77
XARELTO STARTER PACK 77
XATMEP ... 56, 254, 272, 278, 280
XCOPRI 122, 140
XDEMVY 187
XELPROS 196
xelria fe 224, 234, 247
XELSTRYM 116
XEPI 304
XERMELO 198
XIFAXAN 41
XIIDRA 187, 194
XIRUN 307, 318
XOFLUZA (40 MG DOSE) .. 27, 29
XOFLUZA (80 MG DOSE) .. 27, 29
XOLAIR 256, 296
XOLREMDI 79
XOPENEX HFA 73, 298
XOSPATA 56
XPHOZAH 177, 205
XPOVIO (100 MG ONCE WEEKLY) 56
XPOVIO (40 MG ONCE WEEKLY) 56
XPOVIO (40 MG TWICE WEEKLY) 56
XPOVIO (60 MG ONCE WEEKLY) 56
XPOVIO (60 MG TWICE WEEKLY) 57
XPOVIO (80 MG ONCE WEEKLY) 57
XPOVIO (80 MG TWICE WEEKLY) 57
XROMI 57
XTAMPZA ER 147
XTANDI 57
xulane 224, 234, 247
XYNTHA 82
XYNTHA SOLOFUSE 82
xyvona 147
XYWAV 136
YASMIN 28 ..... 224, 234, 247
YAZ 224, 234, 247
YESINTEK 257
YEZTUGO 31
YORVIPATH 237
your choice 215, 224, 247
yulithira 57, 255
YUPELRI 66, 287
YUTREPIA 114, 296
yuvafem 234, 265
YUVIWEL 283
ZACARE 307, 319
ZACLIR CLEANSING 319
zafemy 224, 234, 247
zafirlukast 293
zaleplon 129, 141
ZARONTIN 155
ZARXIO 79
ZAVZPRET 134
ZELAPAR 140, 141
ZELBORAF 57
ZELSUVMI 306, 324
zelvysia 182, 283
ZEMPLAR 330
zenatane 318, 324
ZENBEXUS 57, 278
ZENPEP 183, 202
ZEPOSIA 278

ZEPOSIA 7-DAY STARTER PACK 278
ZEPOSIA STARTER KIT 278
ZIAGEN 34
zidovudine 34
ZILBRYSQ 253, 268
zileuton er 293
ZILXI 25, 43, 186, 304
ZIOPTAN 196
ziprasidone hcl 126, 131
ZIRGAN 38, 187
ZITHROMAX 39
ZITHROMAX TRI-PAK 39
ZITHROMAX Z-PAK 39
ZOKINVY 182, 183, 284
ZOLINZA 57
zolmitriptan 154
zolpidem tartrate 129, 141
zolpidem tartrate er 129, 141
ZOMIG 154
ZONEGRAN 122, 140
ZONISADE 122, 140
zonisamide 122, 140
ZONTIVITY 86
ZORYVE 294, 316, 319, 325
zovia 1/35 (28) 224, 234, 247
ZTALMY 122, 138
ZTLIDO 261, 305
ZUBSOLV 148
zumandimine 224, 234, 247
ZURNAI 148
ZURZUVAE 123
ZYCUBO 180
ZYDELIG 57
ZYLET 187, 194