2026 California Access Large Group 4-Tier HMO and PPO Prescription Drug List

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 All previous versions of this PDL are no longer in effect.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

The current PDL can also be accessed online at **uhc.com/CA-LargeGroup-4TACC-DMHC-Current**. An example of a plan coverage document may be accessed online at **uhc.com/content/dam/uhcdotcom/en/statepdls/lg/2024-CA-LrgGrp-SBC.pdf**.

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

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

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

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

Updated 8/1/2026

United Healthcare®

8/26 © 2026 United HealthCare Services, Inc. All Rights Reserved. WF21077959-G

Contents

Understand your medication options 3

How do I use my PDL? 5

What are tiers? 6

When does the PDL change? 6

Utilization Management programs 7

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

Requesting a prior authorization or step therapy exception 9

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

Prescription delivery options 9

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

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

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

Nondiscrimination notice and access to communication services . . . 12

Prescription drug list 16

Understand your medication options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do I use my PDL?

When choosing a medication, you and your healthcare provider should consult the Prescription Drug List (PDL). It will help you and your healthcare 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 healthcare 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 in the therapeutic category and class to which it belongs;
2. The generic name for a brand-name drug is included after the brand-name in parentheses and all lowercase bold and italicized letters;
3. If a generic equivalent for a brand-name drug is both available and covered, the generic drug will be listed separately from the brand-name drug in all lowercase bold and italicized letters; and
4. If a generic drug is marketed under a proprietary, trademark-protected brand-name, the brand-name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with the first letter of each word capitalized.

Example:

Prescription drug name	Drug tier	Coverage requirements & limits
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG ***(irbesartan)***	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.

Drug Tier 1	Your lowest cost medications
Drug Tier 2	Your mid-range cost medications
Drug Tier 3	Your mid-range cost medications
Drug Tier 4	Your highest cost medications
PA	Prior authorization required
QL	Quantity limit
ST	Step therapy
H	Part of Health Care Reform Preventive when age and/or condition appropriate
SP	Specialty medication
CM	Orally administered anti-cancer medication

M	May be covered under the medical benefit with prior authorization for HMO plans
SMCS	Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit)
E	Excluded from coverage unless covered as part of health care reform preventive
SM	$0 cost-share by state mandate when condition appropriate
IF	Two one-month fills are required before a three-month fill is available if allowed

What are tiers?

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

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

For insulin medications on any tier, the total amount of copayments and/or coinsurance shall not exceed $35 for an individual prescription of up to a 30-day supply.

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.
$$	**Tier 2 and 3** **Your mid-range cost**	Medications that provide good overall value. Mainly preferred brand-name drugs.	Use tier 2 or tier 3 drugs instead of Tier 4 to help reduce your out-of-pocket costs.
$$$	**Tier 4** **Your highest cost**	Medications that provide the lowest overall value. Mainly non-preferred brand-name drugs.	Many tier 4 drugs have lower-cost options in tier 1, 2 or 3. Ask your healthcare 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. Refer to your enrollment and plan materials on **myuhc.com**, or call the toll-free number on your member ID card for more information about your benefit plan. For HMO plans, please reference your Schedule of Benefits for costs associated with medications covered under the medical benefit. For information related to specialty medication cost share, please refer to the Specialty Medication Cost Share (SMCS) section below.

When does the PDL change?

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

- Medications may move to a lower tier or coverage may be added at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier, become non-formulary, or the dosage form covered may change, most often on Jan. 1, May 1, or Sept. 1.
- Medications may become subject to new or revised utilization management procedures, such as prior authorization, step therapy or quantity limits, at any time but most often upon FDA approval of the medication or its generic, Jan. 1, May 1, or Sept. 1.

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

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

Utilization Management programs

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

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

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

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

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

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

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

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

- Abortion*
- COVID-19

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

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

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

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

Your right to request access to a non-formulary drug

This plan must cover all medically necessary Prescription Drug Products.

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

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

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

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

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

Requesting a prior authorization or step therapy exception

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

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

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

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

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

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

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

Prescription delivery options

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

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

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

E-prescribe

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

Ordering prescriptions for home delivery

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

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

You have two options:

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

Designated pharmacies

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

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

How do I get updated information about my pharmacy benefit?

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

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

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

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

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

Learn more

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

Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

The Company complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2))). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT **711**). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://hhs.gov/ocr/complaints/index.html

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

4/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

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 ትል
እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥ

ملاحظة: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপফ্রিফ্রি **বাংলায় (Bengali-Bangala)** কথা বফ্রি, তাহলে বিফ্রামূর্তে ভাষা সহায়তা পফ্রিষেবা এবং বড় মুদ্রফ্রে মতো অফ্রাফ্রি ফফ্রর্মা োগোগেগুলি আপফ্রাফ্রজফ্রি বিফ্রামূর্তে উপলব্ধ। আপফ্রাফ্র সফ্রর্সে ফ্রপফ্রিচয়পফ্রে ফ্রকার্ডেফ্রর্তো -ফ্রি ফ্রম্বফ্রের্ক করুফ্র

ចំណាំ: ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃនិងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត 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.

ધ્યાનહ્યાપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો પ્રિના મૂર્લ્યે ભાષાકીય મદદરૂપ સેપ્રાઓ અને અ
ફોર્મેટમાં પ્રિના મૂર્લ્યે સંસ્થાન કોટી પ્રિન્ટ તમારા માર્ટે ઉપલબ્ધ. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

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

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

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

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

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

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

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

ຫມາຍເຫດ: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ , ເຊັ່ນ : ການພິມຕັວອັກສອນຂະຫນາດໃຫຍ່.
ໂທຫາເບີໂທຟຣີຢູ້ທີ່ບັດປະຈຳຕັວສະມາຊິກຂອງທ່ານ .

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

توجه:گربه زبا ن **فارسی (Persian-Farsi)** صحب ت می‌کنید، خدما ت رایگا ن کمک زبانی و ارتباطا ت رایگا ن در قالب ه‌ای دیگر، مانند چاپ‌بزرگ، در دسترس شما هستند.با شماره رایگا ن مندرج روی کار ت شناسایی عضویت تا ن تماس‌بگیرید.

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: ਿ ਤੁਸ਼ਾਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸ਼ਹਾਇਤਾ ਸ਼ੇਵਾਵਾਂ ਅਤੇ ਹ੍ਰੋ ਫ੍ਰਾ ਮੈਟਾਂ, ਿਿ ਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸ਼ੰਚਾ੍ਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬ੍ਰ ਪਛਾਣ ਕਾ੍ਰ ਡ ਤੇ ਟੋਲ-ਫ੍ਰਾ ਨੰਬ੍ਰ 'ਤੇ ਕਾਲ ਕ੍ਰ ੋ।

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.

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

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.

توجہ دیں: اگر آپ **اردو (Urdu)** بولتے ہیں تو زبان کی معاونت خدمات اور دیگر فارمیٹ میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

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

3/26 © 2026 United HealthCare Services, Inc. All Rights Reserved

State of California

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION 1
ANTIDOTE THERAPEUTICS 16
ANTIHISTAMINE DRUGS - Drugs for Allergy 18
ANTI-INFECTIVE AGENTS - Drugs for Infections 21
ANTINEOPLASTIC AGENTS - Drugs for Cancer 48
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM 63
AUTONOMIC DRUGS 67
AUTONOMIC DRUGS - Drugs for the Nervous System 69
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood 81
CARDIOVASCULAR DRUGS 94
CARDIOVASCULAR DRUGS - Drugs for the Heart 96
CENTRAL NERVOUS SYSTEM AGENTS 125
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System 126
DENTAL AGENTS 177
DENTAL AGENTS - Oral Care 178
DEVICES - Medical Supplies and Durable Medical Equipment 181
DIAGNOSTIC AGENTS 192
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants 195
ELECTROLYTIC, CALORIC, AND WATER BALANCE 195
ENZYMES 205
EYE, EAR, NOSE AND THROAT (EENT) PREPS. 208
GASTROINTESTINAL DRUGS 224
GASTROINTESTINAL DRUGS - Drugs for the Stomach 225
GOLD COMPOUNDS 236
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron 236
HORMONES AND SYNTHETIC SUBSTITUTES 236
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones 236
IMMUNOMODULATORY AGENTS (90:00) 284
LOCAL ANESTHETICS - Drugs for Numbing 295
MISCELLANEOUS THERAPEUTIC AGENTS 295
NONHORMONAL CONTRACEPTIVES - Drugs for Women 321
OXYTOCICS - Drugs for Women 323
PHARMACEUTICAL AIDS 323
RESPIRATORY TRACT AGENTS 323
RESPIRATORY TRACT AGENTS - Drugs for the Lungs 323
SKIN AND MUCOUS MEMBRANE AGENTS 339
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin 340
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles 369
VITAMINS 370

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIDOTE THERAPEUTICS		
ACETAMINOPHEN ANTIDOTE		
acetylcysteine inhalation solution 10 %, 20 %	1	
ALCOHOL DETERRENTS (91:02)		
acamprosate calcium oral tablet delayed release 333 mg	1	
disulfiram oral tablet 250 mg, 500 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTE THERAPEUTICS		
atropine sulfate ophthalmic solution 1 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	SMCS; SP
ft naloxone hcl nasal liquid 4 mg/0.1ml	1	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	4	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	
naloxone hcl nasal liquid 4 mg/0.1ml	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
penicillamine oral tablet 250 mg	1	SMCS; SP
phytonadione oral tablet 5 mg	1	
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	
REZENOPY NASAL LIQUID 10 MG/0.11ML (***naloxone hcl***)	3	
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	2	
ANTIDOTES (91:04)		
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	
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	PA
ANTIHISTAMINE DRUGS - Drugs for Allergy		
ANTIHISTAMINE DRUGS - Drugs for Allergy		
promethazine hcl oral tablet 25 mg	1	
ETHANOLAMINE DERIVATIVES - Drugs for Allergy		
CARBINOXAMINE MALEATE ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	4	
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	4	
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 ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	4	
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
CORPHENA ORAL SOLUTION 2 MG/5ML	4	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	4	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	4	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
OTHER ANTIHISTAMINES - Drugs for Allergy		
bepotastine besilate ophthalmic solution 1.5 %	1	
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
nizatidine oral capsule 150 mg, 300 mg	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
CORPHENA ORAL SOLUTION 2 MG/5ML	4	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	4	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
epinastine hcl ophthalmic solution 0.05 %	1	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	1	
levocetirizine dihydrochloride oral tablet 5 mg	1	
ANTI-INFECTIVE AGENTS - Drugs for Infections		
1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefadroxil oral capsule 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	4	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	1	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	1	
ADAMANTANE ANTIVIRALS - Drugs for Viral Infections		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	
amantadine hcl oral tablet 100 mg	1	
rimantadine hcl oral tablet 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
hydrocortisone-iodoquinol external cream 1-1 %	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	4	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	4	
periogard mouth/throat solution 0.12 %	1	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (***amikacin sulfate liposome***)	4	PA; QL (8.4 ml per day.); SMCS; SP
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
neomycin sulfate oral tablet 500 mg	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	4	PA; QL (280 ml (1 carton) per 56 days.); SMCS; SP
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.); SMCS; SP
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.); SMCS; SP
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (***omadacycline tosylate***)	4	
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml	1	
amoxicillin-potassium clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	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	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED 125-31.25 MG/5ML (***amoxicillin-pot clavulanate***)	4	
PIVYA ORAL TABLET 185 MG (***pivmecillinam hcl***)	4	QL (9 tablets per course of therapy.)
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	4	ST; QL (112 tablets per 180 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	4	ST; 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***)	4	
EGATEN ORAL TABLET 250 MG (***triclabendazole***)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (***mebendazole***)	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***)	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***)	4	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ARAKODA ORAL TABLET 100 MG (***tafenoquine succinate***)	4	QL (16 tablets per month.)
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	1	
AVIDOXY ORAL TABLET 100 MG	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***)	4	PA; SMCS; SP
DORYX MPC ORAL TABLET DELAYED RELEASE 60 MG (***doxycycline hyclate***)	4	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
KRINTAFEL ORAL TABLET 150 MG (***tafenoquine succinate***)	1	
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (***atovaquone-proguanil hcl***)	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	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	1	
pyrimethamine oral tablet 25 mg	1	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
quinine sulfate oral capsule 324 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	4	PA; ST
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
dapsone oral tablet 100 mg, 25 mg	1	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
nitazoxanide oral tablet 500 mg	1	
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
atovaquone oral suspension 750 mg/5ml	1	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (248 tablets per 720 days)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (***nifurtimox***)	4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (***nifurtimox***)	4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	4	
metronidazole oral capsule 375 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (***pentamidine isethionate***)	4	
nitazoxanide oral tablet 500 mg	1	
pentamidine isethionate inhalation solution reconstituted 300 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	4	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (***secnidazole***)	4	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
tinidazole oral tablet 250 mg, 500 mg	1	
ANTIPROTOZOALS,NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat		
tinidazole oral tablet 250 mg, 500 mg	1	
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	4	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***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ethambutol hcl oral tablet 100 mg, 400 mg	1	
isoniazid oral syrup 50 mg/5ml	1	
isoniazid oral tablet 100 mg, 300 mg	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
PRETOMANID ORAL TABLET 200 MG	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	
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (***rifampin***)	3	PA
SIRTURO ORAL TABLET 100 MG, 20 MG (***bedaquiline fumarate***)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (***maribavir***)	4	PA; QL (4 tablets per day.); SMCS; SP
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	SM
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	SM
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***)	4	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AZOLE ANTIFUNGALS - Drugs for Fungus		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (***isavuconazonium sulfate***)	3	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
itraconazole oral capsule 100 mg	1	QL (180 capsules per 365 days)
itraconazole oral solution 10 mg/ml	1	QL (1800 ml per 365 days)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	1	
ketodan external foam 2 %	1	
NOXAFIL ORAL PACKET 300 MG (***posaconazole***)	2	
posaconazole oral suspension 40 mg/ml	1	
posaconazole oral tablet delayed release 100 mg	1	
SPORANOX ORAL CAPSULE 100 MG (***itraconazole***)	4	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***voriconazole***)	4	
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (***oteseconazole***)	3	PA; QL (18 capsules per 84 days.)
voriconazole oral suspension reconstituted 40 mg/ml	1	
voriconazole oral tablet 200 mg, 50 mg	1	
BACITRACIN ANTIBIOTICS - Antibiotics		
bacitracin-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	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	SM
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***)	4	PA; M; QL (30 vials per month.); SMCS; SP; 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***)	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***)	4	
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (***vancomycin hcl***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
vancomycin hcl oral capsule 125 mg, 250 mg	1	
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	1	
VANCOMYCIN+SYRSPEND SF ORAL SUSPENSION 50 MG/ML (***vancomycin hcl***)	3	PA
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (2 packets per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.); SMCS
HARVONI ORAL TABLET 45-200 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; QL (84 tablets per 720 days.); SMCS; SP
SOVALDI ORAL PACKET 150 MG, 200 MG (***sofosbuvir***)	4	PA; ST; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.); SMCS; SP
SOVALDI ORAL TABLET 200 MG (***sofosbuvir***)	4	PA; ST; QL (84 tablets per 720 days.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SOVALDI ORAL TABLET 400 MG (***sofosbuvir***)	4	PA; ST; QL (84 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days); SMCS; SP
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.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days); SMCS; SP
HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (2 packets per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (***sofosbuvir-velpatasvir***)	2	PA; QL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (1 pellet packet per day and 28 pellet packets per month.); SMCS
HARVONI ORAL TABLET 45-200 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (***ledipasvir-sofosbuvir***)	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; QL (1 tablet per day and 28 tablets per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
MAVYRET ORAL PACKET 50-20 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (5 packets per day and 280 packets per 720 days.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days); SMCS; SP
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; QL (84 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days); SMCS; SP
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET 300 MG (***lenacapavir sodium***)	4	QL (24 tablets per year.); H
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	4	QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (***lenacapavir sodium***)	4	QL (4 tablets per year.); H
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
maraviroc oral tablet 150 mg, 300 mg	1	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (***fostemsavir tromethamine***)	4	
SELZENTRY ORAL TABLET 150 MG, 300 MG (***maraviroc***)	4	
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3	QL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	2	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (***raltegravir potassium***)	2	
ISENTRESS ORAL PACKET 100 MG (***raltegravir potassium***)	2	
ISENTRESS ORAL TABLET 400 MG (***raltegravir potassium***)	2	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (***raltegravir potassium***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (***doravirine***)	3	
rilpivirine hcl oral tablet 25 mg	1	
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)
HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections		
abacavir sulfate oral solution 20 mg/ml	1	
abacavir sulfate oral tablet 300 mg	1	
abacavir sulfate-lamivudine oral tablet 600-300 mg	1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3	QL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (***lamivudine-tenofovir***)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	4	QL (1 tablet per day.)
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	QL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3	QL (1 tablet per day.); H
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	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	
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.)
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.)
EMTRIVA ORAL CAPSULE 200 MG (***emtricitabine***)	4	
EMTRIVA ORAL SOLUTION 10 MG/ML (***emtricitabine***)	2	
EPIVIR ORAL SOLUTION 10 MG/ML (***lamivudine***)	4	
EPIVIR ORAL TABLET 150 MG, 300 MG (***lamivudine***)	4	
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	2	QL (1 tablet per day.)
IDVYNSO ORAL TABLET 100-0.25 MG (***doravirine-islatravir***)	3	QL (30 tablets per month.)
lamivudine oral solution 10 mg/ml	1	
lamivudine oral tablet 100 mg, 150 mg, 300 mg	1	
lamivudine-zidovudine oral tablet 150-300 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (***zidovudine***)	4	
RETROVIR ORAL SYRUP 50 MG/5ML (***zidovudine***)	3	
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	2	QL (1 tablet per day.)
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***)	3	QL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	1	H
TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	4	QL (1 tablet per day.)
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***)	4	
zidovudine oral capsule 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
zidovudine oral syrup 50 mg/5ml	1	
zidovudine oral tablet 300 mg	1	
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	
darunavir oral tablet 600 mg, 800 mg	1	
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
fosamprenavir calcium oral tablet 700 mg	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML (***lopinavir-ritonavir***)	3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (***lopinavir-ritonavir***)	4	
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	1	
NORVIR ORAL PACKET 100 MG (***ritonavir***)	2	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (***darunavir***)	2	
PREZISTA ORAL TABLET 150 MG, 75 MG (***darunavir***)	2	
REYATAZ ORAL PACKET 50 MG (***atazanavir sulfate***)	2	
ritonavir oral tablet 100 mg	1	
SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***)	3	QL (1 tablet per day.)
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***)	4	PA; SMCS; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	4	PA; M; QL (0.08 ml per day.); SMCS; SP; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	M; SMCS; SP
LINCOMYCIN ANTIBIOTICS - Antibiotics		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	4	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (***aztreonam lysine***)	4	PA; ST; QL (84 vials per 56 days.); SMCS; SP
MONOCLONAL ANTIBODIES (08:18) - Drugs for Viral Infections		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (***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	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL - Drugs for the Mouth and Throat		
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (248 tablets per 720 days)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
NITROIMIDAZOLE DERIVATIVES, MISC - Drugs for the Mouth and Throat		
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	4	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
adefovir dipivoxil oral tablet 10 mg	1	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (***entecavir***)	2	
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (***entecavir***)	4	
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	4	QL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3	QL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3	QL (1 tablet per day.); H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.)
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.)
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	SM
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3	QL (1 tablet per day.)
ribavirin oral capsule 200 mg	1	
ribavirin oral tablet 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (***brincidofovir***)	4	
TEMBEXA ORAL TABLET 100 MG (***brincidofovir***)	4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	4	QL (1 tablet per day.)
valacyclovir hcl oral tablet 1 gm, 500 mg	1	
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
VEMLIDY ORAL TABLET 25 MG (***tenofovir alafenamide fumarate***)	4	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	4	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	ST; QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***fidaxomicin***)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	4	ST; QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
linezolid oral suspension reconstituted 100 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
linezolid oral tablet 600 mg	1	
SIVEXTRO ORAL TABLET 200 MG (***tedizolid phosphate***)	3	
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	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
POLYMYXIN ANTIBIOTICS - Antibiotics		
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	M
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (***colistimethate sodium***)	4	M
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (***flucytosine***)	4	
ANCOBON ORAL CAPSULE 500 MG (***flucytosine***)	3	
flucytosine oral capsule 250 mg, 500 mg	1	
QUINOLONE ANTIBIOTICS - Antibiotics		
BAXDELA ORAL TABLET 450 MG (***delafloxacin meglumine***)	3	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin oral tablet 300 mg, 400 mg	1	
ofloxacin otic solution 0.3 %	1	
VIGAMOX OPHTHALMIC SOLUTION 0.5 % (***moxifloxacin hcl***)	4	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (***rifapentine***)	2	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (***rifampin***)	3	PA
XIFAXAN ORAL TABLET 200 MG (***rifaximin***)	3	PA
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***)	4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	4	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	4	
sulfadiazine oral tablet 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
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***)	4	
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
AVIDOXY ORAL TABLET 100 MG	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	
DORYX MPC ORAL TABLET DELAYED RELEASE 60 MG (***doxycycline hyclate***)	4	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	4	QL (120 capsules per 180 days.)
tetracycline hcl oral capsule 250 mg, 500 mg	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	4	PA; ST
TRIAZAACENAPHTHYLENES - Antibiotics		
BLUJEPA ORAL TABLET 750 MG (***gepotidacin mesylate***)	4	
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	4	
fosfomycin tromethamine oral packet 3 gm	1	
MACROBID ORAL CAPSULE 100 MG (***nitrofurantoin monohyd macro***)	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***)	4	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
trimethoprim oral tablet 100 mg	1	
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
uretron d/s oral tablet 81.6 mg	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***)	2	
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	1	QL (4 tablets per day.); SMCS; SP; CM
abirtega oral tablet 250 mg	1	QL (4 tablets per day.); SMCS; SP; CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (***niraparib-abiraterone acetate***)	4	PA; ST; QL (2 tablets per day.); SMCS; SP; CM
ALECENSA ORAL CAPSULE 150 MG (***alectinib hcl***)	2	PA; QL (8 capsules per day.); SMCS; SP; CM
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	4	PA
ALUNBRIG ORAL TABLET 180 MG, 90 MG (***brigatinib***)	2	PA; QL (1 tablet per day); SMCS; SP; CM
ALUNBRIG ORAL TABLET 30 MG (***brigatinib***)	2	PA; QL (6 tablets per day); SMCS; SP; CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (***brigatinib***)	2	PA; QL (30 packs per year); SMCS; SP; CM
anastrozole oral tablet 1 mg	1	H
AUGTYRO ORAL CAPSULE 160 MG (***repotrectinib***)	2	PA; QL (60 capsules per month.); SMCS; SP; CM
AUGTYRO ORAL CAPSULE 40 MG (***repotrectinib***)	2	PA; QL (8 capsules per day.); SMCS; SP; CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (***avutometinib-defactinib***)	4	PA; QL (66 capsules/tablets per month.); SMCS; SP; CM
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (***avapritinib***)	4	PA; QL (1 tablet per day.); SMCS; SP; CM
BALVERSA ORAL TABLET 3 MG (***erdafitinib***)	4	PA; QL (3 tablets per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BALVERSA ORAL TABLET 4 MG (***erdafitinib***)	4	PA; QL (2 tablets per day.); SMCS; SP; CM
BALVERSA ORAL TABLET 5 MG (***erdafitinib***)	4	PA; QL (1 tablet per day.); SMCS; SP; CM
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	4	PA; SMCS; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	4	PA; M; QL (0.08 ml per day.); SMCS; SP; CM
bexarotene external gel 1 %	1	SMCS; SP
bexarotene oral capsule 75 mg	1	SMCS; CM
bicalutamide oral tablet 50 mg	1	CM
BOSULIF ORAL CAPSULE 100 MG (***bosutinib***)	2	PA; ST; QL (3 Capsules per day.); SMCS; SP; CM
BOSULIF ORAL CAPSULE 50 MG (***bosutinib***)	2	PA; ST; QL (1 Capsule per day.); SMCS; SP; CM
BOSULIF ORAL TABLET 100 MG (***bosutinib***)	4	PA; ST; QL (4 tablets per day.); SMCS; SP; CM
BOSULIF ORAL TABLET 400 MG, 500 MG (***bosutinib***)	4	PA; ST; QL (1 tablet per day.); SMCS; SP; CM
bosutinib oral tablet 100 mg	1	PA; ST; QL (4 tablets per day.); SMCS; SP; CM
bosutinib oral tablet 400 mg, 500 mg	1	PA; ST; QL (1 tablet per day.); SMCS; SP; CM
BRAFTOVI ORAL CAPSULE 75 MG (***encorafenib***)	4	PA; ST; QL (6 capsules per day); SMCS; SP; CM
BRUKINSA ORAL CAPSULE 80 MG (***zanubrutinib***)	3	PA; ST; QL (60 capsules per month.); SMCS; SP; CM
BRUKINSA ORAL TABLET 160 MG (***zanubrutinib***)	3	PA; ST; QL (60 tablets per month.); SMCS; SP; CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (***cabozantinib s-malate***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
CALQUENCE ORAL TABLET 100 MG (***acalabrutinib maleate***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
capecitabine oral tablet 150 mg, 500 mg	1	SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CAPRELSA ORAL TABLET 100 MG (***vandetanib***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
CAPRELSA ORAL TABLET 300 MG (***vandetanib***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
COMETRIQ ORAL KIT 20 MG (***cabozantinib s-malate***)	2	PA; QL (93 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (***cabozantinib s-malate***)	2	PA; QL (124 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 80 & 20 MG (***cabozantinib s-malate***)	2	PA; QL (62 capsules per month.); SMCS; SP; CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (***duvelisib***)	4	PA; QL (2 capsules per day.); SMCS; SP; CM
COTELLIC ORAL TABLET 20 MG (***cobimetinib fumarate***)	2	PA; QL (63 tablets per 21 days); SMCS; SP; 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.); SMCS; SP; CM
dasatinib oral tablet 20 mg	1	PA; QL (90 tablets per month.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DAURISMO ORAL TABLET 100 MG, 25 MG (***glasdegib maleate***)	2	PA; QL (2 tablets per day.); SMCS; SP; 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.); SMCS; SP; CM
ERIVEDGE ORAL CAPSULE 150 MG (***vismodegib***)	2	PA; QL (1 capsule per day.); SMCS; SP; CM
ERLEADA ORAL TABLET 240 MG (***apalutamide***)	2	PA; QL (1 tablet per day.); SMCS
ERLEADA ORAL TABLET 60 MG (***apalutamide***)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
erlotinib hcl oral tablet 100 mg, 150 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
erlotinib hcl oral tablet 25 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM
etoposide oral capsule 50 mg	1	SMCS; SP; 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.); SMCS; SP; CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
exemestane oral tablet 25 mg	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	M; SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	M; SMCS; SP
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (***tivozanib hcl***)	4	PA; QL (0.75 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FRUZAQLA ORAL CAPSULE 1 MG (***fruquintinib***)	4	PA; ST; QL (84 capsules per 21 days.); SMCS; SP; CM
FRUZAQLA ORAL CAPSULE 5 MG (***fruquintinib***)	4	PA; ST; QL (21 capsules per 21 days.); SMCS; SP; CM
GAVRETO ORAL CAPSULE 100 MG (***pralsetinib***)	4	PA; QL (4 capsules per day.); SMCS; SP; CM
gefitinib oral tablet 250 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (***afatinib dimaleate***)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***lomustine***)	2	SMCS; SP; CM
GOMEKLI ORAL CAPSULE 1 MG (***mirdametinib***)	4	PA; QL (42 capsules per 4 weeks.); SMCS; SP
GOMEKLI ORAL CAPSULE 2 MG (***mirdametinib***)	4	PA; QL (84 capsules per 4 weeks.); SMCS; SP
GOMEKLI ORAL TABLET SOLUBLE 1 MG (***mirdametinib***)	4	PA; QL (168 tablets per 4 weeks.); SMCS
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	M
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	M
HERNEXEOS ORAL TABLET 60 MG (***zongertinib***)	4	PA; QL (90 tablets per month.); SMCS; SP; CM
HYCAMTIN ORAL CAPSULE 0.25 MG (***topotecan hcl***)	2	PA; QL (20 capsules per three weeks.); SMCS; SP; CM
HYCAMTIN ORAL CAPSULE 1 MG (***topotecan hcl***)	2	PA; QL (30 capsules per 3 weeks.); SMCS; SP; CM
hydroxyurea oral capsule 500 mg	1	CM
HYRNUO ORAL TABLET 10 MG (***sevabertinib***)	2	PA; QL (120 tablets per month.); SMCS; SP; CM
IBRANCE ORAL CAPSULE 125 MG (***palbociclib***)	4	PA; ST; QL (21 capsules per month.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
IRESSA ORAL TABLET 250 MG (***gefitinib***)	4	PA; QL (2 tablets per day.); SMCS; SP; CM
ITOVEBI ORAL TABLET 3 MG (***inavolisib***)	2	PA; QL (56 tablets per month.); SMCS; SP; CM
ITOVEBI ORAL TABLET 9 MG (***inavolisib***)	2	PA; QL (28 tablets per month.); SMCS; SP; CM
IWILFIN ORAL TABLET 192 MG (***eflornithine hcl***)	2	PA; QL (8 tablets per day.); SMCS; SP; CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; SMCS; SP; CM
JAYPIRCA ORAL TABLET 100 MG (***pirtobrutinib***)	4	PA; QL (3 tablets per day.); SMCS; SP; CM
JAYPIRCA ORAL TABLET 50 MG (***pirtobrutinib***)	4	PA; QL (1 tablet per day.); SMCS; SP; CM
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (21 tablets per month); SMCS; SP; CM
KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (42 tablets per 21 days.); SMCS; SP; CM
KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (42 tablets per month); SMCS; SP; CM
KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (63 tablets per 21 days.); SMCS; SP; CM
KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (63 tablets per month); SMCS; SP; CM
KOMZIFTI ORAL CAPSULE 200 MG (***ziftomenib***)	4	PA; QL (90 capsules per month.); SMCS; SP; CM
KOSELUGO ORAL CAPSULE 10 MG (***selumetinib sulfate***)	3	PA; QL (8 capsules per day.); SMCS; SP; CM
KOSELUGO ORAL CAPSULE 25 MG (***selumetinib sulfate***)	3	PA; QL (4 capsules per day.); SMCS; SP; CM
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (***selumetinib sulfate***)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
KRAZATI ORAL TABLET 200 MG (***adagrasib***)	4	PA; QL (6 tablets per day.); SMCS; SP; CM
lapatinib ditosylate oral tablet 250 mg	1	PA; QL (186 tablets per month.); SMCS; SP; CM
LAZCLUZE ORAL TABLET 240 MG (***lazertinib mesylate***)	3	PA; QL (30 tablets per month.); SMCS; SP; CM
LAZCLUZE ORAL TABLET 80 MG (***lazertinib mesylate***)	3	PA; QL (60 tablets per month.); SMCS; SP; CM
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (2 capsules per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (3 capsules per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (***lenvatinib mesylate***)	2	PA; QL (1 capsule per day.); SMCS; SP; CM
letrozole oral tablet 2.5 mg	1	H
LEUKERAN ORAL TABLET 2 MG (***chlorambucil***)	2	CM
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; M; SMCS
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (1 carton (18 capsules) per 28 days.); SMCS; SP; CM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (3 blister paks (18 capsules) per 28 days.); SMCS; SP; CM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (9 blister paks (18 capsules) per 28 days.); SMCS; SP; CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (1 carton (27 capsules) per 28 days.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (3 blister paks (27 capsules) per 28 days.); SMCS; SP; CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	4	PA; QL (9 blister paks (27 capsules) per 28 days.); SMCS; SP; CM
lomustine oral capsule 10 mg, 100 mg, 40 mg	1	SMCS; SP; CM
LONSURF ORAL TABLET 15-6.14 MG (***trifluridine-tipiracil***)	4	PA; QL (100 tablets per month.); SMCS; SP; CM
LONSURF ORAL TABLET 20-8.19 MG (***trifluridine-tipiracil***)	4	PA; QL (80 tablets per 21 days.); SMCS; SP; CM
LORBRENA ORAL TABLET 100 MG (***lorlatinib***)	3	PA; ST; QL (30 tablets per month.); SMCS; SP; CM
LORBRENA ORAL TABLET 25 MG (***lorlatinib***)	3	PA; ST; QL (90 tablets per month.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 120 MG (***sotorasib***)	4	PA; QL (240 tablets per month.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 240 MG (***sotorasib***)	4	PA; QL (120 tablets per month.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 320 MG (***sotorasib***)	4	PA; QL (3 tablets per day.); SMCS; SP; CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (***olaparib***)	2	PA; QL (4 tablets per day); SMCS; SP; CM
LYSODREN ORAL TABLET 500 MG (***mitotane***)	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	4	PA; QL (84 tablets per month.); SMCS; SP; CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	4	PA; QL (112 tablets per month.); SMCS; SP; CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	4	PA; QL (140 tablets per month.); SMCS; SP; CM
MATULANE ORAL CAPSULE 50 MG (***procarbazine hcl***)	2	SMCS; SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (***selpercatinib***)	4	PA; QL (60 tablets per month.); SMCS; SP; CM
RETEVMO ORAL TABLET 40 MG (***selpercatinib***)	4	PA; QL (90 tablets per month.); SMCS; SP; CM
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	4	PA
REVUFORJ ORAL TABLET 110 MG (***revumenib citrate***)	4	PA; QL (120 tablets per month.); SMCS; SP; CM
REVUFORJ ORAL TABLET 160 MG (***revumenib citrate***)	4	PA; QL (60 tablets per month.); SMCS; SP; CM
REVUFORJ ORAL TABLET 25 MG (***revumenib citrate***)	4	PA; QL (240 tablets per month.); SMCS; SP; CM
REZLIDHIA ORAL CAPSULE 150 MG (***olutasidenib***)	2	PA; QL (2 capsules per day.); SMCS; SP; CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (***vimseltinib***)	2	PA; QL (8 capsules per 4 weeks.); SMCS; SP; CM
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (***entrectinib***)	2	PA; QL (3 capsules per day.); SMCS; SP; CM
ROZLYTREK ORAL PACKET 50 MG (***entrectinib***)	2	PA; QL (84 packets (2 boxes) per month.); SMCS; SP; CM
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (***rucaparib camsylate***)	3	PA; ST; QL (4 tablets per day.); SMCS; SP; CM
RYDAPT ORAL CAPSULE 25 MG (***midostaurin***)	2	PA; QL (8 capsules per day); SMCS; SP; CM
SCEMBLIX ORAL TABLET 100 MG (***asciminib hcl***)	4	PA; QL (120 tablets per month.); SMCS; SP; CM
SCEMBLIX ORAL TABLET 20 MG, 40 MG (***asciminib hcl***)	4	PA; QL (2 tablets per day.); SMCS; SP; CM
SOLTAMOX ORAL SOLUTION 10 MG/5ML (***tamoxifen citrate***)	4	
sorafenib tosylate oral tablet 200 mg	1	PA; QL (4 tablets per day.); SMCS; SP; CM
STIVARGA ORAL TABLET 40 MG (***regorafenib***)	2	PA; QL (84 tablets per 21 days.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA; QL (1 capsule per day.); SMCS; SP; CM
TABLOID ORAL TABLET 40 MG (***thioguanine***)	2	SMCS; SP; CM
TABRECTA ORAL TABLET 150 MG, 200 MG (***capmatinib hcl***)	4	PA; QL (4 tablets per day.); SMCS; SP; CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (***dabrafenib mesylate***)	4	PA; ST; QL (4 capsules per day.); SMCS; SP; CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (***dabrafenib mesylate***)	4	ST; QL (420 tablets per month.); SMCS; SP; CM
TAGRISSO ORAL TABLET 40 MG, 80 MG (***osimertinib mesylate***)	3	PA; QL (1 tablet per day.); SMCS; SP; CM
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (***talazoparib tosylate***)	4	PA; ST; QL (1 capsule per day.); SMCS; SP; CM
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	SMCS; SP; CM
TEPMETKO ORAL TABLET 225 MG (***tepotinib hcl***)	4	PA; QL (2 tablets per day.); SMCS; SP; CM
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; SMCS; SP; CM
TIBSOVO ORAL TABLET 250 MG (***ivosidenib***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	4	
toremifene citrate oral tablet 60 mg	1	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.06 %, 0.08 %, 0.1 %	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	SMCS; SP; 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.); SP
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (***capivasertib***)	2	PA; QL (64 tablets every month.); SMCS; SP; CM
TUKYSA ORAL TABLET 150 MG (***tucatinib***)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
TUKYSA ORAL TABLET 50 MG (***tucatinib***)	2	PA; QL (10 tablets per day.); SMCS; SP; CM
TURALIO ORAL CAPSULE 125 MG (***pexidartinib hcl***)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (***quizartinib dihydrochloride***)	4	PA; QL (2 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 10 MG (***venetoclax***)	2	PA; QL (14 tablets per month.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 100 MG (***venetoclax***)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 50 MG (***venetoclax***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (***venetoclax***)	2	PA; QL (42 tablets per year.); SMCS; SP; CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***abemaciclib***)	2	PA; QL (2 tablets per day); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 100 MG (***larotrectinib sulfate***)	2	PA; QL (2 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 25 MG (***larotrectinib sulfate***)	2	PA; QL (6 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL SOLUTION 20 MG/ML (***larotrectinib sulfate***)	2	PA; QL (10 mL per day.); SMCS; SP; CM
VONJO ORAL CAPSULE 100 MG (***pacritinib citrate***)	4	PA; QL (4 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VORANIGO ORAL TABLET 10 MG (***vorasidenib***)	2	PA; QL (62 tablets per month.); SMCS; SP; CM
VORANIGO ORAL TABLET 40 MG (***vorasidenib***)	2	PA; QL (31 tablets per month.); SMCS; SP; CM
WELIREG ORAL TABLET 40 MG (***belzutifan***)	4	PA; QL (3 tablets day.); SMCS; SP; CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	4	PA; CM
XOSPATA ORAL TABLET 40 MG (***gilteritinib fumarate***)	3	PA; QL (3 tablets per day.); SMCS; SP; CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (***selinexor***)	4	PA; QL (0.26 tablet per day.); SMCS; SP; CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (***selinexor***)	4	PA; QL (16 tablets per month.); SMCS; SP; CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	4	PA; QL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (***selinexor***)	4	PA; QL (1 therapy pack per month.); SMCS; SP; CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	4	PA; QL (0.86 tablets per day.); SMCS; SP; CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	4	PA; QL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (***selinexor***)	4	PA; QL (4 tablets per month.); SMCS; SP; CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	4	PA; QL (1.15 tablets per day.); SMCS; SP; CM
XROMI ORAL SOLUTION 100 MG/ML (***hydroxyurea***)	4	PA
XTANDI ORAL CAPSULE 40 MG (***enzalutamide***)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
XTANDI ORAL TABLET 40 MG (***enzalutamide***)	2	PA; QL (4 tablets per day.); SMCS; SP; CM
XTANDI ORAL TABLET 80 MG (***enzalutamide***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (***niraparib tosylate***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
ZELBORAF ORAL TABLET 240 MG (***vemurafenib***)	2	PA; QL (8 tablets per day.); SMCS; SP; CM
ZOLINZA ORAL CAPSULE 100 MG (***vorinostat***)	2	PA; QL (4 capsules per day.); SMCS; SP; CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (***idelalisib***)	4	PA; QL (60 tablets per month.); SMCS; SP; CM
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (***timothy grass pollen allergen***)	4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (***dust mite mixed allergen ext***)	4	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	4	PA; QL (3 tablets per year.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***)	4	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	4	PA; QL (1 tablet per day.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	2	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	M; 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	M; H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (***diphth-acell pertussis-tetanus***)	2	M; 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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (***haemophilus b polysac conj vac***)	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	2	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	M; 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 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	M; H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (***mening acyw(tet conj)-b(rcmb)***)	3	H
PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (***dtap-ipv-hib vaccine***)	3	H
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (***pneumococcal vac polyvalent***)	2	H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***pneumococcal 20-val conj vacc***)	3	H
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (***measles, mumps & rubella vac***)	3	H
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (***measles-mumps-rubella-varicell***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	4	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	2	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***)	4	H
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
droxidopa oral capsule 100 mg	1	PA; QL (90 capsules per month.); SMCS; SP
droxidopa oral capsule 200 mg, 300 mg	1	PA; QL (180 capsules per month.); SMCS; SP
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	
LETS KIT	3	PA
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (***epinephrine***)	4	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs		
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	
clonidine hcl oral tablet 0.05 mg, 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***)	4	PA
lofexidine hcl oral tablet 0.18 mg	1	QL (192 tablets per year.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	QL (2 blisters per day.)
atropine sulfate ophthalmic solution 1 %	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (***ipratropium bromide hfa***)	4	QL (0.87 grams per day.)
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.)
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.)
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.)
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	4	
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	1	
dicyclomine hcl oral tablet 20 mg	1	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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	
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	1	QL (0.87 grams per day.)
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	4	
LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***)	4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	QL (0.15 grams per day.)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.)
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***)	4	PA; QL (3 ml per day.)
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System		
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	4	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	2	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***)	4	H
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles		
ATMEKSI ORAL SUSPENSION 750 MG/5ML (***methocarbamol***)	4	PA
carisoprodol oral tablet 250 mg, 350 mg	1	
chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
ENOVARX-CYCLOBENZAPRINE HCL TRANSDERMAL CREAM 20 MG/GM	3	PA
metaxalone oral tablet 400 mg, 800 mg	1	
methocarbamol oral tablet 1000 mg, 500 mg, 750 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ONTRALFY ORAL SOLUTION 2 MG/5ML (***tizanidine hcl***)	4	PA
TABRADOL FUSEPAQ ORAL SUSPENSION 1 MG/ML (***cyclobenzaprine hcl-msm***)	3	PA
TANLOR ORAL TABLET 1000 MG (***methocarbamol***)	3	
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	4	PA; QL (60 sublingual tablets per month.)
VP FC KIT EXTERNAL CREAM	3	PA
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (***tizanidine hcl***)	4	
ZANAFLEX ORAL TABLET 4 MG (***tizanidine hcl***)	4	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (***dantrolene sodium***)	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, 15 mg, 20 mg, 5 mg	1	
ENOVARX-BACLOFEN EXTERNAL CREAM 1 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (***ketoprofen-baclofen-gabap-lido***)	3	PA
OZOBAX DS ORAL SOLUTION 10 MG/5ML (***baclofen***)	4	PA
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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***)	4	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	4	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	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***)	4	PA
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	4	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	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***)	4	PA
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	4	
dihydroergotamine mesylate injection solution 1 mg/ml	1	M
dihydroergotamine mesylate nasal solution 4 mg/ml	1	ST
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	4	ST
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.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	1	
MESTINON ORAL SOLUTION 60 MG/5ML (***pyridostigmine bromide***)	4	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	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***)	4	
SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
silodosin oral capsule 4 mg, 8 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
tamsulosin hcl oral capsule 0.4 mg	1	
SELECTIVE BETA-2-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	QL (2 blisters per day.)
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	QL (2 blisters per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	4	ST; QL (0.44 grams per day.)
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	4	ST; QL (0.44 mcg per day.)
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	4	QL (2 blisters per day.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	4	QL (0.4 grams per day.)
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.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.)
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	4	QL (2 vials per day.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	QL (0.15 grams per day.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	QL (0.15 grams per day.)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.)
terbutaline sulfate oral tablet 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.)
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.)
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	
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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***atenolol***)	3	PA
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
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***)	4	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	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, 37.5 mg, 50 mg, 75 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood		
ANTIANEMIA DRUGS - Vitamins and Minerals		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	M; QL (2 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	M; QL (4 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	M; QL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	M; QL (1 prefill syringe per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	M; QL (2 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	M; QL (4 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	M; QL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	M; QL (2 syringes per month); SMCS; SP
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (8 ml per 21 days); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (12 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	M; SMCS; SP
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (4 ml per 21 days.); SMCS; SP
ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (***anticoagulant cit dext soln a***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML	3	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	M
TRICITRASOL IN VITRO CONCENTRATE 46.7 % (***anticoagulant sodium citrate***)	3	
ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***)	2	PA; M; QL (1 vial per day and 58 vials per 120 days.); SMCS; SP
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	4	QL (1 tablet per day.)
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
AQVESME ORAL TABLET 100 MG (***mitapivat sulfate***)	4	PA; QL (60 tablets per month.); SMCS; SP; CM
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (***mitapivat sulfate***)	3	PA; QL (56 tablets per 28 days.); SMCS; SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (***mitapivat sulfate***)	3	PA; QL (7 tablets per 365 days.); SMCS; SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (***mitapivat sulfate***)	3	PA; QL (14 tablets per 365 days.); SMCS; SP; CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (***fostamatinib disodium***)	4	PA; QL (2 tablets per day); SMCS; SP
WAYRILZ ORAL TABLET 400 MG (***rilzabrutinib***)	4	PA; ST; QL (60 tablets per month.); SMCS; SP
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	ST; 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.)
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***)	4	PA; QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (***dabigatran etexilate mesylate***)	4	PA; QL (2 packets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (***eltrombopag choline***)	4	PA; SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	M; QL (2 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	M; QL (4 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	M; QL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	M; QL (1 prefill syringe per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	M; QL (2 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	M; QL (4 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	M; QL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	M; QL (2 syringes per month); SMCS; SP
DOPTELET ORAL TABLET 20 MG (***avatrombopag maleate***)	4	PA; QL (60 tablets per month.); SMCS; SP
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (***avatrombopag maleate***)	4	PA; QL (60 capsules per month.); SMCS; SP
eltrombopag olamine oral packet 12.5 mg	1	PA; QL (6 packets per day.); SMCS; SP
eltrombopag olamine oral packet 25 mg	1	PA; QL (6 packets per day.); SMCS
eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg	1	PA; SMCS; SP
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (***sargramostim***)	2	M; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (***plerixafor***)	4	M; SMCS; SP
MULPLETA ORAL TABLET 3 MG (***lusutrombopag***)	4	PA; SMCS; SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim***)	2	M; SMCS
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (***filgrastim-aafi***)	2	M; SMCS; SP
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-aafi***)	2	M; SMCS; SP
plerixafor subcutaneous solution 24 mg/1.2ml	1	M; SMCS; SP
PROMACTA ORAL PACKET 12.5 MG (***eltrombopag olamine***)	4	PA; QL (6 packets per day.); SMCS; SP
PROMACTA ORAL PACKET 25 MG (***eltrombopag olamine***)	4	PA; QL (6 packets per day.); SMCS
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (8 ml per 21 days); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (12 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	M; SMCS; SP
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	M; QL (4 ml per 21 days.); SMCS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	M; SMCS
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	M; SMCS; SP
VAFSEO ORAL TABLET 150 MG, 300 MG (***vadadustat***)	4	PA; QL (31 tablets per month.)
XOLREMDI ORAL CAPSULE 100 MG (***mavorixafor***)	2	PA; QL (120 capsules per month.); SMCS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-sndz***)	2	M; SMCS; SP
HEMORRHEOLOGIC AGENTS - Drugs for Blood Flow		
pentoxifylline er oral tablet extended release 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
HEMOSTATICS - Drugs to Prevent Bleeding		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***)	2	M; SMCS; SP
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	2	M; SMCS; SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact single chain***)	2	M; SMCS; SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor-vwf***)	2	M; SMCS; SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***coagulation factor ix***)	2	M; SMCS; SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***coagulation factor ix (rfixfc)***)	3	M; SMCS; SP
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact fc-vwf-xten-ehtl***)	2	M; SMCS; SP
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	M; SMCS; SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (***coagulation factor x (human)***)	2	M; SMCS; SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (***factor xiii concentrate human***)	2	M; SMCS; SP
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (***crinecerfont***)	4	PA; QL (62 capsules per month.); SMCS; SP
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	4	PA; QL (120 mL (4 bottles) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	M
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	M
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	M; SMCS; SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (***antiinhibitor coagulant cmplx***)	2	M; SMCS; SP
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; M; SMCS; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	M; SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT (***antihemophilic factor***)	2	M; SMCS; SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (***antihemophilic factor-vwf***)	2	M; SMCS; SP
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***marstacimab-hncq***)	2	PA; M; QL (4 mL (4 Auto-injectors) per month.); SMCS; SP
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***marstacimab-hncq***)	2	PA; M; SMCS; SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (***coagulation factor ix (rix-fp)***)	3	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***ahf (bdd-rfviii peg-aucl)***)	4	M; SMCS; SP
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	M; SMCS
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (***antihemophilic factor***)	2	M; SMCS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***)	2	M; SMCS; SP
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	M; SMCS; SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (***coagulation factor viia recomb***)	2	M; SMCS; SP
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	M; SMCS; SP
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	M; SMCS; SP
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	3	M; SMCS; SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***factor ix complex***)	2	M; SMCS; SP
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (***fitusiran sodium***)	4	PA; ST; M; QL (0.2 mL (1 vial) per month.); SMCS; SP
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***fitusiran sodium***)	4	PA; ST; M; QL (0.5 mL (1 pen) per month.); SMCS; SP
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (***antihem factor recomb (rfviii)***)	2	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 5000 UNIT (***thrombin (recombinant)***)	3	
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT (***thrombin (recombinant)***)	3	
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	2	M; SMCS; SP
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG (***coagulation factor viia-jncw***)	4	M; SMCS; SP
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	M; SMCS; SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (***von willebrand factor (recomb)***)	2	M; SMCS; SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (***antihemophilic factor-vwf***)	2	M; SMCS; SP
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	4	PA; ST; M; SMCS; SP
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	4	PA; ST; M; SMCS; SP
HEPARINS - Drugs to Prevent Blood Clots		
enoxaparin sodium injection solution 300 mg/3ml	1	M
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	1	M
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (***dalteparin sodium***)	4	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (***dalteparin sodium***)	4	M
heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml	1	M
heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml	1	M
heparin sodium (porcine) +rfid injection solution 1000 unit/ml	1	M
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	1	M
heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml	1	M
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml, 5000 unit/ml	1	M
INDIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	M
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	4	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
prenatal oral tablet 27-1 mg	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
prasugrel hcl oral tablet 10 mg, 5 mg	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (***aspirin***)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (***aspirin***)	E	H
ticagrelor oral tablet 60 mg, 90 mg	1	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (***vorapaxar sulfate***)	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
ft aspirin 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (***aspirin***)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (***aspirin***)	E	H
VON WILLEBRAND FACTOR-RELATED ANTITHROMB - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***)	2	PA; M; QL (1 vial per day and 58 vials per 120 days.); SMCS; SP
CARDIOVASCULAR DRUGS		
BRADYKININ RECEPTORS ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; M; QL (0.6 ml per day.); SMCS; SP
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.); SMCS; SP
methazolamide oral tablet 25 mg, 50 mg	1	
FACTOR XIIA INHIBITORS		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (***garadacimab-gxii***)	2	PA; M; QL (1 auto-injector per month.); SMCS; SP
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SMCS; SP
LOOP DIURETICS (24:36)		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (***bumetanide***)	4	PA
ethacrynic acid oral tablet 25 mg	1	
FUROSCIX READYFLOW SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (***furosemide***)	3	
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***)	4	PA; M
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	4	QL (31 tablets per month.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (24:36)		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	4	
urea external cream 20 %, 40 %, 41 %	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***)	4	PA
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
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***)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
THIAZIDE-LIKE DIURETICS (24:36)		
chlorthalidone oral tablet 25 mg, 50 mg	1	
HEMICLOR ORAL TABLET 12.5 MG (***chlorthalidone***)	4	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	4	
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ACL INHIBITORS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; ST; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; ST; QL (1 tablet per day.)
ALPHA-ADRENERGIC BLOCKING AGENTS (24:16) - Drugs for Varicose Veins		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	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***)	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***)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	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		
azilsartan medoxomil oral tablet 40 mg, 80 mg	1	
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	
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	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	
ARBLI ORAL SUSPENSION 10 MG/ML (***losartan potassium***)	4	PA
azilsartan medoxomil oral tablet 40 mg, 80 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	4	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	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	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
valsartan oral solution 4 mg/ml	1	PA
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	4	
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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***)	4	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***)	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***)	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	
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	4	
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	4	PA; ST; QL (1 capsule per day.); SMCS; SP
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	4	PA; ST; QL (60 capsules per month.); SMCS; SP
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	4	PA; ST; QL (62 capsules per month.); SMCS; SP
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; ST; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; ST; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
omega-3-acid ethyl esters oral capsule 1 gm	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	4	PA; M; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
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+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***atenolol***)	3	PA
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	4	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (***doxazosin mesylate***)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	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, 37.5 mg, 50 mg, 75 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	4	PA
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	4	
BILE ACID SEQUESTRANTS - Drugs for Cholesterol		
cholestyramine light oral packet 4 gm	1	
cholestyramine light oral powder 4 gm/dose	1	
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (***clindamycin-tretinoin-cholesty***)	3	PA
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***)	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***)	4	
QUESTRAN ORAL PACKET 4 GM (***cholestyramine***)	4	
QUESTRAN ORAL POWDER 4 GM/DOSE (***cholestyramine***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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***)	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***)	4	PA
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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***)	4	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure & Angina		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
methazolamide oral tablet 25 mg, 50 mg	1	
CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (***acoramidis hcl***)	2	PA; QL (124 tablets per month.); SMCS; SP
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***mavacamten***)	4	PA; QL (1 capsule per day.); SMCS; SP
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.); SMCS; SP
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***atenolol***)	3	PA
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
clonidine hcl oral tablet 0.05 mg, 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	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
JAVADIN ORAL SOLUTION 0.02 MG/ML (***clonidine hcl***)	4	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	4	
labetalol hcl oral tablet 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
methyldopa oral tablet 250 mg, 500 mg	1	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
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***)	4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
CGMP SYNTHESIS AGENT - Drugs for High Blood Pressure & Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (***vericiguat***)	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; ST; QL (1 tablet per day.)
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG (***ezetimibe-simvastatin***)	4	
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
disopyramide phosphate oral capsule 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NORPACE ORAL CAPSULE 100 MG, 150 MG (***disopyramide phosphate***)	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	
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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***atenolol***)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	4	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	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, 37.5 mg, 50 mg, 75 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	4	PA
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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***)	4	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	1	
MULTAQ ORAL TABLET 400 MG (***dronedarone hcl***)	4	PA
PACERONE ORAL TABLET 100 MG (***amiodarone hcl***)	3	
PACERONE ORAL TABLET 200 MG (***amiodarone hcl***)	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***)	4	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (***dofetilide***)	4	
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (***etripamil***)	4	PA
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	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 BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***amlodipine besylate***)	3	PA
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	1	
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	4	PA
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***)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	4	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***amlodipine besylate***)	3	PA
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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***)	4	
DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***)	3	M; QL (6 units per month)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; 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 KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; QL (6 units per month)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
minoxidil oral tablet 10 mg, 2.5 mg	1	
DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
FIBRIC ACID DERIVATIVES - Drugs for Cholesterol		
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	1	
fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg	1	
fenofibrate oral tablet 120 mg, 145 mg, 160 mg, 40 mg, 48 mg, 54 mg	1	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	1	
fenofibric acid oral tablet 105 mg, 35 mg	1	
gemfibrozil oral tablet 600 mg	1	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (***fenofibrate***)	4	
LOPID ORAL TABLET 600 MG (***gemfibrozil***)	4	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (***atorvastatin calcium***)	4	PA
atorvastatin calcium oral tablet 10 mg, 20 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	4	PA
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	1	
fluvastatin sodium oral capsule 20 mg, 40 mg	1	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (***pitavastatin calcium***)	4	ST
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	H
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	1	ST
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
simvastatin oral tablet 80 mg	1	
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG (***ezetimibe-simvastatin***)	4	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (***pitavastatin magnesium***)	4	ST
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***)	4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	4	QL (31 tablets per month.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
eplerenone oral tablet 25 mg, 50 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG (***finerenone***)	4	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (***finerenone***)	4	PA; QL (30 tablets per month.)
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
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***)	4	PA
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	4	PA; ST; QL (1 capsule per day.); SMCS; SP
JUXTAPID ORAL CAPSULE 2 MG (***lomitapide mesylate***)	4	PA; ST; QL (30 capsules per month.); SMCS
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	4	PA; ST; QL (60 capsules per month.); SMCS; SP
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	4	PA; ST; QL (62 capsules per month.); SMCS; SP
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	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***atenolol***)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
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***)	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, 37.5 mg, 50 mg, 75 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	
nitroglycerin translingual solution 0.4 mg/spray	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	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***)	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	
nitroglycerin translingual solution 0.4 mg/spray	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
omega-3-acid ethyl esters oral capsule 1 gm	1	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***evolocumab***)	2	M; QL (2 pens per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 mg, 50 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	4	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS; SP
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.); SMCS; SP
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 tablets per month)
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 mg, 50 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	4	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS; SP
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.); SMCS; SP
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 tablets per month)
POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	4	PA
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	4	PA; QL (60 tablets per month.); SMCS; SP
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***)	4	PA
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
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	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	4	
VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina		
phenoxybenzamine hcl oral capsule 10 mg	1	
VECAMYL ORAL TABLET 2.5 MG (***mecamylamine hcl***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***amlodipine besylate***)	3	PA
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.); SMCS; SP
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SMCS; SP
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***)	3	M; QL (6 units per month)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; 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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EDEX (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; QL (6 units per month)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	M; QL (6 units per month)
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	4	PA
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.); SMCS; SP
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***)	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***)	4	PA; QL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	4	PA; QL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	4	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	4	PA; QL (744 tablets per month.); SMCS; SP
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***)	4	
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	4	PA; QL (4 tablets per day.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA; SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
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***)	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.); SMCS; SP
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.); SMCS; SP
riluzole oral tablet 50 mg	1	SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA; SMCS; SP
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA; SMCS; SP
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.)
AMPHETAMINE DERIVATIVES - Drugs for the Nervous System		
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	1	PA
diethylpropion hcl oral tablet 25 mg	1	PA
LOMAIRA ORAL TABLET 8 MG (***phentermine hcl***)	3	PA
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	1	PA
phendimetrazine tartrate oral tablet 35 mg	1	PA
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	1	PA
phentermine hcl oral tablet 37.5 mg, 8 mg	1	PA
AMPHETAMINES - Drugs for the Nervous System		
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG (***amphetamine-dextroamphetamine***)	4	QL (2 capsules per day.)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (***amphetamine***)	4	QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
amphetamine er oral tablet extended release dispersible 12.5 mg, 15.7 mg, 18.8 mg, 3.1 mg, 6.3 mg, 9.4 mg	1	QL (1 tablet per day.)
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)
benzphetamine hcl oral tablet 50 mg	1	PA
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	QL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	QL (10 capsules per day.)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (***amphetamine***)	4	QL (15 mL per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 10 MG, 15 MG, 5 MG (***amphetamine***)	4	QL (1 tablet per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 20 MG (***amphetamine***)	4	QL (31 chewable tablets per month.)
EVEKEO ORAL TABLET 10 MG, 5 MG (***amphetamine sulfate***)	4	
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	1	QL (2 capsules per day.)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	1	QL (1 capsule per day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	1	QL (2 tablets per day.)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	1	QL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
methamphetamine hcl oral tablet 5 mg	1	
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (***amphetamine-dextroamphetamine***)	4	QL (1 capsule per day)
PROCENTRA ORAL SOLUTION 5 MG/5ML (***dextroamphetamine sulfate***)	3	
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (***lisdexamfetamine dimesylate***)	4	QL (2 capsules per day.)
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (***lisdexamfetamine dimesylate***)	4	QL (1 capsule per day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (***lisdexamfetamine dimesylate***)	4	QL (2 tablets per day.)
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (***lisdexamfetamine dimesylate***)	4	QL (1 tablet per day)
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
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	QL (Benefit maximum quantity 6 per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (***gabapentin***)	3	PA
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	4	QL (6 capsules per day)
gabapentin oral capsule 100 mg, 200 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
JOURNAVX ORAL TABLET 50 MG (***suzetrigine***)	4	QL (30 tablets per 90 days.)
NEURAPTINE EXTERNAL CREAM 10 % (***gabapentin***)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	4	
NEURORUB EXTERNAL CREAM 10 % (***gabapentin***)	3	PA
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
OXYCODONE-ACETAMINOPHEN ORAL TABLET 5-300 MG, 7.5-300 MG	4	NTT
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG (***oxycodone-acetaminophen***)	4	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
ANOREXIGENIC AGENTS - Drugs for the Nervous System		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (***naltrexone-bupropion hcl***)	3	PA; QL (4 tablets per day.)
phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg	1	PA; QL (1 capsule per day.)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (***phentermine-topiramate***)	3	PA; QL (1 capsule per day.)
ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System		
phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg	1	PA; QL (1 capsule per day.)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (***phentermine-topiramate***)	3	PA; QL (1 capsule per day.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.); SMCS; SP
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (***naltrexone-bupropion hcl***)	3	PA; QL (4 tablets per day.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
liraglutide -weight management subcutaneous solution pen-injector 18 mg/3ml	1	PA; M; QL (0.6 ml per day.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (***liraglutide -weight management***)	3	PA; M; QL (0.6 ml per day.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.); SMCS; SP
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.); SMCS; SP
WEGOVY HD SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.2 MG/0.75ML (***semaglutide-weight management***)	3	PA; M
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (***semaglutide-weight management***)	3	PA; M; QL (0.08 ml per day and 4 ml per 365 days.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (***semaglutide-weight management***)	3	PA; M; QL (0.11 ml per day.)
ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (2 mL (4 vials) per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (2 mL (4 vials) per month. 4 mL (8 vials) per 365 days.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (4 pens per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (4 pens per month and 8 pens per year.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	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***)	4	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (***brivaracetam***)	3	PA
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***)	4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA; SMCS; SP
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA; SMCS; SP
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; SMCS; SP
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	4	
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (***gabapentin***)	3	PA
felbamate oral suspension 600 mg/5ml	1	
felbamate oral tablet 400 mg, 600 mg	1	
FELBATOL ORAL TABLET 400 MG, 600 MG (***felbamate***)	4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML (***fenfluramine hcl***)	4	PA; SMCS
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (***perampanel***)	4	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (***perampanel***)	3	PA
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
KEPPRA ORAL SOLUTION 100 MG/ML (***levetiracetam***)	4	
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (***levetiracetam***)	4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (***levetiracetam***)	4	
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LEVETIRACETAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG	4	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	4	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (***lacosamide***)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	4	
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
perampanel oral suspension 0.5 mg/ml	1	PA
perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
roweepra oral tablet 500 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG (***levetiracetam***)	4	
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	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***)	4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	4	PA; SMCS; SP
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (***dextromethorphan-bupropion***)	4	ST; QL (2 tablets per day.)
AUVELITY TITRATION PACK ORAL TABLET EXTENDED RELEASE THERAPY PACK 30-105 MG & 45-105 MG (***dextromethorphan-bupropion***)	4	ST; 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 ER (XL) ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG	4	QL (1 tablet per day.)
bupropion hcl oral tablet 100 mg, 75 mg	1	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	4	PA; QL (8 devices (4 kits) per month.); SMCS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	4	PA; QL (12 devices (4 kits) per month.); SMCS
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (***zuranolone***)	2	PA; QL (28 capsules per year.); SMCS; SP
ZURZUVAE ORAL CAPSULE 30 MG (***zuranolone***)	2	PA; QL (14 capsules per year.); SMCS; SP
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)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***)	4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	4	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	4	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	4	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	4	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	4	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium oral solution 8 meq/5ml	1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (***lithium carbonate***)	4	
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg	1	QL (1 capsule per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG (***quetiapine fumarate***)	4	
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	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***)	4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	4	
caffeine citrate oral solution 60 mg/3ml	1	
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	4	
diclofenac potassium(migraine) oral packet 50 mg	1	
dihydroergotamine mesylate injection solution 1 mg/ml	1	M
dihydroergotamine mesylate nasal solution 4 mg/ml	1	ST
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***)	4	ST
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (***propranolol hcl***)	4	
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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (***aspirin***)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (***aspirin***)	E	H
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***)	4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	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***)	4	QL (1 tablet per day.)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	4	PA; QL (5.1 mL per day.); SMCS; SP
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	4	PA; QL (1 capsule per day.); SMCS; SP
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
meprobamate oral tablet 200 mg, 400 mg	1	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.); SMCS; SP
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	4	QL (1 capsule per day.)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
aripiprazole oral solution 1 mg/ml	1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (***lumateperone tosylate***)	4	PA; ST; 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***)	4	
FANAPT ORAL TABLET 1 MG (***iloperidone***)	4	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (***iloperidone***)	4	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (***iloperidone***)	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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG (***iloperidone***)	4	QL (1 pack (12 tablets) per 365 days.)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (***iloperidone***)	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***)	4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (***pimavanserin tartrate***)	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***)	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	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG (***quetiapine fumarate***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VERSACLOZ ORAL SUSPENSION 50 MG/ML (***clozapine***)	4	
VRAYLAR ORAL CAPSULE 0.5 MG (***cariprazine hcl***)	4	QL (60 capsules per month.)
VRAYLAR ORAL CAPSULE 0.75 MG (***cariprazine hcl***)	4	QL (30 capsules per month.)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (***cariprazine hcl***)	4	
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (***cariprazine hcl***)	4	QL (1 capsule per day.)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures		
MYSOLINE ORAL TABLET 250 MG, 50 MG (***primidone***)	2	
phenobarbital oral elixir 20 mg/5ml	1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	
primidone oral tablet 125 mg, 250 mg, 50 mg	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	4	
ascomp-codeine oral capsule 50-325-40-30 mg	1	
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	QL (Benefit maximum quantity 6 per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	4	QL (6 capsules per day)
phenobarbital oral elixir 20 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	
lorazepam intensol oral concentrate 2 mg/ml	1	
lorazepam oral concentrate 2 mg/ml	1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) per month.)
BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
alprazolam intensol oral concentrate 1 mg/ml	1	
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	4	
midazolam hcl oral syrup 2 mg/ml	1	
MIDAZOLAM+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (***midazolam***)	3	PA
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	4	
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (***temazepam***)	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	4	PA
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	1	
triazolam oral tablet 0.125 mg, 0.25 mg	1	
BUTYROPHENONES - Drugs for Depression & Psychosis		
haloperidol lactate oral concentrate 2 mg/ml	1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	
CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (***erenumab-aooe***)	2	PA; M; QL (1 pen per month.)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (***galcanezumab-gnlm***)	2	PA; M; QL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***galcanezumab-gnlm***)	2	PA; M; QL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***galcanezumab-gnlm***)	2	PA; M; QL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (***rimegepant sulfate***)	2	PA; QL (0.27 tablets per day for acute use; 0.6 tablets per day for preventive use with PA.)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (***atogepant***)	2	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
UBRELVY ORAL TABLET 100 MG, 50 MG (***ubrogepant***)	2	PA; ST; QL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (***zavegepant hcl***)	4	PA; ST
CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson		
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	1	
entacapone oral tablet 200 mg	1	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG (***opicapone***)	4	QL (1 capsule per day.)
tolcapone oral tablet 100 mg	1	
CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder		
acamprosate calcium oral tablet delayed release 333 mg	1	
ADDYI ORAL TABLET 100 MG (***flibanserin***)	4	PA; QL (1 tablet per day.)
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (***trofinetide***)	2	PA; QL (120 ml per day.)
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***)	4	PA; QL (1 packet per day.); SMCS; SP
LYNKUET ORAL CAPSULE 60 MG (***elinzanetant***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	1	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	4	
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.); SMCS; SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.); SMCS; SP
riluzole oral tablet 50 mg	1	SMCS
sodium oxybate oral solution 500 mg/ml	4	PA; QL (18 ml per day.); SMCS; SP
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA; SMCS; SP
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA; SMCS; SP
VEOZAH ORAL TABLET 45 MG (***fezolinetant***)	4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	4	PA; M; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.); SMCS; SP
XYWAV ORAL SOLUTION 500 MG/ML (***ca, mg, k, and na oxybates***)	4	PA; QL (18 mL per day.); SMCS; SP
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***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	ST
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (***carbidopa-levodopa***)	4	PA
INBRIJA INHALATION CAPSULE 42 MG (***levodopa***)	3	PA; QL (10 tablets per day.); SMCS; SP
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (***carbidopa-levodopa***)	4	
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson		
bromocriptine mesylate oral capsule 5 mg	1	
bromocriptine mesylate oral tablet 2.5 mg	1	
cabergoline oral tablet 0.5 mg	1	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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 er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***)	4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***)	4	QL (1 pack per 365 days.)
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	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***)	4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	4	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA; SMCS; SP
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA; SMCS; SP
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, 200 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***)	4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	4	
NEURAPTINE EXTERNAL CREAM 10 % (***gabapentin***)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	4	
NEURORUB EXTERNAL CREAM 10 % (***gabapentin***)	3	PA
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	1	PA; QL (6 packets per day.); SMCS
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.); SMCS; SP
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SMCS
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SMCS; SP
VIGAFYDE ORAL SOLUTION 100 MG/ML (***vigabatrin***)	1	PA; QL (900 mL per month.); SMCS; SP
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	4	PA; SMCS; SP
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	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
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	4	
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***)	4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	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***)	4	PA; QL (5.1 mL per day.); SMCS; SP
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	4	PA; QL (1 capsule per day.); SMCS; SP
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.); SMCS; SP
MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson		
AZILECT ORAL TABLET 0.5 MG, 1 MG (***rasagiline mesylate***)	4	
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		
AZILECT ORAL TABLET 0.5 MG, 1 MG (***rasagiline mesylate***)	4	
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***)	3	
MARPLAN ORAL TABLET 10 MG (***isocarboxazid***)	3	
NARDIL ORAL TABLET 15 MG (***phenelzine sulfate***)	4	
PARNATE ORAL TABLET 10 MG (***tranylcypromine sulfate***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA; QL (8 devices (4 kits) per month.); SMCS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	4	PA; QL (12 devices (4 kits) per month.); SMCS
NON-BENZODIAZEPINE ANXIOLYTICS - Drugs for Anxiety & Sleep Disorder		
buspirone hcl oral tablet 10 mg, 12.5 mg, 15 mg, 2.5 mg, 30 mg, 5 mg, 7.5 mg	1	
meprobamate oral tablet 200 mg, 400 mg	1	
NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder		
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	4	QL (1 capsule per day.)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (***apomorphine hcl***)	4	PA; M; QL (3 ml per day.); SMCS; SP
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	1	PA; M; QL (3 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	QL (Benefit maximum quantity 6 per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	4	QL (6 capsules per day)
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
OXYCODONE-ACETAMINOPHEN ORAL TABLET 5-300 MG, 7.5-300 MG	4	NTT
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG (***oxycodone-acetaminophen***)	4	NTT
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC - Drugs for Pain		
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	4	
diclofenac potassium oral capsule 25 mg	1	QL (4 capsules per day.)
diclofenac potassium oral tablet 50 mg	1	
diclofenac potassium(migraine) oral packet 50 mg	1	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	1	
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (***ketoprofen-baclofen-gabap-lido***)	3	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	4	PA
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	4	ST
sulindac oral tablet 150 mg, 200 mg	1	
ZIPSOR ORAL CAPSULE 25 MG (***diclofenac potassium***)	4	QL (4 capsules per day.)
OPIOID AGONISTS (28:08) - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
ascomp-codeine oral capsule 50-325-40-30 mg	1	
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	QL (Benefit maximum quantity 6 per day.)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	1	NTT
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***tramadol hcl***)	4	QL (1 capsule per day)
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, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	1	PA; QL (0.34 patches per day)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	1	PA; QL (15 patches per 31 days)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	1	PA; QL (2 capsules per day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	1	PA; QL (0 tablet per 0 days)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	1	PA; QL (1 tablet per day)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	1	PA; QL (2 tablets per day)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg	1	PA; QL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	1	PA; QL (0 tablet per 0 days)
hydromorphone hcl oral liquid 1 mg/ml	1	NTT
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	NTT
hydromorphone hcl rectal suppository 3 mg	1	NTT
levorphanol tartrate oral tablet 2 mg, 3 mg	1	ST; 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)
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 capsule per 100 days)
morphine sulfate er oral tablet extended release 15 mg, 30 mg	1	PA; QL (93 tablets per 31 days)
morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml	1	NTT
morphine sulfate oral tablet 15 mg, 30 mg	1	NTT
morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (***tapentadol hcl***)	3	PA; QL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (***tapentadol hcl***)	3	PA; QL (0 capsule per 100 days)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (***tapentadol hcl***)	4	QL (6 tablets per day); NTT
opium oral tincture 10 mg/ml (1%)	1	
oxycodone hcl oral capsule 5 mg	1	NTT
oxycodone hcl oral concentrate 100 mg/5ml	1	NTT
oxycodone hcl oral solution 5 mg/5ml	1	NTT
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
OXYCODONE-ACETAMINOPHEN ORAL TABLET 5-300 MG, 7.5-300 MG	4	NTT
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg	1	PA; QL (0 tablet per 100 days.)
oxymorphone hcl er oral tablet extended release 12 hour 30 mg, 40 mg	1	PA; QL (0 capsule per 100 days)
oxymorphone hcl oral tablet 10 mg, 5 mg	1	NTT
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG (***oxycodone-acetaminophen***)	4	NTT
SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***tramadol hcl***)	3	PA; NTT
tapentadol hcl oral tablet 100 mg, 50 mg, 75 mg	1	QL (6 tablets per day); NTT
TRAMADOL HCL (ER BIPHASIC) ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG	4	QL (1 capsule per day)
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
tramadol hcl oral tablet 25 mg	1	
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***)	4	PA; QL (2 tablets per day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (***oxycodone***)	4	PA; QL (0 capsule per 100 days)
xyvona oral tablet 2 mg, 3 mg	1	ST; NTT
OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1	QL (2 films per day.)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	1	QL (1 film per day.)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	1	QL (1 sublingual film per day)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1	QL (3 films per day.)
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	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (***naloxone hcl***)	1	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	
naloxone hcl nasal liquid 4 mg/0.1ml	1	
naltrexone hcl oral tablet 50 mg	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	
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***)	4	PA; M; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	4	M; 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	4	M; QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	
REZENOPY NASAL LIQUID 10 MG/0.11ML (***naloxone hcl***)	3	
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	2	
SUBOXONE SUBLINGUAL FILM 12-3 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 4-1 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (1 sublingual film per day)
SUBOXONE SUBLINGUAL FILM 8-2 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (3 films per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (2 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (1 tablet per day)
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (***nalmefene hcl***)	3	
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (***buprenorphine hcl***)	3	PA; QL (2 films per day)
buprenorphine hcl sublingual tablet sublingual 2 mg	1	QL (3 sublingual tablets per day)
buprenorphine hcl sublingual tablet sublingual 8 mg	1	QL (3 tablets per day)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1	QL (2 films per day.)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	1	QL (1 film per day.)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	1	QL (1 sublingual film per day)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1	QL (3 films per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	
buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr	1	PA; QL (4 patches per 28 days)
buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr	1	PA; QL (4 patches per month)
butorphanol tartrate nasal solution 10 mg/ml	1	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
SUBOXONE SUBLINGUAL FILM 12-3 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 4-1 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (1 sublingual film per day)
SUBOXONE SUBLINGUAL FILM 8-2 MG (***buprenorphine hcl-naloxone hcl***)	4	PA; QL (3 films per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (2 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG (***buprenorphine hcl-naloxone hcl***)	1	QL (1 tablet per day)
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	4	QL (1 tablet per day.)
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	2	ST; QL (1 capsule per day.)
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	QL (Benefit maximum quantity 6 per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	QL (6 capsules per day)
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 tablets per day)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	4	
caffeine citrate oral solution 60 mg/3ml	1	
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (***methylphenidate***)	4	QL (1 tablet per day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	1	QL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	1	QL (31 capsules per 31 days.)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
elixophyllin oral elixir 80 mg/15ml	3	
ergotamine-caffeine oral tablet 1-100 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	4	QL (6 capsules per day)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (***dexmethylphenidate hcl***)	4	
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (***methylphenidate hcl***)	4	
METHYLPHENIDATE ER ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG	4	QL (1 tablet per day)
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
methylphenidate hcl er (osm) oral tablet extended release 27 mg, 36 mg, 54 mg	1	QL (2 tablets per day.)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (1 capsule per day.)
methylphenidate hcl er oral tablet extended release 10 mg	1	QL (10 tablets per day.)
methylphenidate hcl er oral tablet extended release 20 mg	1	QL (5 tablets per day.)
methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml	1	
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	1	
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr	1	QL (1 patch per day)
methylphenidate transdermal patch 30 mg/9hr	1	QL (1 patch per day.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (***methylphenidate hcl***)	4	QL (1 tablet per day.)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (***methylphenidate hcl***)	4	QL (360 mL per month.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	4	
diclofenac sodium external gel 3 %	1	PA
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
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	4	PA
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	4	ST
sulindac oral tablet 150 mg, 200 mg	1	
SALICYLATES - Drugs for Pain		
ascomp-codeine oral capsule 50-325-40-30 mg	1	
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec adult low dose oral tablet delayed release 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
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	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (***aspirin***)	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (***aspirin***)	E	H
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
DESVENLAFAXINE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG	4	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***)	4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***)	4	QL (1 capsule per day.)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (***levomilnacipran hcl***)	4	ST; QL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (***levomilnacipran hcl***)	4	ST; 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)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (***milnacipran hcl***)	4	QL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (***milnacipran hcl***)	4	QL (1 pack per 365 days.)
VENLAFAXINE BESYLATE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 112.5 MG	4	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
SELECTIVE SEROTONIN AGONISTS - Migraine Treatment		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
eletriptan hydrobromide oral tablet 20 mg, 40 mg	1	
frovatriptan succinate oral tablet 2.5 mg	1	
naratriptan hcl oral tablet 1 mg, 2.5 mg	1	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC (***sumatriptan succinate***)	4	
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	
sumatriptan nasal solution 20 mg/act, 5 mg/act	1	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	M
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	1	M
TOSYMRA NASAL SOLUTION 10 MG/ACT (***sumatriptan***)	4	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (***sumatriptan succinate***)	4	M
zolmitriptan oral tablet 2.5 mg, 5 mg	1	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	1	
ZOMIG NASAL SOLUTION 2.5 MG (***zolmitriptan***)	2	
ZOMIG NASAL SOLUTION 5 MG (***zolmitriptan***)	1	
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
citalopram hydrobromide oral capsule 30 mg	1	
citalopram hydrobromide oral solution 10 mg/5ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
ESCITALOPRAM OXALATE ORAL CAPSULE 15 MG	4	
escitalopram oxalate oral solution 5 mg/5ml	1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	1	QL (4 capsules per 28 days.)
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ZARONTIN ORAL CAPSULE 250 MG (***ethosuximide***)	4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (***ethosuximide***)	4	
THIOXANTHENES - Drugs for Depression & Psychosis		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	1	
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl external cream 5 %	1	PA
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral concentrate 10 mg/ml	1	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (1 tablet per day)
ENOVARX-AMITRIPTYLINE EXTERNAL KIT 2 %	3	PA
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***)	4	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	
nortriptyline hcl oral solution 10 mg/5ml	1	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	1	
protriptyline hcl oral tablet 10 mg, 5 mg	1	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	4	QL (1 tablet per day)
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (***deutetrabenazine***)	2	PA; QL (4 tablets per day); SMCS; SP
AUSTEDO ORAL TABLET 6 MG (***deutetrabenazine***)	2	PA; QL (2 tablets per day); SMCS; SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (***deutetrabenazine***)	2	PA; QL (30 tablets per month.); SMCS; SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (***deutetrabenazine***)	2	PA; QL (30 Tablets per month.); SMCS; SP
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.); SMCS; SP
INGREZZA ORAL CAPSULE 40 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day); SMCS; SP
INGREZZA ORAL CAPSULE 60 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day.); SMCS
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (30 capsules per month.); SMCS; SP
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (***valbenazine tosylate***)	2	PA; QL (1 kit (28 capsules) per year.); SMCS; SP
tetrabenazine oral tablet 12.5 mg	1	PA; SMCS
tetrabenazine oral tablet 25 mg	1	PA; SMCS; SP
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***)	4	PA; QL (1 packet per day.); SMCS; SP
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	4	PA; QL (1 box (28 packets) per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
modafinil oral tablet 100 mg, 200 mg	1	QL (3 tablets per day.)
sodium oxybate oral solution 500 mg/ml	4	PA; QL (18 ml per day.); SMCS; 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***)	4	PA; QL (2 tablets per day.); SMCS; SP
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
DENTAGEL DENTAL GEL 1.1 %	4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	4	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AEROCHAMBER2GO ANTI-STATIC DEVICE (***spacer/aero-holding chambers***)	2	
ALCOHOL PREP PADS SHEET 70 %	3	
AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	QL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
ASSURE CONTROL SOLUTION 2/3 IN VITRO LIQUID (***blood glucose calibration***)	2	
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM	2	QL (10 pen needles per day.)
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	QL (10 pen needles per day.)
AUM PEN NEEDLE 32G X 5 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	QL (10 pen needles per day.)
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
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	
AUTOLET LITE LANCING DEVICE (***lancet devices***)	3	
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD BLUNT FILL NEEDLE 18G X 1" (***needle (disp)***)	2	
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (***needle (disp)***)	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (***needle (disp)***)	2	
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
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	M; QL (1 meter or meter kit per year.)
BREATHE COMFORT CHAMBER/ADULT DEVICE	2	
BREATHE COMFORT CHAMBER/CHILD DEVICE	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION (***blood glucose calibration***)	2	
CARESENS LANCETS 30G (***lancets***)	3	
CARESENS S CONTROL SOLN A/B IN VITRO LIQUID (***blood glucose calibration***)	3	
CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID (***blood glucose calibration***)	3	
CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" (***needle (disp)***)	2	
CARETOUCH LANCING/EJECTOR (***lancet devices***)	3	
CEQUR SIMPLICITY 1U EXTND WEAR DEVICE (***injection device for insulin***)	3	ST
CEQUR SIMPLICITY 2U DEVICE (***injection device for insulin***)	3	ST
CEQUR SIMPLICITY 2U EXTND WEAR DEVICE (***injection device for insulin***)	3	ST
CHEMSTRIP BG LOG BOOK (***blood glucose monitoring suppl***)	1	M
CHOSEN LANCETS 30G (***lancets***)	3	
CHOSEN LANCING DEVICE (***lancet devices***)	3	
CHOSEN SAFETY LANCETS 28G (***lancets***)	3	
CLEVER CHOICE COMFORT EZ (***lancets***)	3	
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
COMFORT TOUCH TWIST LANCET 30G (***lancets***)	3	
CONTOUR CONTROL IN VITRO LIQUID HIGH (***blood glucose calibration***)	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (***blood glucose calibration***)	2	
CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (***blood glucose calibration***)	2	
CONTOUR NEXT EZ KIT W/DEVICE (***blood glucose monitoring suppl***)	1	M; 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CONTOUR NEXT GEN MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	M; QL (1 meter or meter kit per year.)
CONTOUR NEXT MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	M; QL (1 meter or meter kit per year.)
CONTOUR NEXT ONE KIT , W/DEVICE (***blood glucose monitoring suppl***)	1	M; QL (1 meter or meter kit per year.)
CONTOUR PLUS BLUE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	M; QL (1 meter or meter kit per year.)
CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	2	
DEXCOM G6 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; M; QL (1 kit per 999 days.)
DEXCOM G6 SENSOR (***continuous glucose sensor***)	3	PA; M; QL (3 sensors per month.)
DEXCOM G6 TRANSMITTER (***continuous glucose transmitter***)	3	PA; M; QL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.)
DEXCOM G7 15 DAY SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per month.)
DEXCOM G7 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; M; QL (1 kit per 999 days.)
DEXCOM G7 SENSOR (***continuous glucose sensor***)	3	PA; M; QL (3 sensors per month.)
DIABETES MONITOR DIGIT ADD-ON KIT	3	M; QL (1 meter or meter kit per year.)
DIABETES MONITOR DIGIT SOLN KIT	3	M; QL (1 meter or meter kit per year.)
DROPLET MICRON 34G X 3.5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE ACTI-LANCE 23G (***lancets***)	3	
DROPSAFE AUTOPROTECT DUO 31G X 4 MM , 31G X 5 MM , 31G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE MEDLANCE LANCET 30G (***lancets***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
EASY COMFORT SHARPS CONTAINER	3	
EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (***blood glucose calibration***)	3	
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (***blood glucose calibration***)	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL (***blood glucose calibration***)	3	
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (***blood glucose calibration***)	3	
EMBECTA AUTOSHIELD DUO 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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; M
FLEXICHAMBER ADULT MASK/SMALL (***spacer/aero-hold chamber mask***)	2	
FLEXICHAMBER CHILD MASK/LARGE (***spacer/aero-hold chamber mask***)	2	
FLEXICHAMBER CHILD MASK/SMALL (***spacer/aero-hold chamber mask***)	2	
FLEXICHAMBER DEVICE (***spacer/aero-holding chambers***)	2	
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	
FONDCIRCLE SINGLE USE LANCETS	3	
FORA TEST N' GO ADVANCE DEVICE (***blood glucose/ketone monitor***)	3	M
FREESTYLE LIBRE 14 DAY READER DEVICE (***continuous glucose receiver***)	3	PA; M; QL (1 receiver per 999 days.)
FREESTYLE LIBRE 14 DAY SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per 21 days.)
FREESTYLE LIBRE 2 PLUS SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per month.)
FREESTYLE LIBRE 2 READER DEVICE (***continuous glucose receiver***)	3	PA; M; QL (1 receiver per 999 days.)
FREESTYLE LIBRE 2 SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per 21 days.)
FREESTYLE LIBRE 3 PLUS SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per month.)
FREESTYLE LIBRE 3 READER DEVICE (***continuous glucose receiver***)	3	PA; M; QL (1 reader per 999 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FREESTYLE LIBRE 3 SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per 21 days.)
GUARDIAN 4 GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; M; QL (5 sensors per month.)
GUARDIAN 4 TRANSMITTER (***continuous glucose transmitter***)	3	PA; M; QL (1 transmitter kit per year.)
GUARDIAN REAL-TIME CHARGER (***continuous glucose monitor sup***)	3	M
GUARDIAN REAL-TIME TEST PLUG (***continuous glucose monitor sup***)	3	M
GUARDIAN SENSOR 3 (***continuous glucose sensor***)	3	PA; M; QL (5 sensors per 24 days.)
HAN-EASE (***injection device***)	3	
IHEALTH CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	3	
IHEALTH LANCING DEVICE (***lancet devices***)	3	
INPEN 100-BLUE-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	ST
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	ST
INPEN 100-GREY-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	ST
INPEN 100-GREY-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	ST
INPEN 100-PINK-LILLY-HUMALOG DEVICE (***injection device for insulin***)	3	ST
INPEN 100-PINK-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	ST
INSPIREASE RESERVOIR BAGS (***spacer/aero-hold chamber bags***)	2	
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 31G X 5 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
INSULIN PEN NEEDLES 29G X 4MM , 29G X 5MM , 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 29G X 5/16" 0.5 ML, 29G X 5/16" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML	2	QL (10 syringes per day.)
INSULIN SYRINGES 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 32G X 5/16" 1 ML (***insulin syringe-needle u-100***)	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	M
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	
MINIMED INSTINCT GLUC SENSOR (***continuous glucose sensor***)	3	PA; M; QL (2 sensors per month.)
MOBILE LANCETS 30G	3	M
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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ONETOUCH DELICA PLUS LANCING (***lancet devices***)	1	
ONETOUCH DELICA SAFETY LANCING (***lancets***)	1	
ONETOUCH ULTRA IN VITRO LIQUID (***blood glucose calibration***)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (***blood glucose calibration***)	1	
PARI VORTEX ADULT MASK (***spacer/aero-hold chamber mask***)	2	
PARI VORTEX PEDIATRIC MASK (***spacer/aero-hold chamber mask***)	2	
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
PERFECT POINT SAFETY LANCETS (***lancets***)	3	
PERFECT POINT SAFETY NEEDLE 25G X 1" (***needle (disp)***)	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	3	
PIVOT SUPPLY KIT KIT	2	PA
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; M
TECHLITE LANCETS 26G (***lancets***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (***blood glucose calibration***)	2	
TWIIST REFILL KIT KIT (***insulin disposable pump***)	2	PA
TWIIST REFILL KIT/INFUSION SET KIT (***insulin disposable pump***)	2	PA
TWIIST STARTER KIT KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 730 days.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VERIFINE SAFE LANCET MINI 30G (***lancets***)	3	
VERIFINE SHARPS CONTAINER (***sharps container***)	3	
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (***needle (disp)***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	3	
VIVAGUARD LANCETS 30G (***lancets***)	3	
VIVAGUARD LANCING DEVICE (***lancet devices***)	3	
VIVAGUARD SAFETY LANCETS 28G (***lancets***)	3	
VORTEX VALVE CHAMBER-PEDI MASK DEVICE (***spacer/aero-holding chambers***)	2	
VORTEX VALVED HOLDING CHAMBER DEVICE (***spacer/aero-holding chambers***)	2	
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	4	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	4	PA; ST; QL (21 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	4	PA; ST; M; QL (20 ml per 24 days.); SMCS; SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	4	PA; ST; SMCS; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	4	PA; ST; M; QL (20 ml per 24 days.); SMCS; SP
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (***cosyntropin***)	4	M
cosyntropin injection solution reconstituted 0.25 mg	1	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
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***)	4	QL (51 strips per prescription without history 204 strips per prescription with history.)
DIAGNOSTIC AGENTS		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
CARESTART COVID-19 HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
CLEARDETECT COVID-19 AG HOME IN VITRO KIT (***covid-19 at home test***)	3	SM
CLINITEST RAPID COVID-19 TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
COVID-19 AT HOME ANTIGEN TEST IN VITRO KIT	3	SM
COVID-19 AT-HOME TEST IN VITRO KIT	3	SM
DIATRUST COVID-19 HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
ELLUME COVID-19 HOME TEST IN VITRO KIT	3	SM
FASTEP COVID-19 ANTIGEN TEST IN VITRO KIT	3	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
IHEALTH COVID-19 RAPID TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
INDICAID COVID-19 RAPID TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
ON/GO COVID-19 ANTIGEN TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
ON/GO ONE COVID-19 HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
PILOT COVID-19 AT-HOME TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (***covid-19 at home test***)	3	SM
SPEEDY SWAB COVID-19 ANTIGEN IN VITRO KIT (***covid-19 at home test***)	3	SM
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
formaldehyde external solution 37 %	1	
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***)	4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (***potassium citrate***)	4	
AMMONIA DETOXICANTS		
BUPHENYL ORAL POWDER 3 GM/TSP (***sodium phenylbutyrate***)	4	PA; SMCS
carglumic acid oral tablet soluble 200 mg	1	PA; SMCS; SP
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.); SMCS; SP
KRISTALOSE ORAL PACKET 10 GM, 20 GM (***lactulose***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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; SMCS
sodium phenylbutyrate oral tablet 500 mg	1	PA; SMCS
CALORIC AGENTS - Drugs for Nutrition		
CAMINO PRO COMPLETE/GLYTACTIN ORAL BAR (***nutritional supplements***)	3	M
COMPLEX ESSENTIAL MSD ORAL POWDER (***nutritional supplements***)	3	
DOJOLVI ORAL LIQUID 100 % (***triheptanoin***)	4	PA; SMCS; SP
EAA SUPPLEMENT ORAL PACKET (***nutritional supplements***)	3	
ENCALA ORAL POWDER (***nutritional supplements***)	3	
ENSURE ORIGINAL ORAL LIQUID (***nutritional supplements***)	3	
ENSURE PLUS ORAL LIQUID (***nutritional supplements***)	3	
GLYTACTIN BETTERMILK 15 ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN BETTERMILK DE-LITE ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN BUILD 10PE ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN BUILD 20/20 ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN BUILD 20/20 PKU ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN BURST ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN COMPLETE 10PE ORAL BAR (***nutritional supplements***)	3	M
GLYTACTIN RESTORE 10 ORAL LIQUID (***nutritional supplements***)	3	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
GLYTACTIN RESTORE 5 ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN RESTORE LITE 10 ORAL LIQUID (***nutritional supplements***)	3	M
GLYTACTIN RESTORE LITE 10PE ORAL PACKET (***nutritional supplements***)	3	M
GLYTACTIN RTD 10 ORAL LIQUID (***nutritional supplements***)	3	M
GLYTACTIN RTD 15 ORAL LIQUID (***nutritional supplements***)	3	M
GLYTACTIN RTD LITE 15 ORAL LIQUID (***nutritional supplements***)	3	M
GLYTACTIN SWIRL 15 ORAL PACKET (***nutritional supplements***)	3	
GLYTACTIN SWIRL 15PE ORAL PACKET (***nutritional supplements***)	3	M
L-ISOLEUCINE POWDER	3	PA
MALTOCARB ORAL POWDER (***nutritional supplements***)	3	
NEOCATE SYNEO JUNIOR ORAL POWDER (***nutritional supplements***)	3	
PEPTICATE ORAL POWDER (***infant foods***)	3	
PHENYLADE ESSENTIAL DRINK MIX ORAL POWDER (***nutritional supplements***)	3	M
PHENYLADE GMP MIX DHA/FIBER ORAL POWDER (***nutritional supplements***)	3	
PHENYLADE GMP MIX-IN ORAL POWDER (***nutritional supplements***)	3	M
PHENYLADE GMP ULTRA PACKET ORAL (***nutritional supplements***)	3	
PHENYLADE GMP ULTRA PACKET ORAL (***nutritional supplements***)	3	M
PHENYLADE60 DRINK MIX POWDER ORAL (***nutritional supplements***)	3	
PHENYLADE60 DRINK MIX POWDER ORAL (***nutritional supplements***)	3	M
PKU COOLER 10 ORAL LIQUID (***nutritional supplements***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PKU COOLER 15 ORAL LIQUID (***nutritional supplements***)	3	
PKU COOLER 20 ORAL LIQUID (***nutritional supplements***)	3	
PKU EASY MICROTABS PLUS ORAL TABLET DELAYED RELEASE (***nutritional supplements***)	3	M
PKU EASY MICROTABS TABLET DELAYED RELEASE ORAL (OTC) (***nutritional supplements***)	3	M
PKU EASY MICROTABS TABLET DELAYED RELEASE ORAL (RX) (***nutritional supplements***)	3	
PKU EASY SHAKE & GO ORAL POWDER (***nutritional supplements***)	3	M
PKU GOLIKE 10G P.E. ORAL BAR (***amino acids***)	3	
PKU GOLIKE PLUS 16+ ORAL PACKET	3	M
PKU GOLIKE PLUS 4-16 ORAL PACKET	3	M
PKU PERIFLEX EARLY YEARS ORAL POWDER (***nutritional supplements***)	3	
PKU START ORAL POWDER (***nutritional supplements***)	3	M
pku trio oral powder	1	
PREKUNIL ORAL TABLET (***nutritional supplements***)	3	
PRO-STAT/FIBER ORAL LIQUID (***amino acids-protein hydrolys***)	3	
REAL FOOD BLENDS ENTERAL LIQUID (***nutritional supplements***)	3	
REFRESH AA 15 PKU ORAL LIQUID (***amino acids***)	3	M
RENASTART ORAL POWDER (***nutritional supplements***)	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA
ethacrynic acid oral tablet 25 mg	1	
FUROSCIX READYFLOW SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (***furosemide***)	3	
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***)	4	PA; M
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	4	QL (31 tablets per month.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (40:28) - Drugs for Water Balance		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	ST
XPHOZAH ORAL TABLET 20 MG, 30 MG (***tenapanor hcl (ckd)***)	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)***)	4	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS (40:28) - Drugs for Water Balance		
amiloride hcl oral tablet 5 mg	1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	4	PA
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
REPLACEMENT PREPARATIONS		
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
calcium acetate oral tablet 667 mg	1	
EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (***potassium bicarb-citric acid***)	2	
effer-k oral tablet effervescent 25 meq	1	
GALZIN ORAL CAPSULE 25 MG, 50 MG (***zinc acetate (oral)***)	3	
klor-con 10 oral tablet extended release 10 meq	1	
klor-con m10 oral tablet extended release 10 meq	1	
klor-con m15 oral tablet extended release 15 meq	1	
klor-con m20 oral tablet extended release 20 meq	1	
klor-con oral packet 20 meq	1	
klor-con oral tablet extended release 8 meq	1	
K-PHOS ORAL TABLET 500 MG (***potassium phosphate monobasic***)	2	
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (***k phos mono-sod phos di & mono***)	2	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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 DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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	4	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (***copper histidinate***)	4	PA; M; QL (30 single-dose vials per month.); SMCS; SP
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	4	
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***)	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	
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***)	4	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
HEMICLOR ORAL TABLET 12.5 MG (***chlorthalidone***)	4	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	4	
URICOSURIC AGENTS		
colchicine-probenecid oral tablet 0.5-500 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	4	
probenecid oral tablet 500 mg	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (***tolvaptan (hyponatremia)***)	4	PA; QL (90 tablets per 365 days.); SMCS; SP
SAMSCA ORAL TABLET 30 MG (***tolvaptan (hyponatremia)***)	4	PA; QL (60 tablets per 365 days.); SMCS; SP
tolvaptan (hyponatremia) oral tablet 15 mg	1	PA; QL (90 tablets per 365 days.); SMCS; SP
tolvaptan (hyponatremia) oral tablet 30 mg	1	PA; QL (60 tablets per 365 days.); SMCS; SP
tolvaptan oral tablet 15 mg, 30 mg	1	PA; SMCS; SP
tolvaptan oral tablet therapy pack 15 mg	1	PA; QL (2 tablets per day.); SMCS; SP
tolvaptan oral tablet therapy pack 30 & 15 mg	1	PA; QL (2 tablets per day.); SMCS
tolvaptan oral tablet therapy pack 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	1	PA; QL (2 tablets per day); SMCS; SP
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	4	PA; QL (14 capsules per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	4	PA; QL (16 packets per day.); SMCS; SP
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	4	PA; QL (4 packets per day.); SMCS; SP
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	4	PA; QL (16 tablets per day); SMCS; SP
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (***arimoclomol citrate***)	4	PA; QL (90 capsules per month.); SMCS; SP
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.); SMCS; SP
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.); SMCS; SP
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day); SMCS; SP
SEPHIENCE ORAL PACKET 1000 MG (***sepiapterin***)	4	PA; ST; QL (186 packets per month.); SMCS; SP
SEPHIENCE ORAL PACKET 250 MG (***sepiapterin***)	4	PA; ST; QL (682 packets per month.); SMCS; SP
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.); SMCS; SP
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.); SMCS; SP
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA; SMCS; SP
HARLIKU ORAL TABLET 2 MG (***nitisinone (aku)***)	4	PA; QL (31 tablets per month.); SMCS; SP
miglustat oral capsule 100 mg	1	SMCS
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.); SMCS; SP
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA; SMCS; SP
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA; SMCS; SP
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.); SMCS; SP
ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; ST; M; QL (7 mL per year.); SMCS; SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; ST; M; QL (6 syringes per 365 days.); SMCS; SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (***pegvaliase-pqpz***)	3	PA; ST; M; QL (1 ml per day.); SMCS; SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	ST
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	4	ST
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***dornase alfa***)	2	PA; QL (5 ml per day.); SMCS; SP
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML (***asfotase alfa***)	2	PA; M; QL (12 vials per month.); SMCS; SP
SUCRAID ORAL SOLUTION 8500 UNIT/ML (***sacrosidase***)	2	PA; SMCS; SP
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	4	ST
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	4	
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate external gel 0.33 %	1	PA
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***)	3	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	4	
ANTIALLERGIC AGENTS - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
bepotastine besilate ophthalmic solution 1.5 %	1	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
epinastine hcl ophthalmic solution 0.05 %	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
ANTIBACTERIALS (52:04) - Drugs for Infections		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	4	
AZASITE OPHTHALMIC SOLUTION 1 % (***azithromycin***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BESIFLOXACIN HCL OPHTHALMIC SUSPENSION 0.6 %	3	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (***besifloxacin hcl***)	3	
CETRAXAL OTIC SOLUTION 0.2 % (***ciprofloxacin hcl***)	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (***ciprofloxacin hcl***)	3	
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	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	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin ophthalmic ointment 5 mg/gm	1	H
gatifloxacin ophthalmic solution 0.5 %	1	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
MITOSOL OPHTHALMIC KIT 0.2 MG (***mitomycin***)	3	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
neomycin sulfate oral tablet 500 mg	1	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
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***)	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***)	4	PA; QL (280 ml (1 carton) per 56 days.); SMCS; SP
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.); SMCS; SP
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	4	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.); SMCS; SP
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
VIGAMOX OPHTHALMIC SOLUTION 0.5 % (***moxifloxacin hcl***)	4	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	4	PA; ST
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***)	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***)	4	PA; QL (10 ml per 63 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA; QL (1 bottle per month.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	4	PA; QL (1 ml per day and 56 ml per 365 days.); SMCS; SP
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	PA; QL (60 vials per month.)
ANTIVIRALS (EENT) - Drugs for Infections		
trifluridine ophthalmic solution 1 %	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
ASTRINGENTS (52:04) - Drugs for Infections		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	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***)	4	
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (***timolol maleate***)	4	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	4	
CARBONIC ANHYDRASE INHIBITORS (52:40) - Drugs for the Eye		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
brinzolamide ophthalmic suspension 1 %	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	1	
methazolamide oral tablet 25 mg, 50 mg	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	4	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ALREX OPHTHALMIC SUSPENSION 0.2 % (***loteprednol etabonate***)	4	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.)
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	QL (2 blisters per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.)
BYQLOVI OPHTHALMIC SUSPENSION 0.05 % (***clobetasol propionate***)	4	
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	4	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	1	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	1	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
FLAREX OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone acetate***)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	4	QL (2 blisters per day.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	4	QL (1 inhaler per month.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	4	QL (2 inhalers per month.)
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.)
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	4	QL (0.4 grams per day.)
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.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.)
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (***fluorometholone***)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone***)	4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (***loteprednol etabonate***)	3	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	4	PA
LOTEMAX OPHTHALMIC GEL 0.5 % (***loteprednol etabonate***)	4	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (***loteprednol etabonate***)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (***loteprednol etabonate***)	3	
loteprednol etabonate ophthalmic gel 0.5 %	1	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (***dexamethasone***)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	4	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	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-hc ophthalmic suspension 3.5-10000-1	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	4	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	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	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	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***)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	4	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (***dexamethasone***)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	4	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.)
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
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.)
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	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	
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	4	PA; QL (20 mL per 21 days); SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SMCS; SP
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***)	4	PA; QL (1 bottle per month.)
MUCOSITISRX MOUTH/THROAT PACKET (***artificial saliva***)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	4	PA; QL (1 ml per day and 56 ml per 365 days.); SMCS; SP
TRYPTYR OPHTHALMIC SOLUTION 0.003 % (***acoltremon***)	4	PA; QL (60 vials per month.)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	4	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	1	
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	1	
BROMSITE OPHTHALMIC SOLUTION 0.075 % (***bromfenac sodium***)	4	
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (***nepafenac***)	4	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (***nepafenac***)	4	
PROLENSA OPHTHALMIC SOLUTION 0.07 % (***bromfenac sodium***)	4	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	4	ST
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (***lidocaine hcl***)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (***proparacaine hcl***)	3	
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
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***)	4	PA; QL (20 mL per 21 days); SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SMCS; SP
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (***echothiophate iodide***)	2	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	4	
MYDRIATICS - Drugs for the Eye		
atropine sulfate ophthalmic solution 1 %	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (***cyclopentolate hcl***)	4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
cyclopentolate hcl ophthalmic solution 1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
OSMOTIC AGENTS - Drugs for the Eye		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	4	
urea external cream 20 %, 40 %, 41 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
urea external lotion 40 %	1	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
bimatoprost ophthalmic solution 0.01 %	1	
bimatoprost ophthalmic solution 0.03 %	1	
IYUZEH OPHTHALMIC SOLUTION 0.005 % (***latanoprost***)	4	
LATANOPROST OIL	3	PA
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (***bimatoprost***)	2	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	
tafluprost (pf) ophthalmic solution 0.0015 %	1	ST
travoprost (bak free) ophthalmic solution 0.004 %	1	
XELPROS OPHTHALMIC EMULSION 0.005 % (***latanoprost***)	3	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (***tafluprost***)	3	ST
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***)	3	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
oxymetazoline hcl external cream 1 %	1	PA
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	4	PA
UPNEEQ OPHTHALMIC SOLUTION 0.1 % (***oxymetazoline hcl***)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
GASTROINTESTINAL DRUGS		
ANTACIDS AND ADSORBENTS		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
CHLORIDE CHANNEL ACTIVATORS		
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	4	PA; QL (2 capsules per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	1	PA; QL (2 capsules per day.)
GUANYLATE CYCLASE C (GCC) RECEPT AGONIST		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***)	2	PA; QL (1 capsule per day.)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	4	PA; ST; QL (1 tablet per day)
IMMUNOMODULATORY AGENTS (56:44)		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; M; QL (0.05 ml per day.); SMCS; SP
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; M; QL (3 ml (2 syringes/1 box) per month.); SMCS; SP
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; M; QL (3 ml (2 syringes/1 box) per month.); SMCS; SP
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; M; QL (2 ml (1 auto-injector) per month.); SMCS; SP
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; M; QL (2 ml (1 prefilled syringe) per month.); SMCS; SP
OPIOID ANTAGONISTS (56:18)		
alvimopan oral capsule 12 mg	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	4	PA; M; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	4	M; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	4	M; QL (0.4 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day)
GASTROINTESTINAL DRUGS - Drugs for the Stomach		
5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	4	
granisetron hcl oral tablet 1 mg	1	
GRANISOL ORAL SOLUTION 2 MG/10ML (***granisetron hcl***)	3	M
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***)	4	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (***crofelemer***)	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***)	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); SMCS; SP
ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	PA; QL (4 ml per day)
ANTIFLATULENTS - Drugs for Gas		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
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***)	4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
mesalamine rectal enema 4 gm	1	QL (28 bottles per month.)
mesalamine rectal suppository 1000 mg	1	QL (1 suppository per day.)
mesalamine-cleanser rectal kit 4 gm	1	QL (4 kits per month.)
ROWASA RECTAL KIT 4 GM (***mesalamine-cleanser***)	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***)	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***)	4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
CATHARTICS AND LAXATIVES - Drugs for Constipation		
bisacodyl ec oral tablet delayed release 5 mg	E	H
clearlax oral powder 17 gm/scoop	E	H
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (***sod picosulfate-mag ox-cit acd***)	2	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
ft clearlax oral powder 17 gm/scoop	E	H
ft laxative oral tablet delayed release 5 mg	E	H
ft magnesium citrate oral solution 1.745 gm/30ml	E	H
gavilax oral powder 17 gm/scoop	E	H
gavilyte-c oral solution reconstituted 240 gm	1	H
gavilyte-g oral solution reconstituted 236 gm	1	H
gavilyte-n with flavor pack oral solution reconstituted 420 gm	1	H
gentle laxative oral tablet delayed release 5 mg	E	H
glycolax oral powder 17 gm/scoop	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (***peg 3350-kcl-nabcb-nacl-nasulf***)	1	H
goodsense clearlax oral powder 17 gm/scoop	E	H
laxative osmotic oral powder 17 gm/scoop	E	H
magnesium citrate oral solution 1.745 gm/30ml	E	H
mm clearlax oral powder 17 gm/scoop	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (***peg-kcl-nacl-nasulf-na asc-c***)	4	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	1	
peg 3350 oral powder 17 gm/scoop	E	H
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	H
peg-3350/electrolytes oral solution reconstituted 236 gm	1	H
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	
PEG-PREP ORAL KIT 5-210 MG-GM (***bisacodyl-peg-kcl-nabicar-nacl***)	4	
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
smooth lax oral powder 17 gm/scoop	E	H
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (***peg 3350-kcl-nacl-nasulf-mgsul***)	3	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (***na sulfate-k sulfate-mg sulf***)	3	
SUTAB ORAL TABLET 1479-225-188 MG (***sodium sulfate-mag sulfate-kcl***)	2	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	4	PA; QL (2 capsules per day.); SMCS; SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	4	PA; QL (1 capsule per day.); SMCS; SP
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	4	PA; QL (2 capsules per day.); SMCS; SP
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.); SMCS; SP
CTEXLI ORAL TABLET 250 MG (***chenodiol (basds)***)	4	PA; ST; QL (93 tablets per month.); SMCS; SP
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	4	PA; ST; QL (31 tablets per month.); SMCS; SP
LIVDELZI ORAL CAPSULE 10 MG (***seladelpar lysine***)	4	PA; ST; QL (30 capsules per month.); SMCS; SP
LIVMARLI ORAL SOLUTION 19 MG/ML (***maralixibat chloride***)	4	PA; QL (60 mL (1140 mg) per month.); SMCS; SP
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	4	PA; QL (4 mL per day.); SMCS; SP
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (***maralixibat chloride***)	4	PA; QL (60 tablets per month.); SMCS; SP
LIVMARLI ORAL TABLET 30 MG (***maralixibat chloride***)	4	PA; QL (30 tablets per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
URSODIOL+SYRSPEND SF ORAL SUSPENSION 30 MG/ML (***ursodiol***)	3	PA
DIGESTANTS - Drugs for the Stomach		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; M; QL (1 vial per day.); SMCS; SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	ST
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	4	ST
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	4	ST
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
DOPAMINE RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
GI DRUGS, MISCELLANEOUS - Drugs for the Stomach		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	2	PA; QL (0.036 kits per day (1 kit per month).); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	2	PA; M; QL (0.08 syringe per day.); SMCS; SP
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; M; QL (1.6 mL (2 auto-injectors) per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; M; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; M; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
alvimopan oral capsule 12 mg	1	
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	4	PA; QL (2 capsules per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA; M; SMCS; SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	4	PA; QL (2 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	4	PA; QL (1 capsule per day.); SMCS; SP
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	4	PA; QL (2 capsules per day.); SMCS; SP
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.); SMCS; SP
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (2 syringes (1 carton) per month.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (Maximum quantity 1 kit per 365 days.); SMCS; SP
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; M; QL (0.05 ml per day.); SMCS; SP
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; M; QL (1 vial per day.); SMCS; SP
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	4	PA; ST; QL (31 tablets per month.); SMCS; SP
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***)	4	PA; QL (4 mL per day.); SMCS; SP
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; M; SMCS
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA; M; SMCS
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS
ORLISTAT ORAL CAPSULE 120 MG	3	PA
prucalopride succinate oral tablet 1 mg, 2 mg	1	PA; QL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	4	PA; M; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	4	M; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	4	M; QL (0.4 ml per day.)
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (***resmetirom***)	4	PA; QL (1 Tablet per day.)
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (***octreotide acetate***)	4	PA; M; SMCS
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 auto-injector per month.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (***risankizumab-rzaa***)	2	PA; M; QL (1 prefilled cartridge (180 mg) every 8 weeks after induction.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (***risankizumab-rzaa***)	2	PA; M; QL (1 prefilled cartridge (360 mg) every 8 weeks after induction.); SMCS; SP
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day)
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	4	PA; QL (4 ml per day)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	4	PA; ST; QL (1 tablet per day)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	4	PA; QL (12 capsules per 365 days.); SMCS; SP
XENICAL ORAL CAPSULE 120 MG (***orlistat***)	3	PA
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
nizatidine oral capsule 150 mg, 300 mg	1	
LIPOTROPIC AGENTS - Drugs for the Stomach		
scopolamine transdermal patch 72 hour 1 mg/3days	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	4	
aprepitant oral capsule 125 mg, 40 mg, 80 mg	1	
aprepitant oral capsule therapy pack 80 & 125 mg	1	
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (***aprepitant***)	2	
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	4	ST; QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	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***)	4	ST; 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***)	4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (***misoprostol***)	4	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg	1	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
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 packet 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (***omeprazole magnesium***)	4	
PROTONIX ORAL PACKET 40 MG (***pantoprazole sodium***)	4	
RABEPRAZOLE SODIUM ORAL CAPSULE SPRINKLE 10 MG	4	
rabeprazole sodium oral tablet delayed release 20 mg	1	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	4	PA; QL (60 tablets per month and 60 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
GOLD COMPOUNDS		
GOLD COMPOUNDS		
AURANOFIN ORAL CAPSULE 3 MG	3	SMCS; SP
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	SMCS; SP
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; SMCS; SP
deferasirox oral packet 180 mg, 360 mg, 90 mg	1	PA; SMCS; SP
deferasirox oral tablet 180 mg, 360 mg, 90 mg	1	PA; SMCS; SP
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	1	PA; SMCS; SP
deferiprone oral tablet 1000 mg, 500 mg	1	PA; SMCS; SP
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	SMCS; SP
FERRIPROX ORAL SOLUTION 100 MG/ML (***deferiprone***)	2	PA; SMCS; SP
FERRIPROX ORAL TABLET 1000 MG (***deferiprone***)	4	PA; SMCS; SP
penicillamine oral tablet 250 mg	1	SMCS; SP
trientine hcl oral capsule 250 mg	1	PA; SMCS; SP
trientine hcl oral capsule 500 mg	1	PA; SMCS
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	4	PA; M; QL (4 autoinjector pens (1.2mls) per month.)
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.)
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	QL (2 blisters per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.)
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.)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
budesonide oral capsule delayed release particles 3 mg	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
CORTISONE ACETATE ORAL TABLET 25 MG	4	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	4	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	4	ST; QL (0.44 grams per day.)
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	4	ST; QL (0.44 mcg per day.)
EOHILIA ORAL SUSPENSION 2 MG/10ML (***budesonide***)	4	PA; QL (20 grams per day.)
fludrocortisone acetate oral tablet 0.1 mg	1	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	4	QL (2 blisters per day.)
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	4	QL (1 inhaler per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	4	QL (2 inhalers per month.)
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.)
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	4	QL (0.4 grams per day.)
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.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.)
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INTRAROSA VAGINAL INSERT 6.5 MG (***prasterone***)	4	PA; QL (1 insert per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	4	PA; QL (8 tablets per day.); SMCS; SP
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	4	PA; QL (372 tablets per month.); SMCS; SP
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	4	PA
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (***methylprednisolone***)	4	
MEDROL ORAL TABLET 2 MG (***methylprednisolone***)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (***methylprednisolone***)	4	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	4	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	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***)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.)
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	4	
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.)
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (***budesonide***)	4	PA; QL (4 capsules per day.); SMCS; SP
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.)
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
triderm external cream 0.5 %	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	4	PA; M; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
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.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	M
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	4	M
EC-RX TESTOSTERONE TRANSDERMAL CREAM 0.2 %, 0.4 %, 10 %, 20 %	3	PA
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***)	4	QL (4 capsules per day.)
METHITEST ORAL TABLET 10 MG	2	
methyltestosterone oral capsule 10 mg	1	
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day)
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	M
TESTOSTERONE CYPIONATE SOLUTION 200 MG/ML INTRAMUSCULAR	4	M
testosterone enanthate intramuscular solution 200 mg/ml	1	M
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
mifepristone oral tablet 300 mg	1	PA; QL (4 tablets per day.); SMCS; SP
ANTIESTROGENS - Drugs for Women		
anastrozole oral tablet 1 mg	1	H
exemestane oral tablet 25 mg	1	H
letrozole oral tablet 2.5 mg	1	H
ANTIGONADTROPINS - Hormones		
aftera oral tablet 1.5 mg	1	H
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (***cetrorelix acetate***)	4	PA; ST; QL (14 cartons per 21 days.); SMCS; SP
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	M
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	4	M
econtra one-step oral tablet 1.5 mg	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	M; SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	M; SMCS; SP
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***ganirelix acetate***)	3	QL (7 ml per 21 days.); SMCS; SP
ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml	1	QL (7 ml per 21 days.); SMCS; SP
her style oral tablet 1.5 mg	1	H
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	4	QL (4 capsules per day.)
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
option 2 oral tablet 1.5 mg	1	H
ORGOVYX ORAL TABLET 120 MG (***relugolix***)	3	PA; QL (1 tablet per day); SMCS; SP; 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***)	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)
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	M
TESTOSTERONE CYPIONATE SOLUTION 200 MG/ML INTRAMUSCULAR	4	M
testosterone enanthate intramuscular solution 200 mg/ml	1	M
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.)
your choice oral tablet 1.5 mg	1	H
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (***diazoxide***)	4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
calcitonin (salmon) injection solution 200 unit/ml	1	M
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	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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.)
dapagliflozin base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 5-500 mg	1	
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	1	
metformin hcl oral tablet 850 mg	1	H
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	4	QL (31 Tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	4	QL (62 tablets per month.)
sitagliptin phos-metformin hcl oral tablet 50-1000 mg, 50-500 mg	1	QL (2 tablets per day)
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.)
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	4	QL (31 Tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	4	QL (62 Tablets per month.)
CONTRACEPTIVES - Drugs for Women		
afirmelle oral tablet 0.1-20 mg-mcg	1	H
aftera oral tablet 1.5 mg	1	H
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	H
balziva oral tablet 0.4-35 mg-mcg	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	QL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	4	QL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H
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***)	4	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
mili oral tablet 0.25-35 mg-mcg	1	H
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (***estradiol valerate-dienogest***)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (***drospirenone-estetrol***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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***)	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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	2	QL (1 tablet per day.)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
BRYNOVIN ORAL SOLUTION 25 MG/ML (***sitagliptin hydrochloride***)	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.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	4	QL (31 Tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	4	QL (62 tablets per month.)
SITAGLIPTIN ORAL TABLET 100 MG, 25 MG, 50 MG	4	QL (1 tablet per day.)
sitagliptin phos-metformin hcl oral tablet 50-1000 mg, 50-500 mg	1	QL (2 tablets per day)
sitagliptin phosphate oral tablet 100 mg, 25 mg, 50 mg	1	QL (31 tablets per 31 days.)
TRADJENTA ORAL TABLET 5 MG (***linagliptin***)	2	QL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (2 tablets per day.)
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	4	QL (31 Tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	4	QL (62 Tablets per month.)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (***sitagliptin***)	4	QL (1 tablet 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***)	2	PA; QL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	1	H
SOLTAMOX ORAL SOLUTION 10 MG/5ML (***tamoxifen citrate***)	4	
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H
toremifene citrate oral tablet 60 mg	1	CM
ESTROGENS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	4	
afirmelle 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***)	3	QL (8 patches (1 box) per 28 days.)
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***)	4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (***estradiol-progesterone***)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
camrese oral tablet 0.15-0.03 &0.01 mg	1	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (***estradiol-levonorgestrel***)	2	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***)	2	QL (8 patches per 28 days.)
COVARYX HS ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
COVARYX ORAL TABLET 1.25-2.5 MG (***est estrogens-methyltest***)	2	
cryselle oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
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***)	4	M
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	M
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (***estradiol***)	3	
dolishale oral tablet 90-20 mcg	1	H
dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.)
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)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %	3	PA
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	
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	
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	
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (37.5 grams (1 box) per month.)
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 patches (1 carton) per 28 days.)
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	M
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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***)	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, 4 MCG (***estradiol***)	2	QL (0.29 vaginal insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***)	2	QL (18 inserts per year.)
introvale oral tablet 0.15-0.03 mg	1	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 &0.01 mg	1	H
jasmiel oral tablet 3-0.02 mg	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
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.)
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***)	4	H
nikki oral tablet 3-0.02 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (***conj estrog-medroxyprogest ace***)	2	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
setlakin oral tablet 0.15-0.03 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
taysofy oral capsule 1-20 mg-mcg(24)	1	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***)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	SMCS
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (***follitropin beta***)	2	PA; QL (5.4 mL (15 cartridges)per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML (***follitropin beta***)	2	PA; QL (8.64 mL(12 cartridges)per 21 days.); SMCS; SP
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 900 UNT/1.08ML (***follitropin beta***)	2	PA; QL (8.64 mL (8 cartridges)per 21 days.); SMCS; SP
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***follitropin alfa***)	4	PA; ST; SMCS; SP
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (***follitropin alfa***)	4	PA; ST; SMCS; SP
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; M; SMCS
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (***menotropins***)	4	PA; QL (6 vials per day.); SMCS; SP
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***chorionic gonadotropin***)	3	SMCS; SP
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***choriogonadotropin alfa***)	4	SMCS; SP
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (***chorionic gonadotropin***)	3	SMCS
SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***)	2	
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.)
liraglutide -weight management subcutaneous solution pen-injector 18 mg/3ml	1	PA; M; QL (0.6 ml per day.)
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide***)	2	PA; QL (0.08 ml per day.)
OZEMPIC 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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (***liraglutide -weight management***)	3	PA; M; QL (0.6 ml per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 mL per month.)
WEGOVY HD SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.2 MG/0.75ML (***semaglutide-weight management***)	3	PA; M
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (***semaglutide-weight management***)	3	PA; M; QL (0.08 ml per day and 4 ml per 365 days.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (***semaglutide-weight management***)	3	PA; M; QL (0.11 ml per day.)
ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (2 mL (4 vials) per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (2 mL (4 vials) per month. 4 mL (8 vials) per 365 days.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (4 pens per month.)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML (***tirzepatide-weight management***)	3	PA; M; QL (4 pens per month and 8 pens per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***)	2	
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***)	1	
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (***metreleptin***)	3	PA; M; QL (0.9 vial per day.); SMCS; SP
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***)	1	
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***)	1	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	
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; M; SMCS; SP
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA; M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA; M; SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (***palopegteriparatide***)	4	PA; M; QL (2 pens (1.12 mL) per 28 days.); SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (***palopegteriparatide***)	4	PA; M; QL (2 pens (1.96 mL) per 28 days.); SMCS; SP
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (***palopegteriparatide***)	4	PA; M; QL (2 pens (2.8 mL) per 28 days.); SMCS; SP
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	4	PA; ST; QL (10.5 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	4	PA; ST; QL (21 mL (21 injectors) per treatment course.); SMCS; SP
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	4	PA; ST; M; QL (20 ml per 24 days.); SMCS; SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	4	PA; ST; SMCS; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	4	PA; ST; M; QL (20 ml per 24 days.); SMCS; SP
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (***crinecerfont***)	4	PA; QL (62 capsules per month.); SMCS; SP
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	4	PA; QL (120 mL (4 bottles) per month.); SMCS; SP
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	M
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	M
desmopressin acetate spray nasal solution 0.01 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML (***somatrogon-ghla***)	4	PA; M; QL (0.172 ml per day.); SMCS; SP
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 60 MG/1.2ML (***somatrogon-ghla***)	4	PA; M; QL (4.8 mL (4 Prefilled Pens) per month.); SMCS; SP
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; M; QL (13.5 mL (9 Pens) per month.); SMCS
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; M; QL (9 mL (6 Pens) per month.); SMCS; SP
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; M; QL (27 mL (18 Pens) per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; M; QL (13.5 ml (9 cartridges) per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; M; QL (27 ml (18 cartridges) per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; M; QL (16 vials per month.); SMCS; SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	4	PA; M; QL (1 vial per day.); SMCS; SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (***lonapegsomatropin-tcgd***)	4	PA; M; QL (4 single-dose prefilled cartridges per month.); SMCS; SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (***lonapegsomatropin-tcgd***)	4	PA; M; QL (0.143 cartridge per day.); SMCS; SP
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (***somapacitan-beco***)	4	PA; QL (0.215 ml per day.); SMCS; SP
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***)	4	
afirmelle 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (***estradiol-progesterone***)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
camrese oral tablet 0.15-0.03 &0.01 mg	1	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (***estradiol-levonorgestrel***)	2	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***)	2	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (***progesterone***)	4	ST
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***)	4	QL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	4	QL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H
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
EC-RX PROGESTERONE TRANSDERMAL CREAM 10 %, 20 %	3	PA
elinest oral tablet 0.3-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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
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
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml, 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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	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
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
option 2 oral tablet 1.5 mg	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
orquidea oral tablet 0.35 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMPHASE ORAL TABLET 0.625-5 MG (***conj estrog-medroxyprogest ace***)	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (***conj estrog-medroxyprogest ace***)	2	
progesterone intramuscular oil 50 mg/ml	1	M
PROGESTERONE MICRONIZED TRANSDERMAL CREAM 10 %	3	PA
progesterone oral capsule 100 mg, 200 mg	1	
progesterone vaginal insert 100 mg	1	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (***medroxyprogesterone acetate***)	4	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
setlakin oral tablet 0.15-0.03 mg	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***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	1	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***)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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		
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 &60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (***insulin regular human***)	4	
HUMALOG INJECTION SOLUTION 100 UNIT/ML (***insulin lispro***)	4	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro***)	2	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	1	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***)	2	
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***)	2	
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***)	2	
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***)	1	
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***)	2	
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***)	1	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (***bexagliflozin***)	3	ST; QL (1 tablet per day.)
dapaglifloz base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 5-500 mg	1	
dapagliflozin oral tablet 10 mg, 5 mg	1	
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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; M; SMCS
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA; M; SMCS
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (***octreotide acetate***)	4	PA; M; SMCS
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (***pasireotide diaspartate***)	4	PA; M; QL (2 ampules per day.); SMCS; SP
SOMATOTROPIN AGONISTS - Hormones		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (***tesamorelin acetate***)	4	PA; M; QL (1 vial per day.); SMCS
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (***tesamorelin acetate***)	4	PA; M; QL (4 vials per month.); SMCS; SP
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (***mecasermin***)	2	PA; M; QL (13 vials per month.); SMCS; SP
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; M; QL (13.5 mL (9 Pens) per month.); SMCS
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; M; QL (9 mL (6 Pens) per month.); SMCS; SP
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; M; QL (27 mL (18 Pens) per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; M; QL (13.5 ml (9 cartridges) per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; M; QL (27 ml (18 cartridges) per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; M; QL (16 vials per month.); SMCS; SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	4	PA; M; QL (1 vial per day.); SMCS; SP
SOMATOTROPIN ANTAGONISTS - Hormones		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (***pegvisomant***)	4	PA; M; QL (1 vial per day.); SMCS; SP
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, 15 mg, 2.5 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (***glipizide***)	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***)	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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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)
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***)	2	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
LEVOTHYROXINE SODIUM ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	4	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (***resmetirom***)	4	PA; QL (1 Tablet per day.)
THYQUIDITY ORAL SOLUTION 100 MCG/5ML (***levothyroxine sodium***)	4	PA
thyroid oral tablet 120 mg, 15 mg, 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG (***levothyroxine sodium***)	4	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (***levothyroxine sodium***)	2	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; M; QL (30 ml per month.); SMCS
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; M; QL (12 ml per 21 days.); SMCS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; M; QL (30 ml per month.); SMCS
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; M; QL (12 ml per 21 days.); SMCS
ANTIMETABOLITES		
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.); SMCS
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.); SMCS
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	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***)	4	PA; M; QL (1 prefilled syringe per month.); SMCS; SP
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***)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	4	PA
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	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.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	4	PA; QL (6 capsules per day.); SMCS; SP
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	4	PA; M; QL (0.416 ml per day.); SMCS; SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	4	PA; M; QL (0.574 ml per day.); SMCS; SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	4	PA; M; QL (0.81 ml per day.); SMCS; SP
DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; M; QL (0.05 ml per day.); SMCS; SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; ST; M; QL (4 autoinjectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; ST; M; QL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; ST; M; QL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; ST; M; QL (0.1 ml per day.); SMCS; SP
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
AURANOFIN ORAL CAPSULE 3 MG	3	SMCS; SP
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	4	
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (2 syringes (1 carton) per month.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (Maximum quantity 1 kit per 365 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	4	PA; CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	M; QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	M; QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	SMCS; SP
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; M; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; M; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; M; QL (2 ml (1 auto-injector) per month.); SMCS
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; M; QL (2 ml per 2 months); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; M; QL (2 ml (1 syringe) per month.); SMCS
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; M; QL (4 ml (2 pens/1 box) per month.); SMCS
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	4	PA; CM
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.); SMCS
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.); SMCS
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SMCS
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; M; QL (4 ml per month.); SMCS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; M; QL (4 ml per month.); SMCS; SP
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.); SMCS; SP; CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
mercaptopurine oral suspension 2000 mg/100ml	1	SMCS; SP; CM
mercaptopurine oral tablet 50 mg	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	SMCS; SP; CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP; CM
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab-anoh***)	3	PA; ST; M; QL (4 syringes per month.); SMCS; SP
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; M; QL (0.018 ml per day.); SMCS; SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	4	PA; ST; M; QL (2.28 ml per month.); SMCS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	4	PA; ST; M; QL (2.28 mL per month); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; ST; M; QL (0.67 ml (1 syringe) per day.); SMCS; SP
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-hmny***)	2	PA; M; QL (1 single-dose vial every 3 months.); SMCS
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-hmny***)	2	PA; M; QL (1 prefilled syringe every 3 months.); SMCS
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-stba***)	2	SMCS; SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-stba***)	2	PA; M; QL (1 syringe every 3 months.); SMCS; SP
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-auub***)	2	PA; M; QL (1 single-dose vial every 3 months.); SMCS; SP
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-auub***)	2	PA; M; QL (1 syringe per 3 months.); SMCS; SP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-kfce***)	2	PA; M; QL (1 single-dose vial every 3 months.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-kfce***)	2	PA; M; QL (1 syringe every 3 months.); SMCS; SP
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; ST; QL (1 tablet per day.); SMCS; SP
RINVOQ LQ ORAL SOLUTION 1 MG/ML (***upadacitinib***)	2	PA; QL (360 mL (2 bottles) per month.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.); SMCS; SP
tofacitinib citrate er oral tablet extended release 24 hour 11 mg	1	PA; QL (1 tablet per day.); SMCS; SP
tofacitinib citrate er oral tablet extended release 24 hour 22 mg	1	PA; QL (1 tablet per day.); SMCS
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.); SMCS; SP
tofacitinib citrate oral tablet 10 mg	1	PA; QL (2 tablets per day); SMCS; SP
tofacitinib citrate oral tablet 5 mg	1	PA; QL (2 tablets per day.); SMCS; SP
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; M; QL (0.02 ml per day.); SMCS; SP
MONOCLONAL ANTIBODIES (90:10)		
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (***lecanemab-irmb***)	4	PA; M; QL (7.2 mL (4 autoinjectors) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	4	PA; M; QL (0.04 ml per day.); SMCS; SP
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	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***)	4	PA; M; QL (4 syringes every 50 days.); SMCS; SP
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.); SMCS
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.); SMCS
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***apremilast***)	2	PA; QL (30 tablets per month.); SMCS; SP
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.); SMCS
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.); SMCS
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	4	PA; QL (1 capsule per day.); SMCS
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.); SMCS
T-CELL BLOCKERS (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	4	PA; QL (6 capsules per day.); SMCS; SP
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	2	PA; QL (0.036 kits per day (1 kit per month).); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	2	PA; M; QL (0.08 syringe per day.); SMCS; SP
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; M; QL (1.6 mL (2 auto-injectors) per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; M; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; M; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
LETS KIT	3	PA
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	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	4	
finasteride oral tablet 5 mg	1	
5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence		
disulfiram oral tablet 250 mg, 500 mg	1	
dutasteride oral capsule 0.5 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	4	
finasteride oral tablet 5 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTES (92:12) - Drugs for Overdose or Poisoning		
acetylcysteine inhalation solution 10 %, 20 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
glucagon emergency kit injection solution reconstituted 1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	M
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
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	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	
naltrexone hcl oral tablet 50 mg	1	
phytonadione oral tablet 5 mg	1	
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	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	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 mg, 200 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	1	
colchicine oral tablet 0.6 mg	1	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	1	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (***colchicine***)	4	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	4	
probenecid oral tablet 500 mg	1	
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	4	PA; QL (1 packet per day.); SMCS; SP
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	4	PA; QL (1 box (28 packets) per year.); SMCS; SP
sodium oxybate oral solution 500 mg/ml	4	PA; QL (18 ml per day.); SMCS; SP
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	4	PA; M; QL (1 Auto-injector (0.8 mL) per month.); SMCS; SP
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (***eplontersen sodium***)	2	PA; M; QL (0.029 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA; M; SMCS; SP
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA; M; SMCS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA; M; SMCS; SP
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.)
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (***alendronate sodium***)	4	
calcitonin (salmon) injection solution 200 unit/ml	1	M
calcitonin (salmon) nasal solution 200 unit/act	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (***estradiol valerate***)	4	M
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	M
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM, 1.25 MG/1.25GM (***estradiol***)	3	
dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.)
EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %	3	PA
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (***estradiol***)	3	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm	1	
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (37.5 grams (1 box) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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.)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 patches (1 carton) per 28 days.)
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	M
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	
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***)	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.)
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***)	3	QL (4 patches (1 carton) per 28 days.)
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***)	3	M
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
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	1	
risedronate sodium oral tablet delayed release 35 mg	1	
yuvafem vaginal tablet 10 mcg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BRADYKININ RECEPTOR ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; M; QL (0.6 ml per day.); SMCS; SP
CARBONIC ANHYDRASE INHIBITORS (92:26)		
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.); SMCS; SP
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
FLUORIDEX DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	4	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	4	
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)***)	4	PA; ST; M; QL (0.4 boxes per day.); SMCS; SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; M; QL (5.8 ml per day. 2,100 ml per 360 days.); SMCS; SP
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; M; QL (24 vials per month.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; M; SMCS; SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	4	PA; M; QL (0.27 vials per day.); SMCS; SP
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	4	PA; QL (6 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	2	PA; QL (0.036 kits per day (1 kit per month).); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	2	PA; M; QL (0.08 syringe per day.); SMCS; SP
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; M; QL (1.6 mL (2 auto-injectors) per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; M; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; M; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA; M; SMCS; SP
AURANOFIN ORAL CAPSULE 3 MG	3	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	4	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (2 syringes (1 carton) per month.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (Maximum quantity 1 kit per 365 days.); SMCS; SP
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; M; QL (0.018 ml per day.); SMCS; SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
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	SMCS; SP
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
gengraf oral capsule 100 mg, 25 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	4	PA; CM
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	4	PA; ST; M; QL (2.28 ml per month.); SMCS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	4	PA; ST; M; QL (2.28 mL per month); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; ST; M; QL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; ST; QL (1 tablet per day.); SMCS; SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; ST; M; QL (4 autoinjectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; ST; M; QL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; ST; M; QL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; ST; M; QL (0.1 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
penicillamine oral tablet 250 mg	1	SMCS; SP
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	M; QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***)	2	M; QL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***)	2	M; QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***)	2	M; QL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***)	2	M; QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***)	2	M; QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***)	2	M; QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***)	2	M; QL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	M; QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 auto-injector per month.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
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	1	PA; QL (1 tablet per day.); SMCS; SP
tofacitinib citrate er oral tablet extended release 24 hour 22 mg	1	PA; QL (1 tablet per day.); SMCS
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.); SMCS; SP
tofacitinib citrate oral tablet 10 mg	1	PA; QL (2 tablets per day); SMCS; SP
tofacitinib citrate oral tablet 5 mg	1	PA; QL (2 tablets per day.); SMCS; SP
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	4	PA; CM
ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)		
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	4	PA; QL (60 tablets per month.); SMCS; SP
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	4	PA; QL (30 tablets per month.); SMCS; SP
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; M; QL (4 auto injector per month.); SMCS; SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; ST; M; QL (4 prefilled syringes per month.); SMCS; SP
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (***interferon gamma-1b***)	2	PA; M; QL (8.5 mls per month.); SMCS; SP
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	PA; QL (2 auto injector pens per month.); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	2	PA; QL (0.036 kits per day (1 kit per month).); SMCS; SP
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	2	PA; M; QL (0.08 syringe per day.); SMCS; SP
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	PA; SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; M; QL (1.6 mL (2 auto-injectors) per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; M; QL (0.01 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; M; QL (0.02 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; M; QL (0.03 ml per day.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 auto-injectors (1 carton) per month.); SMCS; SP
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; M; QL (2 syringes per month per month.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA; M; SMCS; SP
AURANOFIN ORAL CAPSULE 3 MG	3	SMCS; SP
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; M; QL (4 pens (1 box) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; M; QL (4 syringes (1 box) per month.); SMCS; SP
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	4	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.); SMCS; SP
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	4	PA; SMCS; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	4	PA; M; QL (0.08 ml per day.); SMCS; SP; CM
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; M; QL (15 vials per month.); SMCS
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (2 syringes (1 carton) per month.); SMCS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; M; QL (Maximum quantity 1 kit per 365 days.); SMCS; SP
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.); SMCS
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.); SMCS
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.); SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	4	PA; M; QL (0.04 ml per day.); SMCS; SP
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.); SMCS
gengraf oral capsule 100 mg, 25 mg	1	
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	4	PA; QL (1 capsule per day.); SMCS
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; M; QL (30 ml per month.); SMCS
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; M; QL (12 ml per 21 days.); SMCS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; M; QL (30 ml per month.); SMCS
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; M; QL (12 ml per 21 days.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JOENJA ORAL TABLET 70 MG (***leniolisib phosphate***)	2	PA; QL (2 tablets per day.); SMCS; SP
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; M; QL (0.02 ml per day.); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; ST; M; QL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); SMCS; SP; CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); SMCS; SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.); SMCS
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.); SMCS
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RHAPSIDO ORAL TABLET 25 MG (***remibrutinib***)	2	PA; QL (60 tablets per month.); SMCS; SP
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 auto-injector per month.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; M; QL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; M; QL (1 syringe per month.); SMCS; SP
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.); SMCS
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.); SMCS
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; SMCS; SP; 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***)	4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (***ozanimod hcl***)	3	PA; ST; QL (7 capsules per year.); SMCS
ZEPOSIA ORAL CAPSULE 0.92 MG (***ozanimod hcl***)	3	PA; ST; QL (1 capsule per day.); SMCS
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (***ozanimod hcl***)	3	PA; ST; SMCS
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; M; QL (4 ml per month.); SMCS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; M; QL (4 ml per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; ST; QL (40 tablets per 720 days.); SMCS
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	4	PA; CM
leflunomide oral tablet 10 mg, 20 mg	1	
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	4	PA; QL (6 capsules per day.); SMCS; SP
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (***cladribine***)	3	PA; ST; QL (40 tablets per 720 days.); SMCS
mercaptopurine oral suspension 2000 mg/100ml	1	SMCS; SP; 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	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
mycophenolate mofetil oral capsule 250 mg	1	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	1	
mycophenolate mofetil oral tablet 500 mg	1	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	1	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	1	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (***mycophenolate mofetil***)	1	
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	4	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	SMCS; SP; CM
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	4	PA; CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (***levacetylleucine***)	4	PA; QL (112 packets per month.); SMCS; SP
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; M; QL (4 vials per 21 days.); SMCS; SP
betaine oral powder	1	SMCS; SP
CARNITOR ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	4	
CARNITOR ORAL TABLET 330 MG (***levocarnitine***)	4	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	4	
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA; SMCS; SP
COMPLEX ESSENTIAL MSD ORAL POWDER (***nutritional supplements***)	3	
CYSTADANE ORAL POWDER (***betaine***)	4	SMCS; SP
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (***cysteamine bitartrate***)	2	SMCS; SP
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day); SMCS
DIABETES MONITOR DIGIT ADD-ON KIT	3	M; QL (1 meter or meter kit per year.)
DIABETES MONITOR DIGIT SOLN KIT	3	M; QL (1 meter or meter kit per year.)
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (***givinostat hcl***)	4	PA; QL (420 mL per month.); SMCS; SP
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (***prasterone (dhea)***)	3	
ELMIRON ORAL CAPSULE 100 MG (***pentosan polysulfate sodium***)	4	ST
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	4	QL (6 packets per day)
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (***risdiplam***)	2	PA; QL (6.7 ml per day, 1280 ml per 180 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
EVRYSDI ORAL TABLET 5 MG (***risdiplam***)	2	PA; QL (30 tablets per month.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	4	PA; QL (60 tablets per month.); SMCS; SP
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.); SMCS; SP
FORZINITY SUBCUTANEOUS SOLUTION 280 MG/3.5ML (***elamipretide hcl***)	4	PA; M; QL (4 vials (14 ml) per month.); SMCS; SP
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	4	PA; QL (14 capsules per 21 days.); SMCS; SP
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	4	PA; QL (8 tablets per day.); SMCS; SP
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	4	PA; QL (372 tablets per month.); SMCS; SP
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	4	PA; QL (16 packets per day.); SMCS; SP
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	4	PA; QL (4 packets per day.); SMCS; SP
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	4	PA; QL (16 tablets per day); SMCS; SP
KYGEVVI ORAL PACKET 2-2 GM (***doxecitine-doxribtimine***)	4	PA; QL (558 packets per month.); SMCS; SP
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine oral tablet 330 mg	1	
levocarnitine sf oral solution 1 gm/10ml	1	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	4	QL (1 tablet per day.)
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
metyrosine oral capsule 250 mg	1	PA
miglustat oral capsule 100 mg	1	SMCS
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.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA; SMCS; SP
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA; SMCS; SP
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (***cysteamine bitartrate***)	4	PA; ST; SMCS; SP
PROCYSBI ORAL PACKET 300 MG, 75 MG (***cysteamine bitartrate***)	4	SMCS; SP
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (***belumosudil mesylate***)	4	PA; QL (1 tablet per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (***nedosiran sodium***)	4	PA; M; QL (0.04 ml per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (***nedosiran sodium***)	4	PA; M; QL (0.03 ml per day.); SMCS; SP
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***nedosiran sodium***)	4	PA; M; QL (0.04 ml per day.); SMCS; SP
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.); SMCS; SP
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day); SMCS; SP
SKYCLARYS ORAL CAPSULE 50 MG (***omaveloxolone***)	2	PA; QL (3 capsules per day.); SMCS; SP
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (***palovarotene***)	4	PA; QL (1 capsule per day.); SMCS; SP
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	2	QL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (***darun-cobic-emtricit-tenofaf***)	3	QL (1 tablet per day.)
tiopronin oral tablet 100 mg	1	SMCS; SP; CM
tiopronin oral tablet delayed release 100 mg, 300 mg	1	SMCS; SP; 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***)	4	PA; QL (28 packets (1 carton) per month.); SMCS; SP
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (***alpelisib***)	4	PA; QL (28 tablets (1 blister pack) per month.); SMCS; SP
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (***alpelisib***)	4	PA; QL (56 tablets (2 blister packs) per month.); SMCS; SP
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	4	PA; QL (12 capsules per 365 days.); SMCS; SP
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (***vosoritide***)	4	PA; M; QL (1 vial per day.); SMCS; SP
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.); SMCS; SP
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.); SMCS; SP
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.); SMCS; SP
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.); SMCS; SP
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.); SMCS; SP
PROTECTIVE AGENTS		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day); SMCS
mesna oral tablet 400 mg	1	SMCS; SP; CM
MESNEX ORAL TABLET 400 MG (***mesna***)	4	SMCS; SP; 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ENCARE VAGINAL SUPPOSITORY 100 MG (***nonoxynol-9***)	E	H
FC2 FEMALE CONDOM (***condoms - female***)	3	QL (12 condoms per month.); H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (***cervical caps***)	3	H
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (***diaphragms***)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (***nonoxynol-9***)	E	H
PHEXX VAGINAL GEL 1.8-1-0.4 % (***lactic ac-citric ac-pot bitart***)	4	H
TODAY SPONGE VAGINAL 1000 MG (***nonoxynol-9***)	E	H
TRUE COVER DEVICE	3	QL (12 condoms per month.); H
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (***nonoxynol-9***)	E	H
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (***nonoxynol-9***)	E	H
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***)	2	H
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***)	2	H
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OXYTOCICS - Drugs for Women		
OXYTOCICS - Drugs for Women		
CERVIDIL VAGINAL INSERT 10 MG (***dinoprostone***)	3	
METHERGINE ORAL TABLET 0.2 MG (***methylergonovine maleate***)	4	QL (28 tablets per year.)
methylergonovine maleate oral tablet 0.2 mg	1	QL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG (***mifepristone***)	3	SM
mifepristone oral tablet 200 mg	1	SM
PREPIDIL VAGINAL GEL 0.5 MG/3GM (***dinoprostone***)	3	
PHARMACEUTICAL AIDS		
PHARMACEUTICAL AIDS		
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AG) ANHYDROUS TRANSDERMAL GEL (***transdermal base***)	3	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (***transdermal base***)	3	
RESPIRATORY TRACT AGENTS		
DUAL PHOSPHODIESTERASE INHIBITOR (48:34)		
OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (***ensifentrine***)	4	PA; QL (150 mL per month.)
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD		
atropine sulfate ophthalmic solution 1 %	1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (***ipratropium bromide hfa***)	4	QL (0.87 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.)
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.)
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.)
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (***revefenacin***)	4	PA; QL (3 ml per day.)
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	4	PA; QL (60 tablets per month.); SMCS; SP
nintedanib esylate oral capsule 100 mg, 150 mg	1	PA; QL (2 capsules per day.); SMCS; SP
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.); SMCS; SP
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.); SMCS; SP
pirfenidone oral tablet 534 mg	1	PA; QL (3 tablets per day.); SMCS
pirfenidone oral tablet 801 mg	1	PA; QL (3 tablets per day.); SMCS; SP
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	4	PA; QL (31 tablets per month.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mepolizumab***)	4	PA; M; QL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***mepolizumab***)	4	PA; M; QL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***mepolizumab***)	4	PA; M; QL (0.015 ml per day.); SMCS
ANTITUSSIVES - Drugs for Cough and Cold		
benzonatate oral capsule 100 mg, 150 mg, 200 mg	1	
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	1	NTT
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
maxi-tuss ac oral solution 100-10 mg/5ml	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	QL (2 blisters per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT, 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.)
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	4	QL (2 blisters per day.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	4	QL (1 inhaler per month.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	4	QL (2 inhalers per month.)
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.)
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	4	QL (0.4 grams per day.)
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.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.)
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.)
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.)
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	4	PA; QL (56 tablets per month.); SMCS; SP
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	4	PA; QL (84 tablets per month.); SMCS; SP
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.); SMCS; SP
ORKAMBI ORAL PACKET 75-94 MG (***lumacaftor-ivacaftor***)	2	PA; QL (2 packets per day and 56 packets per 21 days.); SMCS
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***)	2	PA; QL (1456 tablets per 356 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.); SMCS
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.); SMCS; SP
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.); SMCS; SP
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.); SMCS; SP
ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	4	PA; QL (60 tablets per month.); SMCS; SP
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	4	PA; QL (4 tablets per day.); SMCS; SP
TRYVIO ORAL TABLET 12.5 MG (***aprocitentan***)	4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	4	PA; QL (30 tablets per month.); SMCS; SP
EXPECTORANTS - Drugs for the Lungs		
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml	1	
iodine strong oral solution 5 %	1	
maxi-tuss ac oral solution 100-10 mg/5ml	1	
potassium iodide (expectorant) oral solution 1 gm/ml	1	
SSKI ORAL SOLUTION 1 GM/ML (***potassium iodide (expectorant)***)	3	
FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy		
CARBINOXAMINE MALEATE ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (***diphenhydramine hcl***)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	4	
promethazine hcl oral solution 12.5 mg/10ml, 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; M; QL (4 vials per 21 days.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; M; QL (0.09 ml per day.); SMCS; SP
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (***benralizumab***)	4	PA; M; QL (1 pen every 2 months.); SMCS
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	4	PA; M; QL (0.07 ml per day.); SMCS; SP
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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.); SMCS; SP
sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %	1	
NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation		
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
mometasone furoate nasal suspension 50 mcg/act	1	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	4	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	4	
NEUTROPHIL SERINE PROTEASE INHIBITORS - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	4	PA; QL (31 tablets per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	QL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	4	QL (1 inhaler per month.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	4	QL (2 inhalers per month.)
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.)
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	4	PA; QL (60 tablets per month.); SMCS; SP
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 %, 0.15 % (***roflumilast***)	4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS; SP
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.); SMCS; SP
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	4	PA; QL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	4	PA; QL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	4	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	4	PA; QL (744 tablets per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA; SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (***treprostinil sodium***)	2	PA; QL (140 capsules per month.); SMCS; SP
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; ST; QL (20 capsules per day.); SMCS; SP; CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; ST; QL (20 capsules per day.); SMCS; SP; CM
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.); SMCS; SP
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.); SMCS; SP
pirfenidone oral tablet 534 mg	1	PA; QL (3 tablets per day.); SMCS
pirfenidone oral tablet 801 mg	1	PA; QL (3 tablets per day.); SMCS; SP
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	4	PA; M; QL (0.07 ml per day.); SMCS; SP
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (***sotatercept-csrk***)	4	PA; M; QL (1 kit every 3 weeks.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; M; QL (2 auto injectors per month.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; M; QL (0.04 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; M; QL (0.08 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; M; QL (0.04 ml per day.); SMCS; SP
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.)
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	4	QL (2 vials per day.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	QL (0.15 grams per day.)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	
VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***)	2	PA; QL (3 tablets per day.); SMCS; SP
alyq oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.); SMCS; SP
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.); SMCS; SP
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.); SMCS; SP
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.); SMCS; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	4	PA; QL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	4	PA; QL (336 tablets per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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***)	4	PA; QL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	4	PA; QL (6 tablets per day); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	4	PA; QL (744 tablets per month.); SMCS; SP
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS; SP
tadalafil (pah) oral tablet 20 mg	1	PA; QL (2 tablets per day); SMCS; SP
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	4	PA; QL (4 tablets per day.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA; SMCS; SP
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	4	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	4	PA; QL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	4	PA; QL (2 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	4	PA; QL (200 tablets per year.); SMCS; SP
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.); SMCS; SP
UPTRAVI ORAL TABLET 100 MCG, 150 MCG (***selexipag***)	4	PA; SMCS
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	4	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	4	PA; QL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	4	PA; QL (2 tablets per day.); SMCS; SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	4	PA; QL (200 tablets per year.); SMCS; SP
XANTHINE DERIVATIVES - Drugs for Asthma/COPD		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
SKIN AND MUCOUS MEMBRANE AGENTS		
ANTIPROLIFERANTS		
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
bexarotene external gel 1 %	1	SMCS; SP
bexarotene oral capsule 75 mg	1	SMCS; CM
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
imiquimod external cream 5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	4	ST
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	4	ST
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	4	
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA; SMCS; SP
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ADRENERGIC AGONISTS - Drugs for the Skin		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (***brimonidine tartrate***)	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	4	
brimonidine tartrate external gel 0.33 %	1	PA
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
oxymetazoline hcl external cream 1 %	1	PA
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	4	PA
ALLYLAMINES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
naftifine hcl external cream 1 %, 2 %	1	
naftifine hcl external gel 2 %	1	
NAFTIN EXTERNAL GEL 2 % (***naftifine hcl***)	4	
ANTIBACTERIALS (84:04) - Drugs for the Skin		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	4	
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***sulfacetamide sodium-sulfur***)	3	
AVIDOXY ORAL TABLET 100 MG	4	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
bp 10-1 external emulsion 10-1 %	1	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (***clindamycin-tretinoin-cholesty***)	3	PA
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
DORYX MPC ORAL TABLET DELAYED RELEASE 60 MG (***doxycycline hyclate***)	4	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
erythromycin external solution 2 %	1	
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	2	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
KLARON EXTERNAL LOTION 10 % (***sulfacetamide sodium (acne)***)	4	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
mupirocin calcium external cream 2 %	1	
mupirocin external ointment 2 %	1	
neomycin sulfate oral tablet 500 mg	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	4	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	4	
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sodium sulfacetamide external shampoo 10 %	1	
sodium sulfacetamide wash external liquid 10 %	1	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium (acne) external lotion 10 %	1	
sulfacetamide sodium (cleans) external gel 10 %	1	
sulfacetamide sodium external liquid 10 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	4	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
XEPI EXTERNAL CREAM 1 % (***ozenoxacin***)	3	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	4	PA; ST
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	ST
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	4	PA
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	4	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
doxepin hcl external cream 5 %	1	PA
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral concentrate 10 mg/ml	1	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (1 tablet per day)
DYCLOPRO EXTERNAL SOLUTION 0.5 %	4	
ENOVARX-LIDOCAINE HCL EXTERNAL CREAM 10 %, 5 %	3	PA
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (***dph-lido-alhydr-mghydr-simeth***)	3	PA
glydo external prefilled syringe 2 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (***ketoprofen-baclofen-gabap-lido***)	3	PA
lidocaine external ointment 5 %	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	
LIDTOPIC MAX EXTERNAL CREAM 10 % (***lidocaine***)	3	PA
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***)	4	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
PYRIDIUM ORAL TABLET 100 MG, 200 MG (***phenazopyridine hcl***)	3	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	4	QL (1 tablet per day)
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
DENAVIR EXTERNAL CREAM 1 % (***penciclovir***)	4	
penciclovir external cream 1 %	1	
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	4	
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	4	
ASTRINGENTS (84:12) - Drugs for the Skin		
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.)
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	4	
DRYSOL EXTERNAL SOLUTION 20 % (***aluminum chloride***)	2	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	4	
ASTRINGENTS, ANTI-INFECTIVE - Drugs for the Skin		
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
hydrocortisone-iodoquinol external cream 1-1 %	1	
iodine strong oral solution 5 %	1	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
clotrimazole mouth/throat troche 10 mg	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
econazole nitrate external cream 1 %	1	
ECONAZOLE NITRATE EXTERNAL FOAM 1 %	4	
ECOZA EXTERNAL FOAM 1 % (***econazole nitrate***)	4	
EXELDERM EXTERNAL CREAM 1 % (***sulconazole nitrate***)	3	
EXELDERM EXTERNAL SOLUTION 1 % (***sulconazole nitrate***)	3	
GYNAZOLE-1 VAGINAL CREAM 2 % (***butoconazole nitrate (1 dose)***)	3	
JUBLIA EXTERNAL SOLUTION 10 % (***efinaconazole***)	4	QL (4 ml per month.)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	1	
LULICONAZOLE EXTERNAL CREAM 1 %	4	
LUZU EXTERNAL CREAM 1 % (***luliconazole***)	4	
miconazole 3 vaginal suppository 200 mg	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	4	
ORAVIG BUCCAL TABLET 50 MG (***miconazole***)	3	
oxiconazole nitrate external cream 1 %	1	
OXISTAT EXTERNAL LOTION 1 % (***oxiconazole nitrate***)	4	
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	4	
BASIC LOTIONS AND LINIMENTS - Drugs for the Skin		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***)	2	
methyl salicylate external liquid	1	
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (***salicylic acid-urea in lactac***)	3	
turpentine external spirit	1	
VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID	3	
XIRUN EXTERNAL GEL 40-10 %	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***)	3	
BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin		
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	4	
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	4	QL (30 grams per month.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	4	PA
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
benzoin external tincture	1	
CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin		
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	4	PA
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (***clindamycin-tretinoin-cholesty***)	3	PA
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	4	
finasteride oral tablet 5 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	4	PA
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.06 %, 0.08 %, 0.1 %	1	PA
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	SMCS; SP; CM
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
amcinonide external ointment 0.1 %	1	
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	4	
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	4	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BRYHALI EXTERNAL LOTION 0.01 % (***halobetasol propionate***)	4	ST
budesonide rectal foam 2 mg, 2 mg/act	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
clobetasol prop emollient base external cream 0.05 %	1	
clobetasol propionate e external cream 0.05 %	1	
clobetasol propionate emulsion external foam 0.05 %	1	
clobetasol propionate external cream 0.05 %	1	
clobetasol propionate external foam 0.05 %	1	
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external liquid 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
clobetasol propionate external lotion 0.05 %	1	
clobetasol propionate external ointment 0.05 %	1	
clobetasol propionate external shampoo 0.05 %	1	
clobetasol propionate external solution 0.05 %	1	
clocortolone pivalate external cream 0.1 %	1	
clodan external shampoo 0.05 %	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	4	
desonide external cream 0.05 %	1	
desonide external gel 0.05 %	1	
desonide external lotion 0.05 %	1	
desonide external ointment 0.05 %	1	
desoximetasone external cream 0.05 %, 0.25 %	1	
desoximetasone external gel 0.05 %	1	
desoximetasone external liquid 0.25 %	1	
desoximetasone external ointment 0.05 %, 0.25 %	1	
diflorasone diacetate external cream 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
diflorasone diacetate external ointment 0.05 %	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	4	
DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 %	3	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	4	
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %, 0.1 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
flurandrenolide external lotion 0.05 %	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
halcinonide external cream 0.1 %	1	
halobetasol propionate external cream 0.05 %	1	
halobetasol propionate external ointment 0.05 %	1	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	4	
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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocortisone-iodoquinol external cream 1-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	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	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	4	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
ORALONE MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***)	4	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	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***)	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	4	
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	4	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (***desoximetasone***)	4	
tovet external foam 0.05 %	1	
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin		
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	4	
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ciclodan external solution 8 %	1	
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	1	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
CICLOPIROX TREATMENT EXTERNAL KIT 8 %	4	
DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 %	3	
IMMUNOMODULATORY AGENTS (84:06) - Drugs for the Skin		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***tralokinumab-ldrm***)	2	PA; M; QL (2 auto-injectors per month.); SMCS; SP
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (1 auto-injector per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (2 ml (1 syringe) per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (1 syringe per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (2 ml (1 syringe) per month.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; M; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; M; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; M; QL (1 pen (2 ml) per month.); SMCS; SP
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; M; QL (1 pen (2 ml) per month.); SMCS; SP
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	4	PA; QL (10 g per 23 days.)
ICOTYDE ORAL TABLET 200 MG (***icotrokinra hcl***)	2	PA; QL (30 tablets per month.); SMCS; SP
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***tildrakizumab-asmn***)	4	PA; ST; M; QL (1 ml per 63 days.); SMCS; SP
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (***nemolizumab-ilto***)	2	PA; M; QL (2 pens every 4 weeks.); SMCS; SP
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	4	PA
RHAPSIDO ORAL TABLET 25 MG (***remibrutinib***)	2	PA; QL (60 tablets per month.); SMCS; SP
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; M; QL (1 prefilled syringe (150 mg) every 12 weeks.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; M; QL (1 prefilled syringe (150 mg) every 12 weeks.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 55 MG/0.37ML (***risankizumab-rzaa***)	2	PA; M; SMCS; SP
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***spesolimab-sbzo***)	4	PA; M; QL (2 Prefilled syringes per month.); SMCS; SP
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***spesolimab-sbzo***)	4	PA; M; QL (1 prefilled syringe per month.); SMCS; SP
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; M; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; M; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; M; QL (2 ml (1 auto-injector) per month.); SMCS
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; M; QL (2 ml per 2 months); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; M; QL (2 ml (1 syringe) per month.); SMCS
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; M; QL (4 ml (2 pens/1 box) per month.); SMCS
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
ANZUPGO EXTERNAL CREAM 20 MG/GM (***delgocitinib***)	4	PA; SMCS; SP
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); SMCS; SP; CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; SMCS; SP; CM
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	4	PA; QL (240 grams per prescription and 1200 grams per 365 days.); SMCS; SP
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
SOTYKTU ORAL TABLET 6 MG (***deucravacitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	4	PA
KERATOLYTIC AGENTS - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	4	PA
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
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***)	4	
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	4	
DOREVI EXTERNAL SHAMPOO 0.77-0.05-3-0.2 %	3	
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	4	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
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 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	4	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	4	
tazarotene external cream 0.05 %, 0.1 %	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	4	PA; QL (50 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	4	PA
trilitas external gel 0.1 %	1	PA
URAMAXIN EXTERNAL GEL 45 % (***urea***)	4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	ST
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		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	4	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
benzoyl peroxide-erythromycin external gel 5-3 %	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	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***)	4	
hydrocortisone-iodoquinol external cream 1-1 %	1	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	4	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	4	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
diclofenac sodium external gel 3 %	1	PA
ENOVARX-IBUPROFEN EXTERNAL CREAM 10 %	3	PA
ENOVARX-NAPROXEN EXTERNAL CREAM 10 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FROTEK EXTERNAL CREAM 10 % (***ketoprofen***)	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (***ketoprofen-baclofen-gabap-lido***)	3	PA
KETORUB EXTERNAL CREAM 10 % (***ketoprofen***)	3	PA
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
OXABOROLES - Drugs for the Skin		
tavaborole external solution 5 %	1	QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	ST
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	4	PA; QL (60 tablets per month.); SMCS; SP
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 %, 0.15 % (***roflumilast***)	4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	4	PA; QL (60 grams per 30 days.)
PIGMENTING AGENTS - Drugs for the Skin		
methoxsalen rapid oral capsule 10 mg	1	
POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
klayesta external powder 100000 unit/gm	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
SCABICIDES AND PEDICULICIDES - Drugs for the Skin		
CROTAN EXTERNAL LOTION 10 % (***crotamiton***)	3	
EURAX EXTERNAL CREAM 10 % (***crotamiton***)	2	
malathion external lotion 0.5 %	1	
OVIDE EXTERNAL LOTION 0.5 % (***malathion***)	4	
permethrin external cream 5 %	1	
PRURADIK EXTERNAL LOTION 10 % (***crotamiton***)	3	
SOOLANTRA EXTERNAL CREAM 1 % (***ivermectin***)	1	
spinosad external suspension 0.9 %	1	
sulfurated lime external solution	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
A.A.G.C. KIT IN TERODERM EXTERNAL CREAM 8-4-10-4 % (***amantad-amitrip-gabap-cycloben***)	3	PA
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	4	PA
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
azelaic acid external gel 15 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
B & C EXTERNAL OINTMENT	3	
balsam peru-castor oil external ointment	1	
bexarotene external gel 1 %	1	SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (1 auto-injector per month.); SMCS; SP
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; ST; M; QL (1 syringe per month.); SMCS; SP
brimonidine tartrate external gel 0.33 %	1	PA
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
calcitriol external ointment 3 mcg/gm	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP; CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (***clindamycin-tretinoin-cholesty***)	3	PA
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	4	
COPASIL EXTERNAL GEL (***scar treatment products***)	3	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; M; QL (0.018 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; M; QL (0.036 ml per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; M; QL (0.072 ml per day.); SMCS; SP
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; M; QL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; M; QL (0.15 ml per day.); SMCS; SP
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	4	QL (6 packets per day)
ENOVARX-TRAMADOL EXTERNAL CREAM 5 %	3	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	4	
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	4	
FILSUVEZ EXTERNAL GEL 10 % (***birch triterpenes***)	4	PA; QL (14.4 grams per day.); SMCS; SP
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	2	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (***dermatological products, misc.***)	3	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	4	PA; QL (10 g per 23 days.)
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***tildrakizumab-asmn***)	4	PA; ST; M; QL (1 ml per 63 days.); SMCS; SP
imiquimod external cream 5 %	1	
isotretinoin 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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (***ketoprofen-baclofen-gabap-lido***)	3	PA
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	4	ST
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	4	ST
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.); SMCS; SP
MEDERMA SPF 30 EXTERNAL CREAM (***scar treatment products***)	3	PA
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
MIRVASO EXTERNAL GEL 0.33 % (***brimonidine tartrate***)	2	PA
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	4	PA; QL (240 grams per prescription and 1200 grams per 365 days.); SMCS; SP
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.); SMCS
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.); SMCS
oxymetazoline hcl external cream 1 %	1	PA
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
pimecrolimus external cream 1 %	1	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	4	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	4	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
SCARCIN EXTERNAL CREAM	3	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; M; QL (1 prefilled syringe (150 mg) every 12 weeks.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; M; QL (1 prefilled syringe (150 mg) every 12 weeks.); SMCS; SP
SOTYKTU ORAL TABLET 6 MG (***deucravacitinib***)	2	PA; QL (1 tablet per day.); SMCS; SP
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (***calcipotriene-betameth diprop***)	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	
tazarotene external cream 0.05 %, 0.1 %	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	4	PA; QL (50 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	4	PA
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	4	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; M; QL (1 mL (1 device) every 8 weeks.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; M; QL (2 ml per 2 months); SMCS; SP
trilitas external gel 0.1 %	1	PA
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA; SMCS; SP
VENELEX EXTERNAL OINTMENT (***balsam peru-castor oil***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	ST
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	4	PA
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	4	
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	4	PA
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles		
ANTIMUSCARINICS - Drugs for the Urinary System		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (***xanomeline-trospium chloride***)	4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	4	PA; QL (1 starter pack per year.)
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	1	
flavoxate hcl oral tablet 100 mg	1	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 2.5 mg, 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	1	
tolterodine tartrate oral tablet 1 mg, 2 mg	1	
trospium chloride er oral capsule extended release 24 hour 60 mg	1	
trospium chloride oral tablet 20 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
VESICARE ORAL TABLET 10 MG, 5 MG (***solifenacin succinate***)	4	
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
elixophyllin oral elixir 80 mg/15ml	3	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.); SMCS; SP
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (***theophylline***)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
GEMTESA ORAL TABLET 75 MG (***vibegron***)	4	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	1	ST
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (***mirabegron***)	4	
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	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
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 suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	4	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (***ped multivitamins-fl-iron***)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (***ped multivitamins-fl-iron***)	3	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	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 cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
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	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN A		
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAMIN B COMPLEX		
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
cyanocobalamin injection solution 1000 mcg/ml	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
cyanocobalamin nasal solution 500 mcg/0.1ml	1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
ELITE-OB ORAL TABLET 50-1.25 MG (***prenatal vit-iron carbonyl-fa***)	3	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
folic acid oral tablet 400 mcg, 800 mcg	E	H
folic acid tablet 1 mg oral (rx)	1	
ft folic acid oral tablet 400 mcg, 800 mcg	E	H
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	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	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
NEONATAL PLUS ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
NESTABS ORAL TABLET 32-1 MG (***prenat-fe bisgly-fa-w/o vit a***)	3	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
prenatal oral tablet 27-1 mg	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

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	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (***prenat-fe poly-methfol-fa-dha***)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (***prenatal mv-min-fe fum-fa-dha***)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN C		
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (***peg-kcl-nacl-nasulf-na asc-c***)	4	
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	1	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	1	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VITAMIN D		
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

Prescription drug name	Drug tier	Coverage requirements & limits
ergocalciferol oral capsule 1.25 mg (50000 ut)	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***)	3	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	1	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (***paricalcitol***)	4	
VITAMIN E		
wheat germ oil oral oil	1	
VITAMIN K ACTIVITY		
phytonadione oral tablet 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); E: Excluded from coverage unless covered as part of health care reform preventive; SM: $0 cost-share by state mandate when condition appropriate; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents; IF: Two one-month fills are required before a three-month fill is available if allowed.

A.A.G.C. KIT IN TERODERM . 364
abacavir sulfate 36
abacavir sulfate-lamivudine ... 36
abigale 256, 270
abigale lo 256, 270
abiraterone acetate 48
abirtega 48
ABRYSVO 64
acamprosate calcium 16, 150
ACANYA 39, 340, 361
acarbose 242
ACCU-CHEK AVIVA 181
ACCU-CHEK FASTCLIX LANCET KIT 181
ACCU-CHEK GUIDE 181
ACCU-CHEK GUIDE CONTROL 181
ACCU-CHEK GUIDE ME 181
ACCU-CHEK GUIDE TEST 193
ACCU-CHEK SMARTVIEW CONTROL 181
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT 181
accutane 359, 364
ACD-A NOCLOT-50 81
acebutolol hcl 80, 101, 107, 109, 117
acetaminophen-codeine 128, 158, 160
acetazolamide 94, 106, 132, 198, 213
acetazolamide er 94, 106, 132, 198, 213
acetic acid 220
acetylcysteine 16, 295, 332
acitretin 359, 364
ACTEMRA 289, 303, 308
ACTEMRA ACTPEN 289, 303, 308
ACTHAR 192, 269
ACTHAR GEL 192, 269
ACTHIB 64
ACTIMMUNE 308
ACTIVELLA 256, 270
ACTOPLUS MET 246, 282
ACULAR 169, 221
ACULAR LS 169, 221
ACUVAIL 170, 221
acyclovir 41, 347
ADACEL 63, 64
ADALIMUMAB-AATY (1 PEN) 230, 293, 304, 308, 309
ADALIMUMAB-AATY (2 PEN) 231, 293, 304, 309
ADALIMUMAB-AATY (2 SYRINGE) 231, 293, 304, 309
ADALIMUMAB-AATY CD/UC/HS START 231, 293, 304, 309
ADALIMUMAB-ADAZ 231, 293, 304, 309
adapalene-benzoyl peroxide 321, 359, 361, 364
ADBRY 356, 364
ADDERALL XR 126
ADDYI 150
adefovir dipivoxil 41
ADEMPAS 337, 339
ADRENALIN 69, 223, 323
ADVAIR HFA 78, 213, 236, 326
ADVANTAGE SAFETY LANCETS 28G 181
ADVATE 86
ADVOCATE SAFETY LANCETS 21G 181
ADVOCATE SAFETY LANCETS 23G 181
ADVOCATE SAFETY LANCETS 28G 181
ADYNOVATE 86
ADZENYS XR-ODT 126
AEROCHAMBER HOLDING CHAMBER 181
AEROCHAMBER PLS FLOVU MTHPIECE 181
AEROCHAMBER PLUS FLO-VU INTERM 181
AEROCHAMBER PLUS FLO-VU LARGE 181
AEROCHAMBER PLUS FLO-VU MEDIUM 181
AEROCHAMBER PLUS FLO-VU SMALL 181
AEROCHAMBER2GO ANTI-STATIC 182
afirmelle 247, 256, 270
AFREZZA 279
AFSTYLA 86
aftera 244, 247, 271
AIMOVIG 149
AIRSUPRA 78, 213, 236, 326, 333, 336
AKEEGA 48
AKLIEF 359, 364
AKTEN 221
AKYNZEO 225, 234
albendazole 25
albuterol sulfate 78, 336
ALBUTEROL SULFATE ... 78, 336
albuterol sulfate hfa 78, 336
ALCAINE 221
alclometasone dipropionate 350
ALCOHOL PREP PADS 182
ALECENSA 48
alendronate sodium 298
alfuzosin hcl er 77
aliskiren fumarate 121
allopurinol 297
ALLZITAL 128, 146, 158
almotriptan malate 172
ALOGLIPTIN BENZOATE 255
ALOGLIPTIN-METFORMIN HCL 246, 255
ALOGLIPTIN-PIOGLITAZONE 255, 282
ALORA 257, 298
alosetron hcl 226
ALPHAGAN P 208, 340
ALPHANATE 86
ALPHANINE SD 86
alprazolam 148
alprazolam er 148
alprazolam intensol 148
alprazolam xr 148
ALPROLIX 86
ALREX 214
ALTACAINE 221, 295
altavera 247, 257, 271
ALTRENO 48, 350
ALTUVIIIO 86
ALUNBRIG 48
ALVAIZ 84
alvimopan 224, 231
alyacen 1/35 ..... 247, 257, 271
alyacen 7/7/7 ..... 247, 257, 271
ALYFTREK 328, 329
alyq 120, 121, 334, 337
amantadine hcl 22, 126
ambrisentan 123, 330, 337
amcinonide 350, 351
AMELUZ 339, 364
amethyst 247, 257, 271

amiloride hcl 95, 121, 200
amiloride-hydrochlorothiazide 200, 203
aminocaproic acid 86
amiodarone hcl 111
AMITIZA 224, 231
amitriptyline hcl 175
AMJEVITA 231, 294, 304, 309
AMJEVITA-PED 15KG TO <30KG 231, 294, 304, 309
AMLODIPINE BES+SYRSPEND SF 112, 113, 123
amlodipine besylate 112, 113, 123
amlodipine besylate-benazepril hcl 99, 112
amlodipine besylate-valsartan 97, 112
amlodipine-atorvastatin 112, 115
amlodipine-olmesartan ... 97, 112
amlodipine-valsartan-hctz 97, 112, 203
amnesteem 359, 364
amoxapine 175
amoxicill-clarithro-lansopraz 24, 42, 43, 235
amoxicillin 24, 227
amoxicillin trihydrate 24, 227
amoxicillin-potassium clavulanate 24
amoxicillin-potassium clavulanate er 24
amphetamine er 127
amphetamine sulfate 127
amphetamine-dextroamphetamine 127
amphetamine-dextroamphetamine er 127
amphet-dextroamphet 3-bead er 127
ampicillin 24
AMZEEQ 25, 46, 208, 340
anagrelide hcl 93
ANALPRAM HC 214, 236, 345, 351
anastrozole 48, 244
ANCOBON 44
ANDEMBRY 94
ANGELIQ 257, 271
ANNOVERA 248, 257, 271
ANORO ELLIPTA 70, 78
ANTICOAGULANT SODIUM CITRATE 82
ANUCORT-HC 214, 237, 351
ANUSOL-HC 214, 237, 351
ANZUPGO 358
apap-caff-dihydrocodeine 128, 158, 161, 167
APOKYN 157
apomorphine hcl 157
apraclonidine hcl 208, 220
aprepitant 234
apri 248, 257, 271
APRISO 226
APTIOM 132, 155
APTIVUS 38
AQ INSULIN SYRINGE 182
AQINJECT PEN NEEDLE 182
AQNEURSA 317
AQUORAL 220
AQVESME 82
ARAKODA 26
aranelle 248, 257, 271
ARANESP (ALBUMIN FREE) 81, 84
ARBLI 97
ARCALYST 317, 331
AREXVY 64
arformoterol tartrate 78, 336
ARIKAYCE 23
aripiprazole 137, 144
armodafinil 176
ARMOUR THYROID 283
ARNUITY ELLIPTA 214, 237, 326, 333
ARTISS 349, 364
ARZOL SILVER NIT APPLICATORS 211
ascomp-codeine 146, 161, 167, 171
asenapine maleate 137, 138, 144
ashlyna 248, 257, 271
aspirin 92, 93, 141, 171
aspirin 81 ..... 92, 93, 140, 171
aspirin adult low dose 92, 93, 140, 171
aspirin adult low strength 92, 93, 140, 171
aspirin childrens 92, 93, 140, 171
aspirin ec adult low dose 92, 93, 140, 171
aspirin ec low dose 92, 93, 141, 171
aspirin ec low strength 92, 93, 141, 171
aspirin low dose 92, 93, 141, 171
aspirin regimen . 92, 93, 141, 171
aspirin-dipyridamole er 92, 120, 171, 193
ASSURE CONTROL SOLUTION 2/3 182
ASSURE ID DUO PRO PEN NEEDLES 182
ASSURE ID PRO PEN NEEDLES 182
ASTRINGYN 86
atazanavir sulfate 38
atenolol 80, 101, 107, 109, 117
ATENOLOL+SYRSPEND SF 80, 101, 107, 109, 117
atenolol-chlorthalidone 101, 107, 205
ATMEKSI 73
atomoxetine hcl 150, 167
ATORVALIQ 115
atorvastatin calcium 115, 116
atovaquone 27
atovaquone-proguanil hcl 26
atropine sulfate . 16, 70, 222, 324
ATROVENT HFA 70, 324
ATTRUBY 106
aubra eq 248, 257, 271
AUGMENTIN 24
AUGTYRO 48
AUM INSULIN SAFETY PEN NEEDLE 182
AUM MINI INSULIN PEN NEEDLE 182
AUM PEN NEEDLE 182
AUM READYGARD DUO PEN NEEDLE 182
AUM SAFETY PEN NEEDLE . 182
AURANOFIN ... 236, 286, 304, 309
aurovela 1.5/30 ..... 248, 257, 271
aurovela 1/20 ..... 248, 257, 271
aurovela 24 fe 248, 257, 271
aurovela fe 1.5/30 .. 248, 257, 271
aurovela fe 1/20 ..... 248, 257, 271
AUSTEDO 176
AUSTEDO XR 176
AUSTEDO XR PATIENT TITRATION 176
AUTOKEEPER SAFETY PEN NEEDLE 182
AUTOLET LANCING DEVICE 182

AUTOLET LITE LANCING DEVICE....182
AUVELITY....137
AUVELITY TITRATION PACK 137
AUVI-Q....69, 323
avanafil....120, 121
AVAR CLEANSER....341, 359
AVAR LS CLEANSER....341, 359
AVAR-E EMOLLIENT....341, 359
aviane....248, 257, 271
AVIDOXY....26, 46, 341
AVIDOXY DK....46, 359, 369
AVMAPKI FAKZYNJA CO-PACK....48
AVONEX PEN....289, 309
AVONEX PREFILLED....289, 310
AVTOZMA....289, 290
ayuna....248, 257, 271
AYVAKIT....48
AZASAN....285, 305, 310, 314
AZASITE....208
azathioprine....285, 305, 310, 314
azelaic acid....341, 364
azelastine hcl....208, 336
AZELEX....341, 365
AZILECT....156
azilsartan medoxomil....97
azithromycin....42, 43
AZSTARYS....167
AZULFIDINE....45, 226, 286, 305, 310
AZULFIDINE EN-TABS....45, 226, 286, 305, 310
azurette....248, 257, 271
B & C....365
bac (butalbital-acetamin-caff)....128, 146, 158, 167
bacitracin-polymyxin b....30, 209, 341
bacitra-neomycin-polymyxin-hc....30, 209, 214, 341
baclofen....74
BACTRIM....27, 45, 47
BACTRIM DS....27, 45, 47
BAFIERTAM....287, 310
BALCOLTRA....248, 257, 271
balsalazide disodium....226
balsam peru-castor oil....365
BALVERSA....48, 49
balziva....248, 257, 271
BANZEL....132, 155
BAQSIMI ONE PACK 16, 265, 295
BAQSIMI TWO PACK....16, 265, 295
BARACLUDE....41
BAXDELA....44
BD AUTOSHIELD DUO PEN NEEDLES....182
BD BLUNT FILL NEEDLE....182
BD ECLIPSE LUER-LOK NEEDLE....182
BD ECLIPSE NEEDLE....182
BD PEN NEEDLE MICRO ULTRAFINE....182
BD PEN NEEDLE MINI ULTRAFINE....183
BD PEN NEEDLE NANO ULTRAFINE....183
BD PEN NEEDLE ORIG ULTRAFINE....183
BD PEN NEEDLE SHORT ULTRAFINE....183
BD SAFETYGLIDE NEEDLE....183
BD SHARPS COLLECTOR....183
BD ULTRA-FINE INSULIN SYRINGES....183
BD ULTRA-FINE PEN NEEDLES....183
BD VEO INSULIN SYR ULTRAFINE....183
BELBUCA....165
belladonna alkaloids-opium....70, 161
BELSOMRA....143, 166
benazepril hcl....98, 99
benazepril-hydrochlorothiazide....99, 203
BENEFIX....86
BENLYSTA....288, 314
benzalkonium chloride....347, 361
BENZAMYCIN....341, 361
BENZNIDAZOLE....27, 41
benzoin....350
benzonatate....325
benzoyl peroxide-erythromycin....341, 362
benzphetamine hcl....127
benztropine mesylate....72, 131
bepotastine besilate....20, 208
BERINERT....302, 303
BESIFLOXACIN HCL....209
BESIVANCE....209
BESREMI....38, 49, 310
BESREMI PEN....38, 49, 310
BETADINE OPHTHALMIC PREP....211
betaine....317
betamethasone dipropionate....237, 351
betamethasone dipropionate aug....237, 351
betamethasone valerate....237, 351
BETAPACE AF....75, 101, 107, 109, 111, 117
BETASERON....289, 310
betaxolol hcl....80, 101, 107, 109, 117, 212
bethanechol chloride....76
BETIMOL....75, 101, 109, 212
BEVESPI AEROSPHERE....70, 78, 347
bexarotene....49, 339, 365
BEXSERO....64
BEYFORTUS....40
bicalutamide....49
BIGFOOT UNITY PROGRAM 183
BIJUVA....257, 271
BIKTARVY....34, 35, 36
BILTRICIDE....25
bimatoprost....223
BIMZELX....356, 357, 365
BINAXNOW COVID-19 AG HOME TEST....193
BINOSTO....298
bis subcit-metronid-tetracyc....25, 27, 46, 225, 227
bisacodyl ec....228
bismuth/metronidaz/tetracyc lin....25, 27, 46, 225, 227
bisoprolol fumarate....80, 101, 107, 110, 117
bisoprolol-hydrochlorothiazide....101, 107, 203
blisovi 24 fe....248, 257, 271
blisovi fe 1.5/30....248, 257, 271
blisovi fe 1/20....248, 257, 271
BLUJEPA....47
BONSITY....268, 298
BOOSTRIX....64, 65
bosentan....123, 330, 337
BOSULIF....49
bosutinib....49
bp 10-1....341, 359
BRAFTOVI....49

BREATHE COMFORT CHAMBER/ADULT 183
BREATHE COMFORT CHAMBER/CHILD 183
BRENZAVVY 280
BREO ELLIPTA 78, 214, 237, 326
BREZTRI AEROSPHERE 70, 78, 237
briellyn 248, 257, 271
brimonidine tartrate 208, 340, 365
BRINSUPRI 325, 332
brinzolamide 213
brivaracetam 132
BRIVIACT 132
bromfenac sodium 221
bromfenac sodium (once-daily) 221
bromocriptine mesylate 152
BROMSITE 221
BRONCHITOL 335
BRONCHITOL TOLERANCE TEST 335
BRUKINSA 49
BRYHALI 351
BRYNOVIN 255
budesonide 237, 238, 327, 333, 351
bumetanide 94, 116, 199
BUMEX 94, 116, 199
BUPHENYL 195
buprenorphine 166
buprenorphine hcl 165
buprenorphine hcl-naloxone hcl 164, 165, 166
bupropion hcl 137
bupropion hcl er (smoking det) 67, 137
bupropion hcl er (sr) 137
bupropion hcl er (xl) 137
BUPROPION HCL ER (XL) 137
buspirone hcl 143, 157
butalbital-acetaminophen 128, 146, 158
butalbital-apap-caff-cod 128, 146, 158, 161, 167
butalbital-apap-caffeine 128, 146, 158, 167
BUTALBITAL-APAP-CAFFEINE 128, 146, 158, 167
butalbital-asa-caff-codeine 146, 161, 167, 171
butalbital-aspirin-caffeine 146, 168, 171
butorphanol tartrate 141, 166
BYLVAY 229, 232
BYLVAY (PELLETS) 229, 231, 232
BYQLOVI 214
cabergoline 152
CABLIVI 82, 94
CABOMETYX 49
CAFERGOT 76, 141, 168
caffeine citrate 141, 168
CALCIFOL 201, 373, 375
calcipotriene 349, 365
calcipotriene-betameth diprop 349, 351, 365
calcitonin (salmon) 245, 298
CALCITRENE 349, 365
calcitriol 365, 375
calcium acetate 200, 201
calcium acetate (phos binder) 199, 200, 201
CALQUENCE 49
CAMBIA 141, 159
camila 248, 271
CAMINO PRO COMPLETE/GLYTACTIN 196
camrese 248, 258, 272
camrese lo 248, 257, 271
CAMZYOS 106
candesartan cilexetil 97
candesartan cilexetil-hctz 97, 203
capecitabine 49
CAPLYTA 144
CAPRELSA 50
captopril 98, 99
captopril-hydrochlorothiazide 99, 204
CAPVAXIVE 65
carbamazepine 132, 138
carbamazepine er 132, 138
CARBATROL 132, 138
carbidopa 152
carbidopa-levodopa 152
carbidopa-levodopa er 152
carbidopa-levodopa-entacapone 150, 152
carbinoxamine maleate 18, 19, 331
CARBINOXAMINE MALEATE ER 18, 19, 330
CARBZAH 18, 19, 331
CARDAMYST 104, 111
CARDURA 76, 96, 101
CARDURA XL 76, 96, 101
CAREPOINT POLY HUB NEEDLE 183
CAREPOINT PRECISION POLY HUB 183
CAREPOINT SAFETY 1ST NEEDLE 183
CARESENS CONTROL SOLUTION A/B 184
CARESENS LANCETS 30G 184
CARESENS S CONTROL SOLN A/B 184
CARESTART COVID-19 HOME TEST 193
CARETOUCH CONTROL SOL LEVEL 2 184
CARETOUCH HYPODERMIC NEEDLE 184
CARETOUCH LANCING/EJECTOR 184
carglumic acid 195
carisoprodol 73
CARNITOR 317
CARNITOR SF 317
CAROSPIR 95, 116, 117, 121, 122, 201
carteolol hcl 212
cartia xt 103, 104, 105, 111, 123
carvedilol 75, 77, 96, 101, 107, 110, 118
carvedilol phosphate er 75, 77, 96, 101, 107, 110, 118
CAVERJECT 114, 123
CAVERJECT IMPULSE 114, 123
CAYA 321
CAYSTON 40
cefaclor 22
cefaclor er 22
cefadroxil 21, 22
cefdinir 22
cefixime 22
CEFIXIME 22
cefpodoxime proxetil 22
cefprozil 22
cefuroxime axetil 22
celecoxib 151
CELONTIN 174
cephalexin 22
CEQUR SIMPLICITY 1U EXTND WEAR 184
CEQUR SIMPLICITY 2U 184

CEQUR SIMPLICITY 2U EXTND WEAR 184
CERDELGA 206, 317
CERVIDIL 323
CETRAXAL 209
CETROTIDE 244
cevimeline hcl 76
charlotte 24 fe 248, 258, 272
chateal eq 248, 258, 272
CHEMET 16, 236, 295
CHEMSTRIP BG LOG BOOK .184
CHEMSTRIP K 194
CHEMSTRIP UGK 194
chlordiazepoxide hcl 148
chlordiazepoxide-amitriptyline 148, 175
chlordiazepoxide-clidinium 70, 148
chlorhexidine gluconate 23, 211, 212, 347, 362
chloroquine phosphate 26
chlorpromazine hcl 166
chlorthalidone 96, 122, 205
chlorzoxazone 73
CHOLBAM 229, 232
cholestyramine 103
cholestyramine light 103
CHORIONIC GONADOTROPIN 265
CHOSEN LANCETS 30G 184
CHOSEN LANCING DEVICE . 184
CHOSEN SAFETY LANCETS 28G 184
CIBINQO 291, 305, 358, 365
ciclodan 356
ciclopirox 356
ciclopirox olamine 356
CICLOPIROX TREATMENT ...356
cilostazol 92, 120, 121
CILOXAN 209
CIMDUO 36
cimetidine 20, 234
cimetidine hcl 20, 234
CIMZIA (1 SYRINGE) 232, 286, 294, 305, 310
CIMZIA (2 SYRINGE) 232, 286, 294, 305, 310
CIMZIA-STARTER 232, 286, 294, 305, 310
cinacalcet hcl 245
CIPRO 28, 44
CIPRO HC 209, 214
ciprofloxacin hcl 28, 45, 209
ciprofloxacin-dexamethasone 209, 214
ciprofloxacin-hydrocortisone 209, 214
citalopram hydrobromide 173
cladribine (10 tabs) 50, 284, 310, 315
cladribine (4 tabs) 50, 284, 310, 315
cladribine (5 tabs) 50, 284, 310, 315
cladribine (6 tabs) 50, 284, 310, 315
cladribine (7 tabs) 50, 284, 310, 315
cladribine (8 tabs) 50, 284, 310, 315
cladribine (9 tabs) 50, 285, 311, 315
claravis 359, 365
CLARINEX-D 12 HOUR 21, 69
clarithromycin 28, 42, 43, 227
clarithromycin er . 28, 42, 43, 227
CLEARDETECT COVID-19 AG HOME 193
clearlax 228
clemastine fumarate . 18, 19, 331
CLEMSZA 19, 331
CLENPIQ 228
CLEOCIN 39, 341
CLEOCIN-T 39, 341
CLEVER CHOICE COMFORT EZ 184
CLIMARA PRO 258, 272
clindacin 39, 341
clindacin etz 39, 341
clindacin-p 39, 341
CLINDAGEL 39, 341
clindamycin hcl 39, 341
clindamycin palmitate hcl 39, 341
clindamycin phos (once-daily) 39, 342
clindamycin phos (twice-daily) 39, 342
clindamycin phos-benzoyl perox 39, 342, 362
clindamycin phosphate .. 39, 342
clindamycin-tretinoin 40, 342, 350, 365
CLINDESSE 40, 342
CLINITEST RAPID COVID-19 TEST 193
CLINOIN 103, 342, 350, 365
CLINPRO 5000 .....178, 300
clobazam 147, 148
clobetasol prop emollient base 351
clobetasol propionate ...351, 352
clobetasol propionate e 351
clobetasol propionate emulsion 351
clocortolone pivalate 352
clodan 352
clomid 256
clomiphene citrate 256
clomipramine hcl 175
clonazepam 147, 148
clonidine 69, 107, 114
clonidine hcl 69, 107, 114
clonidine hcl er 69, 114
clopidogrel bisulfate 92
clorazepate dipotassium 147, 148
clotrimazole 348
clotrimazole-betamethasone 348, 352
clozapine 144
CLOZARIL 144
COAGADEX 86
coal tar 361
COARTEM 26
COBENFY 143, 369
COBENFY STARTER PACK 143, 369
codeine sulfate 161, 325
colchicine 297
colchicine-probenecid ..205, 297
colesevelam hcl 103, 243
COLESTID 103
colestipol hcl 103
colistimethate sodium (cba) .. 44
COLY-MYCIN M 44
COMBIGAN 208, 212, 340
COMBIPATCH 258, 272
COMBIVENT RESPIMAT 70, 79, 324
COMETRIQ 50
COMFORT EZ PRO PEN NEEDLES 184
COMFORT TOUCH TWIST LANCET 30G 184
COMPLERA 35, 36, 41
COMPLEX ESSENTIAL MSD 196, 317
COMPRO 167, 226

CONDOMS 321
CONDYLOX 359, 365
constulose 195
CONTOUR CONTROL 184
CONTOUR NEXT CONTROL . 184
CONTOUR NEXT EZ 184
CONTOUR NEXT GEN MONITOR 185
CONTOUR NEXT MONITOR . 185
CONTOUR NEXT ONE 185
CONTOUR NEXT TEST 193
CONTOUR PLUS BLUE 185
CONTOUR PLUS CONTROL SOLUTION 185
CONTOUR PLUS TEST 193
CONTRAVE 130
CONZIP 161
COPASIL 365
COPIKTRA 50
CORDRAN 352
CORIFACT 86
CORLANOR 106, 123
CORPHENA 19, 21
CORTANE-B 214, 238, 345, 352, 362
CORTEF 214, 238, 352
CORTENEMA 214, 238, 352
CORTIFOAM 215, 238, 352
CORTISONE ACETATE 238
CORTISPORIN-TC 209, 215
CORTROPHIN 192, 269
CORTROPHIN GEL 192, 269
CORTROSYN 192
COSENTYX (300 MG DOSE) 290, 305, 365
COSENTYX 150 MG/ML 290, 305, 365
COSENTYX SENSOREADY (300 MG) 290, 305, 366
COSENTYX SENSOREADY PEN 290, 305, 366
COSENTYX UNOREADY 290, 305, 366
COSOPT 212, 213
cosyntropin 192
COTELLIC 50
COTEMPLA XR-ODT 168
COVARYX 242, 258
COVARYX HS 242, 258
COVID-19 AT HOME ANTIGEN TEST 193
COVID-19 AT-HOME TEST 193
CRENESSITY 86, 269
CREON 207, 230
CRESEMBA 30
CREXONT 152
CRINONE 272
cromolyn sodium .. 208, 220, 332
CROTAN 364
cryselle 248, 258, 272
CTEXLI 229
CUVPOSA 70, 347
cyanocobalamin 92, 373
CYANOCOBALAMIN 92, 373
cyclobenzaprine hcl 73
CYCLOGYL 222
CYCLOMYDRIL 222, 223
cyclopentolate hcl 222
cyclophosphamide . 50, 288, 315
CYCLOPHOSPHAMIDE 50, 288, 315
cycloserine 28
CYCLOSET 243
cyclosporine 212, 285, 305, 311, 315
cyclosporine modified 212, 285, 305, 311, 315
cyproheptadine hcl 19, 331
cyred eq 248, 258, 272
CYSTADANE 317
CYSTADROPS 220, 222
CYSTAGON 317
CYSTARAN 220, 222
CYTOTEC 234
cytra k crystals 195
dabigatran etexilate mesylate 83
dalfampridine er 317, 321
danazol 242
DANTRIUM 74
dantrolene sodium 74
dapaglifloz base-metformin er 246, 280
dapagliflozin 280
dapsone 25, 27, 342, 366
DAPTACEL 64, 65
DARAPRIM 26
darifenacin hydrobromide er 369
darunavir 38
dasatinib 50
dasetta 1/35 (28) 248, 258, 272
dasetta 7/7/7 ..... 248, 258, 272
DAURISMO 51
DAYBUE 150
DAYBUE STIX 150
daysee 248, 258, 272
DEBACTEROL 220, 362
deblitane 249, 272
deferasirox 236
deferasirox granules 236
deferiprone 236
DELESTROGEN 258, 298
DELSTRIGO 35, 36
delyla 249, 258, 272
demeclocycline hcl 46
DENAVIR 347
DENGVAXIA 65
DENTA 5000 PLUS 177, 178, 300
DENTA 5000 PLUS SENSITIVE 178, 300
DENTAGEL 177, 178, 300
DEPAKOTE 132, 138, 141, 153
DEPAKOTE ER 132, 138, 141, 153
DEPAKOTE SPRINKLES 132, 138, 141
DEPEN TITRATABS . 16, 236, 305
DEPO-ESTRADIOL 258, 298
DEPO-PROVERA 249, 272
DEPO-SUBQ PROVERA 104 ..... 249, 272
DEPO-TESTOSTERONE 243, 244
DERMACINRX UREA 95, 199, 222, 359
DERMACURE ... 95, 199, 222, 359
DERMA-SMOOTHE/FS BODY 215, 352
DERMA-SMOOTHE/FS SCALP 215, 352
DERMOTIC 215, 352
DESCOVY 36, 41
desipramine hcl 175
desloratadine 21, 336
DESMODA 87, 269
desmopressin ace spray refrig 87, 269
desmopressin acetate 87, 269
DESMOPRESSIN ACETATE 87, 269
desmopressin acetate pf 87, 269
desmopressin acetate spray 87, 269
desonide 352
desoximetasone 352
DESVENLAFAXINE ER 172
desvenlafaxine succinate er 172
dexamethasone 215, 238

dexamethasone intensol 215, 238
dexamethasone sodium phosphate 215
DEXCOM G6 RECEIVER 185
DEXCOM G6 SENSOR 185
DEXCOM G6 TRANSMITTER 185
DEXCOM G7 15 DAY SENSOR 185
DEXCOM G7 RECEIVER 185
DEXCOM G7 SENSOR 185
dexmethylphenidate hcl 168
dexmethylphenidate hcl er ... 168
dextroamphetamine sulfate . 127
dextroamphetamine sulfate er 127
dextromethorphan-quinidine 150
DIABECIN HR 345, 362
DIABETES MONITOR DIGIT ADD-ON 185, 317
DIABETES MONITOR DIGIT SOLN 185, 317
DIACOMIT 133, 153
DIASTIX REAGENT 194
DIATRUST COVID-19 HOME TEST 193
diazepam 147, 148
diazepam intensol 147, 148
diazoxide 245
dichlorphenamide 94, 300
diclofenac potassium 159
diclofenac potassium(migraine) 141, 159
diclofenac sodium 159, 170, 176, 221, 363
diclofenac sodium er 159
diclofenac-misoprostol 159, 235
dicloxacillin sodium 44
DICOPANOL FUSEPAQ 19, 72, 131, 143, 325, 331
dicyclomine hcl 70
diethylpropion hcl 126
diethylpropion hcl er 126
DIFICID 43
diflorasone diacetate 352, 353
diflunisal 159, 170
difluprednate 215
digoxin 100, 106, 107
dihydroergotamine mesylate 76, 141
DILANTIN 109, 154
DILANTIN INFATABS 109, 154
DILANTIN-125 ..... 109, 154
diltiazem hcl .. 104, 105, 112, 123
diltiazem hcl er 103, 104, 105, 111, 112, 123
diltiazem hcl er beads 103, 104, 105, 111, 123
diltiazem hcl er coated beads 103, 104, 105, 111, 123
dilt-xr 104, 105, 112, 123
dimethyl fumarate 288, 311
dimethyl fumarate starter pack 288, 311
DIPENTUM 226
diphenhydramine hcl 19, 72, 131, 143, 326, 331
diphenoxylate-atropine .. 70, 225
DIPROLENE 238, 353
dipyridamole 92, 120, 123, 193
diskets 161
disopyramide phosphate 108
disulfiram 16, 295
divalproex sodium 133, 138, 141, 153
divalproex sodium er 133, 138, 141, 153
DIVIGEL 258, 298
dofetilide 111
DOJOLVI 196
dolishale 249, 258, 272
donepezil hcl 76
DOPTELET 84
DOPTELET SPRINKLE 84
DOREVI 353, 356, 359
DORYX MPC 26, 46, 342
DORZOLAMIDE HCL 213
dorzolamide hcl 213
dorzolamide hcl-timolol mal 213
dorzolamide hcl-timolol mal pf 213
dotti 258, 298
DOUBLE PM 209, 215
DOVATO 34, 36
doxazosin mesylate .. 76, 96, 101
doxepin hcl 175, 345
doxercalciferol 375
doxycycline hyclate .. 26, 46, 342
doxycycline monohydrate 26, 46, 342
DRIZALMA SPRINKLE 172
dronabinol 225, 232
DROPLET MICRON 185
DROPSAFE ACTI-LANCE 23G 185
DROPSAFE AUTOPROTECT DUO 185
DROPSAFE MEDLANCE LANCET 30G 185
DROPSAFE SAFETY SYRINGE/NEEDLE 186
DROPSAFE SICURA 186
drospiren-eth estrad-levomefol 249, 258, 272, 373
drospirenone-ethinyl estradiol 249, 258, 272
DROXIA 51
droxidopa 69
DRYSOL 347
DUAVEE 256, 258
DUETACT 282, 283
DULERA 79, 238
duloxetine hcl 152, 172
DUOPA 152
DUPIXENT 331, 357, 366
DUREX EXTRA SENSITIVE THIN 321
DUREX TROPICAL 321
dutasteride 295
dutasteride-tamsulosin hcl 77, 295
DUVYZAT 317
DYANAVEL XR 127
DYCLOPRO 345
E.E.S. GRANULES 31
EAA SUPPLEMENT 196
EASIVENT 186
EASY COMFORT SHARPS CONTAINER 186
EASY TOUCH HEALTHPRO HIGH/LOW 186
EASYGEL 177, 178, 300
EASYMAX 15 LEVEL 2-3 CONTROL 186
EASYMAX CONTROL 186
EASYMAX CONTROL NORMAL/HIGH 186
EBGLYSS 357
econazole nitrate 348
ECONAZOLE NITRATE 348
econtra one-step ... 244, 249, 272
ECOZA 348
EC-RX DHEA 317
EC-RX ESTRADIOL 259, 298
EC-RX PROGESTERONE 272
EC-RX TESTOSTERONE 243
EDARBYCLOR 98, 204
EDEX (2 CARTRIDGE) ... 114, 124

EDEX (6 CARTRIDGE) ...114, 124
EDLUAR 143, 157
EDURANT 35
EDURANT PED 35
EEMT 243, 259
EEMT HS 243, 259
efavirenz 35
efavirenz-emtricitab-tenofo df 35, 36
efavirenz-lamivudine-tenofovir 35, 36
EFFER-K 201
effer-k 201
EGATEN 25
EGRIFTA SV 281
EGRIFTA WR 281
ELESTRIN 259, 298
eletriptan hydrobromide 173
elinest 249, 259, 272
ELIQUIS 83
ELIQUIS (1.5 MG PACK) 82
ELIQUIS (2 MG PACK) 83
ELIQUIS DVT/PE STARTER PACK 83
ELITE-OB 90, 370, 373
elixophyllin 115, 168, 198, 339, 370
ELLA 249, 273
ELLUME COVID-19 HOME TEST 193
ELMIRON 317
ELOCTATE 87
eltrombopag olamine 84
eluryng 249, 259, 273
EMBECTA AUTOSHIELD DUO 186
EMBECTA INS SYR U/F 1/2 UNIT 186
EMBECTA INSULIN SYR ULTRAFINE 186
EMBECTA INSULIN SYRINGE 186
EMBECTA INSULIN SYRINGE U-100 186
EMBECTA INSULIN SYRINGE U-500 186
EMBECTA PEN NEEDLE NANO 186
EMBECTA PEN NEEDLE NANO 2 GEN 186
EMBECTA PEN NEEDLE ULTRAFINE 187
EMBRACE PEN NEEDLES 187
EMBRACE WAVE GLUCOSE CONTROL 187
EMEND 234
EMGALITY 149
EMPAVELI 302, 303
EMSAM 156
emtricitabine 36
emtricitabine-tenofovir df 36, 42
emtricitab-rilpivir-tenofov df 35, 37, 42
EMTRIVA 37
EMVERM 25
emzahh 249, 273
enalapril maleate 98, 99
enalapril-hydrochlorothiazide 99, 204
ENBRACE HR 90, 317, 370, 373
ENBREL 294, 306, 311
ENBREL MINI 294, 305, 311
ENBREL SURECLICK 294, 306, 311
ENBUMYST 95, 199
ENCALA 196
ENCARE 322
ENDARI 317, 366
endocet 129, 158, 161
ENDOMETRIN 273
ENFLONSIA 40
ENGERIX-B 65
enilloring 249, 259, 273
ENLITE GLUCOSE SENSOR 187
ENOVARX-AMITRIPTYLINE 175
ENOVARX-BACLOFEN 74
ENOVARX-CYCLOBENZAPRINE HCL 73
ENOVARX-IBUPROFEN 363
ENOVARX-LIDOCAINE HCL 345
ENOVARX-NAPROXEN 363
ENOVARX-TRAMADOL 366
enoxaparin sodium 89
ENSACOVE 51
enskyce 249, 259, 273
ENSPRYNG 292, 311
ENSTILAR 349, 353, 366
ENSURE ORIGINAL 196
ENSURE PLUS 196
entacapone 150
ENTADFI 120, 121, 295, 350
entecavir 42
ENTRESTO 97, 98, 122
ENTYVIO PEN 224, 232, 286
enulose 195
EOHILIA 238
EPCLUSA 32, 33
EPIDIOLEX 133
EPIFOAM 345, 353
epinastine hcl 21, 208
epinephrine 69, 323
EPINEPHRINE 69, 323
EPIVIR 37
eplerenone 95, 117, 121, 122, 201
EQUETRO 133, 138
ergocalciferol 376
ERGOMAR 76, 141
ergotamine-caffeine 76, 141, 168
ERIVEDGE 51
ERLEADA 51
erlotinib hcl 51
errin 249, 273
ERY 31, 209, 342
ERYPED 400 31
erythromycin 31, 209, 342, 343
erythromycin base 31
erythromycin ethylsuccinate 31
ESCITALOPRAM OXALATE 173
escitalopram oxalate 173
eslicarbazepine acetate 133, 155
esomeprazole magnesium 235
est estrogens-methyltest 243, 259
est estrogens-methyltest ds 243, 259
est estrogens-methyltest hs 243, 259
estarylla 249, 259, 273
estazolam 148
estradiol 259, 298, 299
estradiol valerate 259, 299
estradiol-norethindrone acet 259, 273
ESTRATEST H.S. 243, 259
ESTRING 259, 299
estrogens conjugated 260, 299
eszopiclone 143, 157
ethacrynic acid 95, 116, 199
ethambutol hcl 29
ethosuximide 174
etodolac 159, 170
etodolac er 159, 170
etonogestrel-ethinyl estradiol 249, 260, 273
etoposide 51
etravirine 35
EUCRISA 345, 363
EURAX 364

EVAMIST 260, 299
EVEKEO 127
everolimus 51, 288, 315
EVEXITHROID 283
EVOTAZ 38, 317
EVRYSDI 317, 318
EXELDERM 348
exemestane 51, 244
EXODERM 18, 345, 359
EXXUA 174
EXXUA TITRATION PACK 174
ezetimibe 108
ezetimibe-simvastatin ... 108, 116
FABHALTA 285, 302
falmina 249, 260, 273
famciclovir 42
famotidine 20, 234
FANAPT 144
FANAPT TITRATION PACK A 144
FANAPT TITRATION PACK B 145
FANAPT TITRATION PACK C 145
FANATREX FUSEPAQ ... 129, 133
FASENRA PEN 331
FASTEP COVID-19 ANTIGEN TEST 193
FBL KIT 74, 345, 363, 366
FC2 FEMALE CONDOM 322
febuxostat 297
FEIBA 87
feirza 1.5/30 ..... 249, 260, 273
feirza 1/20 ..... 249, 260, 273
felbamate 133
FELBATOL 133
felodipine er 113
FEM PH 362, 366
FEMCAP 322
FEMLYV 249, 260, 273
FEMRING 260, 299
fenofibrate 115
fenofibrate micronized 115
fenofibric acid 115
fentanyl 161
FERRIPROX 236
FETZIMA 172
FETZIMA TITRATION 172
fidaxomicin 43
FILSPARI 122, 308, 318, 330
FILSUVEZ 366
FINACEA 343, 366
finasteride 295, 350
fingolimod hcl 292, 311
FINTEPLA 133
finzala 249, 260, 273
FIORICET 129, 146, 158, 168
FIRDAPSE 76, 318
FIRMAGON 51, 244
FIRMAGON (240 MG DOSE) 51, 244
FIRST-LANSOPRAZOLE 235
FIRST-MOUTHWASH BLM 19, 222, 224, 226, 228, 346
FIRVANQ 31
FLAREX 215
flavoxate hcl 369
flecainide acetate 109
FLEXICHAMBER 187
FLEXICHAMBER ADULT MASK/SMALL 187
FLEXICHAMBER CHILD MASK/LARGE 187
FLEXICHAMBER CHILD MASK/SMALL 187
FLOLIPID 116
FLORIVA 177, 178, 300, 376
FLORIVA PLUS 177, 179, 300, 370
FLOTREX 177, 179, 300, 370, 371
FLOWFLEX COVID-19 AG HOME TEST 194
FLUAD 65
FLUARIX 65
FLUCELVAX 65
fluconazole 30
flucytosine 44
fludrocortisone acetate 238
FLULAVAL 65
FLUMIST 65
flunisolide 215, 238, 327, 332
fluocinolone acetonide . 215, 353
fluocinolone acetonide body 215, 353
fluocinolone acetonide scalp 215, 353
fluocinonide 353
fluocinonide emulsified base 353
FLUORIDEX 179, 300
FLUORIDEX DAILY RENEWAL 177, 179, 300
FLUORIDEX ENHANCED WHITENING 179, 300
FLUORIMAX 5000 ..... 179, 300
FLUORIMAX 5000 SENSITIVE 179, 300
fluorometholone 215
fluorouracil 51, 339, 366
fluoxetine hcl 173
fluoxetine hcl (pmdd) 173
fluphenazine hcl 167
flurandrenolide 353
flurazepam hcl 148
flurbiprofen 159, 170, 221
flurbiprofen sodium 170, 221
FLUTICASONE FUROATE-VILANTEROL 79, 216, 238, 327
fluticasone propionate 216, 238, 239, 327, 332, 353
FLUTICASONE PROPIONATE HFA 216, 238, 239, 327, 333
fluticasone propionate hfa 216, 239, 327, 333
FLUTICASONE-SALMETEROL .. 79, 216, 239, 327
fluticasone-salmeterol 79, 216, 239, 327
fluvastatin sodium 116
fluvastatin sodium er 116
fluvoxamine maleate 174
fluvoxamine maleate er 174
FLUZONE 65
FLUZONE HIGH-DOSE 65
FML FORTE 216
FML LIQUIFILM 216
FOCALIN 168
folic acid 373
FOLLISTIM AQ 265, 266
fondaparinux sodium 82, 90
FONDCIRCLE CONTROL SOLUTION 187
FONDCIRCLE LANCING DEVICE 187
FONDCIRCLE SINGLE USE LANCETS 187
FORA TEST N' GO ADVANCE 187
FORA TEST N'GO ADV-VOICE-6 CON 193
FORANE 155
formaldehyde 195
formoterol fumarate 79, 337
FORZINITY 318
FOSAMAX 299
FOSAMAX PLUS D 299, 376
fosamprenavir calcium 38
fosfomycin tromethamine 47
fosinopril sodium 99
fosinopril sodium-hctz ... 99, 204
FOSRENOL 200, 295
FOTIVDA 51

FRAGMIN 89, 90
FREESTYLE LIBRE 14 DAY READER 187
FREESTYLE LIBRE 14 DAY SENSOR 187
FREESTYLE LIBRE 2 PLUS SENSOR 187
FREESTYLE LIBRE 2 READER 187
FREESTYLE LIBRE 2 SENSOR 187
FREESTYLE LIBRE 3 PLUS SENSOR 187
FREESTYLE LIBRE 3 READER 187
FREESTYLE LIBRE 3 SENSOR 188
FROTEK 363
frovatriptan succinate 173
FRUZAQLA 52
ft aspirin 93, 141, 171
ft aspirin adult low dose 92, 93, 141, 171
ft aspirin low dose .. 93, 141, 171
ft clearlax 228
ft folic acid 373
ft laxative 228
ft magnesium citrate 228
ft naloxone hcl 16, 164
ft nicotine 68, 72
ft nicotine mini 67, 72
FUROSCIX READYFLOW 95, 199
furosemide 95, 116, 199
fyavolv 260, 273
FYCOMPA 133
FYREMADEL 244
gabapentin 129, 133, 153
GALAFOLD 205, 318
galantamine hydrobromide 77
galantamine hydrobromide er 77
galbriela 249, 260, 273
gallifrey 273
GALZIN 201
ganirelix acetate 244
GARDASIL 9 65
gatifloxacin 209
GATTEX 230, 232
gavilax 228
gavilyte-c 228
gavilyte-g 228
gavilyte-n with flavor pack ... 228
GAVRETO 52
gefitinib 52
GELFILM 87
gemfibrozil 115
gemmily 250, 260, 273
GEMTESA 370
generlac 195
gengraf ... 212, 285, 306, 311, 315
gentamicin sulfate .. 23, 209, 343
gentle laxative 228
GENVOYA 34, 37
GILENYA 292, 311
GILOTRIF 52
glatiramer acetate 284, 311
glatopa 284, 311
GLEOSTINE 52
glimepiride 282
glipizide 282
glipizide er 282
glipizide-metformin hcl . 246, 282
GLOPERBA 297
glucagon emergency kit 16, 265, 295
GLUCAGON EMERGENCY KIT 16, 265, 296
GLUCOTROL XL 282
glutaraldehyde 195
glyburide 282
glyburide-metformin 246, 282
glycerol phenylbutyrate 195
glycolax 228
glycopyrrolate 70, 347
glydo 346
GLYTACTIN BETTERMILK 15 196
GLYTACTIN BETTERMILK DE-LITE 196
GLYTACTIN BUILD 10PE 196
GLYTACTIN BUILD 20/20 196
GLYTACTIN BUILD 20/20 PKU 196
GLYTACTIN BURST 196
GLYTACTIN COMPLETE 10PE 196
GLYTACTIN RESTORE 10 196
GLYTACTIN RESTORE 5 197
GLYTACTIN RESTORE LITE 10 197
GLYTACTIN RESTORE LITE 10PE 197
GLYTACTIN RTD 10 197
GLYTACTIN RTD 15 197
GLYTACTIN RTD LITE 15 197
GLYTACTIN SWIRL 15 197
GLYTACTIN SWIRL 15PE 197
GLYXAMBI 255, 280
GOLYTELY 228
GOMEKLI 52
GONAL-F 266
GONAL-F RFF REDIJECT 266
goodsense aspirin low dose 93, 94, 142, 171
goodsense clearlax 228
goodsense nicotine 68, 72
goodsense nicotine policrilex 68, 72
GORDOFILM 349, 360
granisetron hcl 225
GRANISOL 225
GRASTEK 63
griseofulvin microsize 25
griseofulvin ultramicrosize 25
guaifenesin-codeine 326, 330
guanfacine hcl 107, 114, 150
guanfacine hcl er 150
GUARDIAN 4 GLUCOSE SENSOR 188
GUARDIAN 4 TRANSMITTER 188
GUARDIAN REAL-TIME CHARGER 188
GUARDIAN REAL-TIME TEST PLUG 188
GUARDIAN SENSOR 3 188
GVOKE HYPOPEN 1-PACK 16, 265, 296
GVOKE HYPOPEN 2-PACK 16, 265, 296
GVOKE KIT 16, 265, 296
GVOKE PFS 16, 265, 296
GYNAZOLE-1 348
habitrol 68, 73
HAEGARDA 302, 303
hailey 1.5/30 ..... 250, 260, 273
hailey 24 fe 250, 260, 273
hailey fe 1.5/30 ..... 250, 260, 273
hailey fe 1/20 ..... 250, 260, 273
halcinonide 353
halobetasol propionate 353
haloperidol 149
haloperidol lactate 149
HALUCORT 366
HAN-EASE 188
HARLIKU 206
HARVONI 32, 33
HAVRIX 65
heather 250, 273

HEMANGEOL 75, 101, 107, 110, 118, 142
HEMATINIC/FOLIC ACID . 90, 373
HEMICLOR 96, 205
HEMLIBRA 87
HEMMOREX-HC 216, 239, 353
HEMOFIL M 87
heparin na (pork) lock flsh pf . 90
heparin sod (pork) lock flush . 90
heparin sodium (porcine) 90
heparin sodium (porcine) +rfid 90
heparin sodium (porcine) pf .. 90
HEPCLUDEX 31
HEPLISAV-B 65
HEPZATO W/50MM CATHETER 52
HEPZATO W/62MM CATHETER 52
her style 244, 250, 273
HERNEXEOS 52
HETLIOZ 143, 156
HETLIOZ LQ 143, 156
HIBERIX 66
HUMALOG 279
HUMALOG KWIKPEN 279
HUMALOG MIX 50/50 KWIKPEN 279
HUMALOG MIX 75/25 KWIKPEN 279
HUMALOG MIX 75/25 VIAL 279
HUMALOG U-100 JUNIOR KWIKPEN 279
HUMATE-P 87
HUMULIN 70/30 KWIKPEN 268, 280
HUMULIN 70/30 VIAL 268, 280
HUMULIN N KWIKPEN 268
HUMULIN N VIAL 268
HUMULIN R U-500 KWIKPEN 280
HUMULIN R VIAL 280
HYCAMTIN 52
hydralazine hcl 114
HYDRO 40 ..... 95, 199, 222, 360
hydrochlorothiazide 95, 122, 204
hydrocod poli-chlorphe poli er 19, 21, 326
hydrocodone bitartrate er 161
hydrocodone bit-homatrop mbr 70, 326
hydrocodone-acetaminophen 129, 158, 159, 161
hydrocodone-ibuprofen 160, 161, 170
hydrocortisone 216, 217, 239, 354
hydrocortisone (perianal) 216, 239, 353
hydrocortisone ace-pramoxine 216, 239, 346, 353
HYDROCORTISONE ACETATE 216, 239, 354
hydrocortisone acetate 216, 239, 354
hydrocortisone butyrate 216, 239, 354
hydrocortisone valerate 217, 239, 354
hydrocortisone-acetic acid 217, 220, 239, 354
hydrocortisone-iodoquinol 23, 347, 354, 362
hydrocort-pramoxine (perianal) 217, 239, 346, 354
hydromorphone hcl 162
hydromorphone hcl er .. 161, 162
hydroxychloroquine sulfate 26, 287, 306, 312
hydroxyurea 52
hydroxyzine hcl 19, 20, 143
hydroxyzine pamoate 19, 20, 143
HYFTOR 292, 315, 357, 366
HYMPAVZI 87
hyoscyamine sulfate 16, 17, 71, 324
hyoscyamine sulfate er 16, 70, 324
hyoscyamine sulfate sl 17, 71, 324
hyosyne 17, 71, 324
HYPERSAL 332
HYRNUO 52
ibandronate sodium 299
IBRANCE 52, 53
IBTROZI 53
ibuprofen 142, 160, 170
icatibant acetate 94, 300, 303
iclevia 250, 260, 273
ICLUSIG 53
ICOTYDE 357
IDELVION 87
IDHIFA 53
IDVYNSO 35, 37
IHEALTH CONTROL SOLUTION 188
IHEALTH COVID-19 RAPID TEST 194
IHEALTH LANCING DEVICE . 188
ILEVRO 221
ILUMYA 357, 366
imatinib mesylate 53
IMBRUVICA 53
imipramine hcl 175
imipramine pamoate 175
imiquimod 339, 366
IMKELDI 53
IMPAVIDO 27, 40
IMVEXXY MAINTENANCE PACK 260
IMVEXXY STARTER PACK ... 260
INBRIJA 152
incassia 250, 273
INCRELEX 281
indapamide 96, 122, 205
INDERAL LA 75, 101, 107, 110, 118, 142
INDICAID COVID-19 RAPID TEST 194
indomethacin 160, 170, 297
indomethacin er 160, 170, 297
INFANRIX 64, 66
INGREZZA 176
INLURIYO 53
INLYTA 53
INPEN 100-BLUE-LILLY-HUMALOG 188
INPEN 100-BLUE-NOVOLOG-FIASP 188
INPEN 100-GREY-LILLY-HUMALOG 188
INPEN 100-GREY-NOVOLOG-FIASP 188
INPEN 100-PINK-LILLY-HUMALOG 188
INPEN 100-PINK-NOVOLOG-FIASP 188
INQOVI 53
INREBIC 53
INSPIREASE RESERVOIR BAGS 188
INSULIN LISPRO 279
INSULIN LISPRO (1 UNIT DIAL) 279
INSULIN LISPRO JUNIOR KWIKPEN 280

INSULIN LISPRO PROT & LISPRO 280
INSULIN PEN NEEDLES 188, 189
INSULIN SYRINGES 189
INSUPEN32G EXTR3ME 189
INTELENCE 35
INTELISWAB COVID-19 RAPID TEST 194
INTRAROSA 239
introvale 250, 260, 273
INVELTYS 217
INZIRQO 95, 204
iodine strong 17, 25, 246, 330, 347
iodine tincture 347, 362
IOPIDINE 208, 220
IPOL 66
ipratropium bromide 71, 324
ipratropium bromide hfa 71, 324
ipratropium-albuterol 71, 79, 324
IQIRVO 229, 232
irbesartan 97, 98
irbesartan-hydrochlorothiazide 98, 204
IRESSA 54
ISENTRESS 34
ISENTRESS HD 34
isibloom 250, 260, 273
isoflurane 155
isoniazid 29
isosorb dinitrate-hydralazine 114, 118, 119
isosorbide dinitrate 118, 119
isosorbide mononitrate 118, 119
isosorbide mononitrate er 118, 119
isotretinoin 360, 366
isradipine 113
ISTALOL 75, 101, 110, 213
ISTURISA 240, 318
ITOVEBI 54
itraconazole 30
ivabradine hcl 106, 107, 124
ivermectin 25
IWILFIN 54
IYUZEH 223
jaimiess 250, 260, 274
JAKAFI 54, 358
JAKAFI XR 54, 358
JARDIANCE 280
JASCAYD 325, 333, 363
jasmiel 250, 260, 274
JAVADIN 69, 107
JAVYGTOR 206, 318
JAYPIRCA 54
jencycla 250, 274
JENTADUETO 246, 255
JENTADUETO XR 246, 255
jinteli 260, 274
JIVI 88
JOENJA 312
jolessa 250, 260, 274
JOURNAVX 129
joyeaux 250, 261, 274
JUBLIA 348
juleber 250, 261, 274
JULUCA 35
junel 1.5/30 ..... 250, 261, 274
junel 1/20 ..... 250, 261, 274
junel fe 1.5/30 ..... 250, 261, 274
junel fe 1/20 ..... 250, 261, 274
junel fe 24 ..... 250, 261, 274
JUST RIGHT 5000 ..... 179, 300
JUXTAPID 100, 117
JYLAMVO 54, 287, 306, 312, 315
K.B.G.L IN TERODERM 74, 160, 346, 363, 367
kaitlib fe 250, 261, 274
KALETRA 38
kalliga 250, 261, 274
KALYDECO 329
KAPSPARGO SPRINKLE 80, 102, 107, 110, 118
KARBINAL ER 19, 20, 331
kariva 250, 261, 274
KATERZIA 113, 124
kelnor 1/35 ..... 250, 261, 274
KEPPRA 133
KEPPRA XR 133
KERENDIA 117
KESIMPTA 291, 312
ketoconazole 30, 348
ketodan 30, 348
KETO-DIASTIX 194
KETONE CARE 194
ketorolac tromethamine 160, 170, 221
KETORUB 363
KETOSTIX 194
KEVZARA 290, 306
KHINDIVI 217, 240, 354
KINERET 290, 306, 312
KISQALI (200 MG DOSE) 54
KISQALI (400 MG DOSE) 54
KISQALI (600 MG DOSE) 54
KLARON 343
klayesta 44, 363
KLISYRI (250 MG) 340, 367
KLISYRI (350 MG) 340, 367
klor-con 201
klor-con 10 201
klor-con m10 201
klor-con m15 201
klor-con m20 201
KLOXXADO 17, 164
KOATE 88
KOATE-DVI 88
KOMZIFTI 54
KOSELUGO 54
KOURZEQ 354
KOVALTRY 88
K-PHOS 201
K-PHOS NO 2 195
K-PHOS-NEUTRAL 201
KRAZATI 55
KRINTAFEL 26
KRISTALOSE 195
KT TAPE CGM PATCH 189
kurvelo 250, 261, 274
KYGEVVI 318
KYZATREX 243, 244
labetalol hcl 75, 77, 96, 102, 107, 110, 118
lacosamide 133, 155
lactulose 196
lactulose encephalopathy 196
LAGEVRIO 42
LAMICTAL 134, 138
LAMICTAL ODT 134, 138
LAMICTAL STARTER 134, 138
LAMICTAL XR 134, 139
lamivudine 37
lamivudine-zidovudine 37
lamotrigine 134, 139
lamotrigine er 134, 139
lamotrigine odt 134, 139
lamotrigine starter kit-blue 134, 139
lamotrigine starter kit-green 134, 139
lamotrigine starter kit-orange 134, 139
LAMPIT 27
LANCETS 189
LANCETS 28G THIN 189
LANCETS SUPER THIN 189
LANOXIN 100, 107
lansoprazole 235
lanthanum carbonate 200, 296

LANTUS SOLOSTAR 268
LANTUS U-100 VIAL 268
lapatinib ditosylate 55
larin 1.5/30 ..... 250, 261, 274
larin 1/20 ..... 250, 261, 274
larin 24 fe 250, 261, 274
larin fe 1.5/30 ..... 250, 261, 274
larin fe 1/20 ..... 251, 261, 274
LASIX 95, 116, 199
LASIX ONYU 95, 199
LATANOPROST 223
latanoprost 223
laxative osmotic 228
LAZCLUZE 55
lederle leucovorin ... 18, 296, 373
LEDIPASVIR-SOFOSBUVIR 32, 33
leflunomide 291, 306, 312, 315
lenalidomide 55, 312
LENVIMA 55
LEQEMBI IQLIK 291
lessina 251, 261, 274
letrozole 55, 244
LETS 69, 295
leucovorin calcium . 18, 296, 373
LEUKERAN 55
LEUKINE 84
leuprolide acetate 55, 266
levalbuterol hcl 79, 337
LEVALBUTEROL HFA 79, 337
LEVBID 17, 71, 324
levetiracetam 134
LEVETIRACETAM 135
levetiracetam er 134
levobunolol hcl 213
levocarnitine 318
levocarnitine sf 318
levocetirizine dihydrochloride 21
levofloxacin 29, 45, 209, 343
levonest 251, 261, 274
levonorgest-eth estrad 91-day 251, 261, 274
levonorgest-eth estradiol-iron 251, 261, 274
levonorgestrel 244, 251, 274
levonorgestrel-ethinyl estrad 251, 261, 274
levonorg-eth estrad triphasic 251, 261, 274
levorphanol tartrate 162
LEVOTHYROXINE SODIUM .. 283
levothyroxine sodium 283
levoxyl 283
LEVSIN 17, 71, 324
LEVSIN/SL 17, 71, 324
LEVULAN KERASTICK .. 340, 367
l-glutamine 318, 367
lidocaine 346
lidocaine hcl 222, 346
lidocaine hcl urethral/mucosal 346
lidocaine viscous hcl 222
lidocaine-prilocaine 346
LIDTOPIC MAX 346
LIFYORLI (125 MG DOSE) 55
LIFYORLI (150 MG DOSE) .55, 56
LIKMEZ 23, 27, 41, 227, 343
linezolid 43, 44
LINZESS 224, 232
liomny 283
liothyronine sodium 283
LIPOFEN 115
liraglutide 130, 266
liraglutide -weight management 131, 266
lisdexamfetamine dimesylate 127
lisinopril 99
lisinopril-hydrochlorothiazide 99, 204
L-ISOLEUCINE 197
LITFULO 358, 367
lithium 139
lithium carbonate 139
lithium carbonate er 139
LITHOBID 139
LITHOSTAT 196
LIVALO 116
LIVDELZI 229
LIVMARLI 229, 232
LIVTENCITY 29
LO LOESTRIN FE ... 251, 261, 275
LODOCO 82, 318
lofexidine hcl 69
lojaimiess 251, 261, 275
LOKELMA 200
LOMAIRA 126
LOMOTIL 71, 225
lomustine 56
LONSURF 56
LOPID 115
lopinavir-ritonavir 38
LOPRESSOR 80, 102, 110
lorazepam 147, 148
lorazepam intensol 147, 148
LORBRENA 56
LOREEV XR 147, 149
loryna 251, 261, 275
losartan potassium 97, 98
losartan potassium-hctz .98, 204
LOTEMAX 217
LOTEMAX SM 217
LOTENSIN 99, 100
LOTENSIN HCT 100, 204
loteprednol etabonate 217
loteprednol-tobramycin 209, 217
lovastatin 116
low-ogestrel 251, 261, 275
loxapine succinate 143, 151
lo-zumandimine 251, 261, 275
lubiprostone 224, 232
LUGOLS STRONG IODINE 347, 362
luizza 1.5/30 ..... 251, 262, 275
luizza 1/20 ..... 251, 262, 275
LULICONAZOLE 348
LUMAKRAS 56
LUMIGAN 223
LUMRYZ 150, 176, 297
LUMRYZ STARTER PACK 176, 297
LUPKYNIS 293, 315
lurasidone hcl 145
LURBIRO 160, 170, 221
lutera 251, 262, 275
LUZU 348
lyleq 251, 275
lyllana 262, 299
LYNKUET 150
LYNPARZA 56
LYRICA 135, 152, 153
LYSODREN 56
LYTGOBI (12 MG DAILY DOSE) 56
LYTGOBI (16 MG DAILY DOSE) 56
LYTGOBI (20 MG DAILY DOSE) 56
LYUMJEV KWIKPEN 280
LYUMJEV VIAL 280
lyza 251, 275
macitentan 124, 330, 337
MACROBID 47
magnesium citrate 228
MALARONE 26
malathion 364
MALTOCARB 197
maraviroc 34

marlissa 251, 262, 275
MARPLAN 156
MATULANE 56
matzim la 104, 105, 112, 124
MAVENCLAD 56, 285, 312, 315
MAVYRET 33, 34
MAXIDEX 217
MAXITROL 209, 217
maxi-tuss ac 326, 330
MAYZENT 292, 293, 312
MAYZENT STARTER PACK 293, 312
me/naphos/mb/hyo1 ..... 47, 71, 318
meclofenamate sodium 160, 170
MEDERMA SPF 30 367
MEDROL 240
medroxyprogesterone acetate 251, 275
mefenamic acid 160, 170
mefloquine hcl 26
megestrol acetate 56, 275
MEKINIST 57
MEKTOVI 57
meleya 251, 275
MELOXICAM 160, 170
meloxicam 160, 170
memantine hcl 150, 151
memantine hcl er 150
memantine hcl-donepezil hcl er 77, 151
MENOPUR 266
MENOSTAR 262, 299
MENQUADFI 66
MENVEO 66
meperidine hcl 162
meprobamate 143, 157
mercaptopurine 57, 288, 315
mesalamine 226, 227
mesalamine-cleanser 227
mesna 321
MESNEX 321
MESTINON 77
metaxalone 73
metformin hcl 246
metformin hcl er 246
methadone hcl 162
methadone hcl intensol 162
METHADOSE 162
methadose 162
METHADOSE SUGAR-FREE 162
methamphetamine hcl 128
methazolamide 94, 106, 213
methenamine hippurate 47
methenamine mandelate 47
METHERGINE 323
methimazole 246
METHITEST 243
methocarbamol 35, 73
methotrexate sodium 57, 287, 306, 312, 316
methotrexate sodium (pf) 57, 287, 306, 312, 315
methoxsalen rapid 363
methscopolamine bromide 71
methsuximide 174
methyl salicylate 349
methyldopa 69, 108, 114
methylergonovine maleate 323
METHYLIN 168
methylphenidate 169
METHYLPHENIDATE ER 168
methylphenidate hcl 169
methylphenidate hcl er 169
methylphenidate hcl er (cd) 168
methylphenidate hcl er (la) 168
methylphenidate hcl er (osm) 169
methylphenidate hcl er (xr) 169
methylprednisolone 240
methyltestosterone 243
metoclopramide hcl 234
metolazone 96, 122, 205
METOPIRONE 194
metoprolol succinate er 80, 102, 108, 110, 118
metoprolol tartrate 80, 102, 108, 110, 118
metoprolol-hydrochlorothiazide 102, 108, 204
metronidazole 23, 27, 28, 41, 227, 343
metyrosine 194, 318
mexiletine hcl 109
MIACALCIN 245, 299
mibelas 24 fe 251, 262, 275
miconazole 3 348
MICONAZOLE-ZINC OXIDE-PETROLAT 347, 348, 356
microgestin 1.5/30 ..... 251, 262, 275
microgestin 1/20 ..... 251, 262, 275
microgestin fe 1.5/30 ..... 251, 262, 275
microgestin fe 1/20 251, 262, 275
MICROLET NEXT LANCETS 189
MICROLET NEXT LANCING DEVICE 189
midazolam hcl 149
MIDAZOLAM+SYRSPEND SF 149
midodrine hcl 69
MIEBO 212, 220
MIFEPREX 323
mifepristone 244, 323
MIGERGOT 76, 142, 169
miglitol 242
miglustat 206, 318
mili 252, 262, 275
milnacipran hcl 153, 172
milophene 256
mimvey 262, 275
MINIMED INSTINCT GLUC SENSOR 189
minocycline hcl 26, 46, 47, 210, 343
minocycline hcl er 26, 46, 210, 343, 367
minoxidil 115, 350
minzoya 252, 262, 275
MIPLYFFA 206
mirabegron er 370
mirtazapine 137, 174
MIRVASO 208, 340, 367
misoprostol 235
MITIGARE 297
MITOSOL 210
mm aspirin 93, 94, 142, 171
mm clearlax 228
M-M-R II 66
M-NATAL PLUS 90, 371, 373
MNEXSPIKE 66
MOBILE LANCETS 30G 189
modafinil 177
MODEYSO 57
moexipril hcl 99, 100
molindone hcl 143, 151
mometasone furoate 217, 240, 327, 332, 354
mono-linyah 252, 262, 275
MONSELS FERRIC SUBSULFATE 88
montelukast sodium 331
morphine sulfate 162
morphine sulfate (concentrate) 162
morphine sulfate er 162
morphine sulfate er beads 162
MOTPOLY XR 135, 155

MOUNJARO 266
MOVIPREP 228, 375
moxifloxacin hcl 29, 45, 210, 343
moxifloxacin hcl (2x day) 45, 210
MOZOBIL 85
MUCOSITISRX 220
MULPLETA 85
MULTAQ 111
multivitamin w/fluoride 177, 179, 300, 371
multivitamin/fluoride 177, 179, 300, 301, 371, 373
multi-vitamin/fluoride 177, 179, 301, 371
multi-vitamin/fluoride/iron 90, 301, 371
mupirocin 343
mupirocin calcium 343
my choice 244, 252, 275
my way 244, 252, 275
MYALEPT 268
mycophenolate mofetil . 285, 316
mycophenolate sodium 316
mycophenolic acid 316
MYDAYIS 128
MYFEMBREE 244, 262, 276
MYHIBBIN 316
MYLERAN 57
MYRBETRIQ 370
MYSOLINE 146
MYTESI 225
MYXREDLIN 201, 280
na sulfate-k sulfate-mg sulf . 228
nabumetone 160, 170
nadolol 75, 80, 96, 102, 108, 110, 118
naftifine hcl 340
NAFTIN 340
naloxone hcl 17, 18, 164, 296
naltrexone hcl 16, 18, 68, 164, 295, 296
NAMZARIC 77, 151
naproxen 142, 160, 170, 297
naproxen dr ... 142, 160, 170, 297
naproxen sodium 142, 160, 170, 297
naproxen sodium er 142, 160, 170, 297
naratriptan hcl 173
NARCAN 17, 164
NARDIL 156
NASCOBAL 92, 373
NATACYN 211
NATAL PNV 90, 371, 373
NATAZIA 252, 262, 276
nateglinide 268
NAYZILAM 147, 149
nebivolol hcl 75, 102, 108, 110
NEBUPENT 28
NEBUSAL 332
necon 0.5/35 (28) ... 252, 262, 276
nefazodone hcl 174
NEFFY 69
NEMLUVIO 357
NEOCATE SYNEO JUNIOR ... 197
neomycin sulfate 23, 210, 343
neomycin-bacitracin zn-polymyx 210
neomycin-polymyxin-dexameth 210, 217
neomycin-polymyxin-gramicidin 210
neomycin-polymyxin-hc 210, 217, 218
NEONATAL COMPLETE 90, 371, 373
NEONATAL PLUS 90, 371, 374
NEO-SYNALAR 343, 354
NEOTUSS PLUS .. 20, 21, 69, 326
NERLYNX 57
NESTABS 91, 371, 374
NESTABS ONE 90, 318, 371, 374
neuac 40, 343, 362
NEULASTA 85
NEUPRO 158
NEURAPTINE 129, 153
NEURONTIN ... 129, 135, 153, 154
NEURORUB 129, 154
NEVANAC 221
nevirapine 36
nevirapine er 35
new day 244, 252, 276
NEXLETOL 96, 100
NEXLIZET 96, 100, 108
NEXTSTELLIS 252, 262, 276
NGENLA 270
niacin er (antihyperlipidemic) 101, 374
nicardipine hcl 113, 114, 124
NICORETTE 68, 73
NICORETTE MINI 68, 73
nicotine 68, 73
nicotine mini 68, 73
nicotine polacrilex 68, 73
nicotine polacrilex mini 68, 73
nicotine step 1 ..... 68, 73
nicotine step 2 ..... 68, 73
nicotine step 3 ..... 68, 73
NICOTROL NS 68, 73
nifedipine 113, 114, 124
nifedipine er 113, 114, 124
nifedipine er osmotic release 113, 114, 124
nikki 252, 262, 276
nilotinib hcl 57
nimodipine 113, 114, 124
NIMODIPINE 113, 114, 124
NINLARO 57
nintedanib esylate 325
nisoldipine er 113, 114
nitazoxanide 27, 28
nitro-bid 118, 119
NITRO-DUR 118, 119
nitrofurantoin 47
nitrofurantoin macrocrystal ... 47
nitrofurantoin monohydrate macrocrystals 47
nitroglycerin .. 118, 119, 349, 367
NITROSTAT 118, 119
NITRO-TIME 119
NIVA THYROID 283
NIVESTYM 85
nizatidine 20, 234
nora-be 252, 276
NORDIPEN 5 INJECTION DEVICE 189
NORDITROPIN FLEXPRO 270, 281
norelgestromin-eth estradiol 252, 262, 276
norethin ace-eth estrad-fe 252, 262, 276
norethindrone 252, 276
norethindrone acetate 276
norethindrone acet-ethinyl est 252, 262, 276
norethindrone-eth estradiol 262, 276
norgestimate-eth estradiol 252, 263, 276
norgestimate-ethinyl estradiol triphasic . 252, 263, 276
NORLIQVA 113, 114, 124
norlyroc 252, 276
NORPACE 109
NORPRAMIN 175
nortrel 0.5/35 (28) .. 252, 263, 276
nortrel 1/35 (21) 252, 263, 276
nortrel 1/35 (28) 252, 263, 276

nortrel 7/7/7 .....252, 263, 276
nortriptyline hcl 175
NORVIR 38
NOURIANZ 126, 151
NOVAREL 266
NOVOEIGHT 88
NOVOFINE PEN NEEDLE 189
NOVOFINE PLUS PEN NEEDLE 189
NOVOPEN ECHO 189
NOVOSEVEN RT 88
NOXAFIL 30
np thyroid 283
NUBEQA 57
NUCALA 325
NUCORT 218, 240, 354
NUCYNTA 163
NUCYNTA ER 163
NUEDEXTA 151
NULEV 17, 71, 324
NUPLAZID 145
NURTEC 149
NUVESSA 23, 41, 343
NUWIQ 88
NUZYRA 24
nylia 1/35 .....252, 263, 276
nylia 7/7/7 .....252, 263, 276
NYMALIZE 113, 114, 124
nystatin 44, 363, 364
nystatin-triamcinolone 44, 354, 364
nystop 44, 364
OBIZUR 88
octreotide acetate 232, 281
OCUFLOX 45, 210
ODACTRA 63
ODEFSEY 36, 37, 42
ODOMZO 57
ofloxacin 45, 210
OGSIVEO 57
OHTUVAYRE 323
OJEMDA 57, 58
OJJAARA 58
olanzapine 139, 145, 225, 226
olanzapine-fluoxetine hcl 139, 145, 174, 226
olmesartan medoxomil 97, 98
olmesartan medoxomil-hctz 98, 204
olmesartan-amlodipine-hctz 98, 113, 204
olopatadine hcl 20, 208
OLUMIANT 291, 306
omega-3-acid ethyl esters 101, 120
omeprazole 235
OMNARIS 218, 240, 327
OMNIFLEX DIAPHRAGM 322
OMNIPOD 5 DEXG7G6 INTRO GEN 5 189
OMNIPOD 5 DEXG7G6 PODS GEN 5 189
OMNIPOD 5 LIBRE INTRO 189
OMNIPOD 5 LIBRE PODS 189
OMNITROPE 270, 282
OMVOH 224
OMVOH (300 MG DOSE) 224
ON/GO COVID-19 ANTIGEN TEST 194
ON/GO ONE COVID-19 HOME TEST 194
ondansetron hcl 225
ondansetron odt 225
ONE VITE WOMENS PLUS 91, 371, 374
ONENATAL RX .91, 202, 371, 374
ONETOUCH DELICA PLUS LANCING 190
ONETOUCH DELICA SAFETY LANCING 190
ONETOUCH ULTRA 190
ONETOUCH VERIO 190
ONEXTON 40, 343, 362
ONFI 147, 149
ONGENTYS 150
ONTRALFY 74
ONUREG 58
ONYDA XR 70
ONZETRA XSAIL 173
opcicon one-step .. 244, 252, 276
OPFOLDA 206, 318
OPILL 252, 276
opium 163, 225
option 2 .....245, 253, 277
OPTIONS GYNOL II CONTRACEPTIVE 322
OPVEE 164
OPZELURA 58, 359, 367
ORACIT 195
ORALAIR 63
ORALAIR ADULT STARTER PACK 63
ORALAIR CHILDRENS STARTER PACK 63
ORALONE 354
ORAPRED ODT 218, 240
ORAVIG 348
ORENCIA 286, 306, 313
ORENCIA CLICKJECT 286, 306, 313
ORENITRAM .. 124, 125, 334, 338
ORENITRAM MONTH 1 ..... 124, 334, 337
ORENITRAM MONTH 2 ..... 124, 334, 337
ORENITRAM MONTH 3 ..... 124, 334, 338
ORFADIN 206, 319
ORGOVYX 58, 245
ORIAHNN 245, 263, 277
ORILISSA 245
ORKAMBI 328, 329
ORLISTAT 232
ORLYNVAH 47, 205, 297
orphenadrine citrate er 74, 80, 132
orquidea 253, 277
ORSERDU 58
OSCIMIN 17, 71, 324
oseltamivir phosphate 40
OSPHENA 256
OTEZLA 292, 307, 313, 367
OTEZLA XR 292
OTEZLA/OTEZLA XR INITIATION PK 292
OVIDE 364
OVIDREL 266
oxaprozin 160, 170
oxazepam 149
oxcarbazepine 135, 155
OXERVATE 212, 220
oxiconazole nitrate 348
OXISTAT 348
oxybutynin chloride 369
oxybutynin chloride er 369
oxycodone hcl 163
oxycodone-acetaminophen 129, 159, 163
OXYCODONE-ACETAMINOPHEN .129, 159, 163
oxymetazoline hcl . 223, 340, 367
oxymorphone hcl 163
oxymorphone hcl er 163
OZEMPIC 266, 267
OZOBAX DS 74
PACERONE 111
paliperidone er 145
PALYNZIQ 207
PANCREAZE 207, 230

PANRETIN 340, 367
pantoprazole sodium 235
PARI VORTEX ADULT MASK 190
PARI VORTEX PEDIATRIC MASK 190
paricalcitol 376
PARNATE 156
paroxetine hcl 174
paroxetine hcl er 174
paroxetine mesylate 174
PAXLOVID (150/100) 29, 30
PAXLOVID (300/100 & 150/100) 29, 31
PAXLOVID (300/100) 29, 31
pazopanib hcl 58
PEDIARIX 64, 66
PEDVAXHIB 66
peg 3350 228
peg 3350-kcl-na bicarb-nacl . 228
peg-3350/electrolytes 228
peg-3350/electrolytes/ascorbat 228, 375
PEGASYS 38, 39, 58, 289, 313
peg-kcl-nacl-nasulf-na asc-c 229, 375
PEG-PREP 229
PEMAZYRE 58
PEN NEEDLE/5-BEVEL TIP ... 190
PENBRAYA 66
penciclovir 347
penicillamine 17, 236, 307
penicillin v potassium 40
PENMENVY 66
PENTACEL 64, 66
pentamidine isethionate 28
pentazocine-naloxone hcl 164, 166
pentoxifylline er 85
PEPTICATE 197
perampanel 135
PERFECT POINT SAFETY LANCETS 190
PERFECT POINT SAFETY NEEDLE 190
PERFOROMIST 79, 337
PERIDEX .. 23, 211, 212, 347, 362
perindopril erbumine 99, 100
periogard . 23, 211, 212, 348, 362
permethrin 364
perphenazine 167
perphenazine-amitriptyline 167, 175
PERTZYE 207, 230
phenazopyridine hcl 346
phendimetrazine tartrate 126
phendimetrazine tartrate er .. 126
phenelzine sulfate 156
phenobarbital 146, 147
phenoxybenzamine hcl .. 76, 122
phentermine hcl 126
phentermine-topiramate er .. 130
PHENYLADE ESSENTIAL DRINK MIX 197
PHENYLADE GMP MIX DHA/FIBER 197
PHENYLADE GMP MIX-IN 197
PHENYLADE GMP ULTRA 197
PHENYLADE60 DRINK MIX ... 197
phenylephrine hcl 222, 223
phenytek 109, 154
phenytoin 109, 154
phenytoin infatabs 109, 154
phenytoin sodium extended 109, 154
PHEXX 322
philith 253, 263, 277
PHOSPHA 250 NEUTRAL 202
PHOSPHOLINE IODIDE 222
phosphorous 202
phospho-trin 250 neutral 202
PHOXILLUM B22K4/0 202
PHOXILLUM BK4/2.5 202
phytonadione 17, 296, 376
PIFELTRO 36
pilocarpine hcl 77, 222
PILOT COVID-19 AT-HOME TEST 194
pimecrolimus 316, 357, 367
pimozide 143, 152
pimtrea 253, 263, 277
pindolol 75, 102, 108, 110, 119
pioglitazone hcl 283
pioglitazone hcl-glimepiride 282, 283
pioglitazone hcl-metformin hcl 246, 283
PIP GLUCOSE CONTROL SOLUTION 190
PIQRAY 58
pirfenidone 325, 335
piroxicam 160, 171
pitavastatin calcium 116
PIVOT SUPPLY KIT 190
PIVYA 24
PKU COOLER 10 197
PKU COOLER 15 198
PKU COOLER 20 198
PKU EASY MICROTABS 198
PKU EASY MICROTABS PLUS 198
PKU EASY SHAKE & GO 198
PKU GOLIKE 10G P.E. 198
PKU GOLIKE PLUS 16+ 198
PKU GOLIKE PLUS 4-16 198
PKU PERIFLEX EARLY YEARS 198
PKU START 198
pku trio 198
PLAN B ONE-STEP 245, 253, 277
PLEGRIDY 313
PLEGRIDY STARTER PACK . 313
plerixafor 85
PLEXION 344, 360
PLEXION CLEANSER 344, 360
PLEXION CLEANSING CLOTH 344, 360
PNEUMOVAX 23 66
pnv 27-ca/fe/fa 91, 371, 374
PODOCON-25 ..... 360, 367
podofilox 360, 367
polyethylene glycol 3350 229
polymyxin b-trimethoprim 44, 210, 344
POLY-VI-FLOR 177, 179, 301, 371
POLY-VI-FLOR/IRON 91, 301, 371
pomalidomide 58, 313
portia-28 ..... 253, 263, 277
posaconazole 30
potassium chloride 202
potassium chloride crys er .. 202
potassium chloride er 202
potassium citrate er 195
potassium citrate-citric acid 195
potassium iodide (expectorant) 330
PRADAXA 83
pramipexole dihydrochloride 158
PRAMOSONE 346, 354, 355
PRAMOTIC 211, 222
prasugrel hcl 93
pravastatin sodium 116
praziquantel 25
prazosin hcl 76, 96, 102

PRED MILD 218, 240
prednisolone 218, 240
prednisolone acetate 218, 240
prednisolone sodium phosphate 218, 240
prednisone 240, 241
prednisone intensol 240
pregabalin 135, 153, 154
pregabalin er 129, 153, 154
PREGNYL 266
PREKUNIL 198
PREMARIN 263, 299
PREMESISRX 202, 319, 371, 374
PREMPHASE 263, 277
PREMPRO 263, 277
prenatal 91, 371, 374
PRENATE 202, 372, 374
PRENATE DHA 91, 202, 319, 372, 374
PRENATE ELITE 91, 372, 374
PRENATE ENHANCE 91, 202, 319, 372, 374
PRENATE ESSENTIAL 91, 202, 319, 372, 374
PRENATE MINI 91, 202, 319, 372, 374
PRENATE PIXIE 91, 202, 319, 372, 374
PRENATE RESTORE 91, 202, 319, 372, 374
PREPIDIL 323
PRETOMANID 29
prevalite 103
PREVIDENT 178, 180, 301
PREVIDENT 5000 BOOSTER PLUS 179, 301
PREVIDENT 5000 DRY MOUTH 177, 179, 301
PREVIDENT 5000 ENAMEL PROTECT 179, 301
PREVIDENT 5000 KIDS . 179, 301
PREVIDENT 5000 ORTHO DEFENSE 180, 301
PREVIDENT 5000 PLUS 178, 180, 301
PREVIDENT 5000 SENSITIVE 180, 301
PREVNAR 20 66
PREVYMIS 29
PREZCOBIX 38, 319
PREZISTA 38
PRIFTIN 29, 45
PRILOSEC 235
primaquine phosphate 26
primidone 146
PRIORIX 66
PRISMASOL B22GK 4/0 203
PRISMASOL BGK 0/2.5 203
PRISMASOL BGK 2/0 203
PRISMASOL BGK 2/3.5 203
PRISMASOL BGK 4/0/1.2 203
PRISMASOL BGK 4/2.5 203
PRISMASOL BK 0/0/1.2 203
probenecid 205, 297
PROCENTRA 128
prochlorperazine 167, 226
prochlorperazine maleate 167, 226
PROCORT 218, 241, 346, 355
PROCTOCORT 218, 241, 355
PROCTOFOAM HC 218, 241, 346, 355
procto-med hc 218, 241, 355
PROCTOSOL HC ... 218, 241, 355
PROCTOZONE-HC 218, 241, 355
PROCYSBI 319
PROFILNINE 88
progesterone 277
PROGESTERONE MICRONIZED 277
PROGLYCEM 245
PROGRAF 285, 316, 357
PROLATE 129, 159, 163
PROLENSA 221
PROMACTA 85
promethazine hcl 18, 20, 21, 143, 226, 230, 331
promethazine-codeine 20, 21, 326
promethazine-dm 20, 21, 326
promethazine-phenylephrine 20, 21, 70
PROMETHEGAN 20, 21, 144, 226, 230, 331
PRONAL 349, 360
propafenone hcl 109
propafenone hcl er 109
proparacaine hcl 222
propranolol hcl 75, 102, 108, 110, 119, 142
propranolol hcl er 75, 102, 108, 110, 119, 142
propylthiouracil 246
PROQUAD 66
PRO-STAT/FIBER 198
PROTONIX 235
protriptyline hcl 175
PROVERA 277
prucalopride succinate 232
PRURADIK 364
pseudoephedrine-bromphen-dm 20, 21, 69, 326
PULMOSAL 332
PULMOZYME 207, 332
PURE COMFORT SAFETY LANCET 30G 190
PURE COMFORT SAFETY PEN NEEDLE 190
PURIXAN 58, 288, 316
PYLERA 25, 28, 47, 225, 227
pyrazinamide 29
PYRIDIUM 346
pyridostigmine bromide 77
pyridostigmine bromide er 77
PYRIDOSTIGMINE BROMIDE ER 77
pyrimethamine 26
PYROGALLIC ACID 323, 360, 368
PYRUKYND 82
PYRUKYND TAPER PACK 82
QBRELIS 100
QFITLIA 88
QINLOCK 58
QNASL 218, 241, 327, 332
QNASL CHILDRENS 218, 241, 327, 332
QSYMIA 130
QUADRACEL 64, 67
QUESTRAN 103
QUESTRAN LIGHT 103
quetiapine fumarate 140, 145
quetiapine fumarate er . 140, 145
QUICK TOUCH INSULIN PEN NEEDLE 190
QUICKVUE AT-HOME COVID-19 TEST 194
QUILLICHEW ER 169
QUILLIVANT XR 169
quinapril hcl 99, 100
quinapril-hydrochlorothiazide 100, 204
quinidine gluconate er 27, 109
quinidine sulfate 27, 109
quinine sulfate 27
QULIPTA 149
QVAR REDIHALER 241, 327, 333
RABEPRAZOLE SODIUM 235
rabeprazole sodium 235
RADICAVA ORS 125, 151

RADICAVA ORS STARTER KIT 126, 151
RADIOGARDASE 18, 199, 296
RAGWITEK 63
RALDESY 174
raloxifene hcl 256, 299
ramelteon 144, 156
ramipril 99, 100
ranolazine er 106
rasagiline mesylate 156
RASUVO 287, 307
RAYA SURE PEN NEEDLE ... 190
REAL FOOD BLENDS 198
reclipsen 253, 263, 277
RECOMBINATE 88
RECOMBIVAX HB 67
RECOTHROM 89
RECOTHROM SPRAY KIT 89
RECTIV 119, 349, 368
REFRESH AA 15 PKU 198
REGLAN 234
RELENZA DISKHALER 40
RELION GLUCOSE TEST STRIPS 193
RELISTOR 164, 165, 224, 233
RELNATE DHA 91, 319, 372, 374
RENASTART 198
RENTHYROID 283
repaglinide 268
REPATHA SURECLICK 120
RESTASIS 212, 220, 285
RESTASIS MULTIDOSE 212, 220, 285
RESTORIL 149
RETACRIT 81, 85
RETEVMO 59
RETIN-A MICRO PUMP ... 59, 350
RETROVIR 37
REVUFORJ 59
REXTOVY 17, 165
REXULTI 145
REYATAZ 38
REZDIFFRA 233, 283
REZENOPY 17, 165
REZLIDHIA 59
REZUROCK 319
RHAPSIDO 314, 357
RHOFADE 223, 340, 368
RHOPRESSA 223
ribavirin 42
RIDAURA 236, 287, 307, 314
rifabutin 29, 45
rifampin 29, 45
RIFAMPIN+SYRSPEND SF 29, 45
rilpivirine hcl 36
riluzole 126, 151
rimantadine hcl 22
RINVOQ 291, 307
RINVOQ LQ 291
risedronate sodium 299
risperidone 140, 145
ritonavir 38
rivaroxaban 83
rivastigmine 77
rivastigmine tartrate 77
rivelsa 253, 263, 277
RIVFLOZA 319
RIVIVE 17, 165
RIXUBIS 89
rizatriptan benzoate 173
ROCKLATAN 223
roflumilast 333, 359, 363
ROMVIMZA 59
ropinirole hcl 158
ropinirole hcl er 158
rosuvastatin calcium 116
rosyrah 253, 263, 277
ROTARIX 67
ROTATEQ 67
ROWASA 227
roweepra 135
ROZLYTREK 59
RUBRACA 59
RUCONEST 302, 303
rufinamide 135, 155
RUKOBIA 34
RYALTRIS 20, 208, 218, 241, 328, 332
RYBELSUS 267
RYCLORA 20, 21
RYDAPT 59
sacubitril-valsartan ... 97, 98, 122
SAFETY PEN NEEDLES 190
SALAGEN 77, 222
SALICATE 360
salicylic acid 360
salsalate 171
SALVAX DUO PLUS 349, 360
SAMSCA 205
SANDOSTATIN 233, 281
SANTYL 207, 349, 368
sapropterin dihydrochloride 206, 319, 320
SAVAYSA 83
SAVELLA 153, 172
SAVELLA TITRATION PACK 153, 172
saxagliptin hcl 255
saxagliptin-metformin er 246, 255
SAXENDA 131, 267
SCALACORT DK 355, 360
SCARCIN 368
SCEMBLIX 59
scopolamine 71, 226, 234
SELECT-OB 91, 372, 374
selegiline hcl 156, 157
selenium sulfide 348, 362
SELZENTRY 34
SENSILANCE SAFETY LANCETS 21G 190
SENSILANCE SAFETY LANCETS 26G 190
SENSILANCE SAFETY LANCETS 28G 190
SEPHIENCE 206
SEREVENT DISKUS 79, 337
SERNIVO 241, 355
SEROQUEL XR 140, 145
SEROSTIM 270, 282
sertraline hcl 174
setlakin 253, 263, 277
sevelamer carbonate 18, 200, 296
SEVENFACT 89
sevoflurane 155
sf 178, 180, 301
sf 5000 plus 178, 180, 301
sharobel 253, 277
SHARPS COLLECTOR 190
SHARPS CONTAINER 190
shewise 245, 253, 277
SIGNIFOR 281
sildenafil citrate 120, 121, 334, 338, 370
SILENOR 175, 346
silodosin 77
SILVADENE 348, 362
silver nitrate 211
silver sulfadiazine 348, 362
SIMBRINZA 208, 213
simliya 253, 263, 277
simpesse 253, 263, 277
SIMPLERA SYNC SENSOR ... 190
SIMPONI 233, 294, 307, 308, 314
simvastatin 116
SINEMET 152
SINGULAIR 331

sirolimus 292, 316, 357
SIRTURO 29
SITAGLIPT BASE-METFORM HCL ER 246, 247, 255
SITAGLIPTIN 255
SITAGLIPTIN BASE-METFORMIN HCL 247, 255
sitagliptin phos-metformin hcl 247, 255
sitagliptin phosphate 255
SIVEXTRO 44
SKYCLARYS 320
SKYRIZI 233, 358, 368
SKYRIZI PEN 357, 368
SKYTROFA 270
SLYND 245, 253, 277
smooth lax 229
SOAANZ 95, 116, 199
sod citrate-citric acid 195
sod fluoride-potassium nitrate 180, 301
sodium chloride 332
sodium fluoride 178, 180, 302
sodium fluoride 5000 enamel 180, 301
sodium fluoride 5000 plus 178, 180, 302
sodium fluoride 5000 ppm 178, 180, 302
sodium fluoride 5000 sensitive 180, 302
sodium oxybate 151, 177, 297
sodium phenylbutyrate 196
sodium polystyrene sulfonate 18, 200, 296
sodium sulfacetamide 344
sodium sulfacetamide wash 344
SOFOSBUVIR-VELPATASVIR 32, 34
SOGROYA 270
SOHONOS 320
solifenacin succinate 369
SOLIQUA 267, 268
SOLOSEC 28
SOLTAMOX 59, 256
SOMAVERT 282
SOOLANTRA 364
sorafenib tosylate 59
sotalol hcl 75, 102, 108, 110, 111, 119
sotalol hcl (af) 75, 102, 108, 110, 111, 119
SOTYKTU 359, 368
SOTYLIZE 75, 102, 108, 110, 111, 119
SOVALDI 32, 33
SPEEDY SWAB COVID-19 ANTIGEN 194
SPEVIGO 358
SPIKEVAX 67
SPIKEVAX 6M-11Y 67
spinosad 364
SPIRIVA HANDIHALER 71, 325
SPIRIVA RESPIMAT 71, 325
spironolactone 95, 117, 121, 122, 201
spironolactone-hctz 95, 117, 122, 201, 204
SPORANOX 30
SPRAVATO (56 MG DOSE) 137, 157
SPRAVATO (84 MG DOSE) 137, 157
sprintec 28 ..... 253, 263, 277
SPRITAM 135
SPRIX 160, 171, 221
SPS (SODIUM POLYSTYRENE SULF) 18, 200, 296
ssd 348, 362
SSKI 330
sss 10-5 ..... 344, 360
ST JOSEPH LOW DOSE 93, 94, 142, 171, 172
STARJEMZA 290
STENDRA 120, 121
STEQEYMA 290
STIOLTO RESPIMAT 72, 79
STIVARGA 59
STRENSIQ 207
STRIBILD 35, 37, 320
STRIVERDI RESPIMAT 79, 337
STROMECTOL 25
SUBOXONE 165, 166
SUBVENITE 135, 140
subvenite 135, 140
subvenite starter kit-blue 135, 140
subvenite starter kit-green 135, 140
subvenite starter kit-orange 135, 140
SUCRAID 207
sucralfate 235
SUFLAVE 229
SULAR 113, 114
SULCONAZOLE NITRATE 348, 349
sulfacetamide sodium 210, 344
sulfacetamide sodium (acne) 344
sulfacetamide sodium (cleans) 344
sulfacetamide sodium-sulfur 344, 360
sulfacetamide sod-sulfur wash 344, 361
sulfacetamide-prednisolone 210, 218
sulfacetamide-sulfur in urea 344, 361
SULFACLEANSE 8/4 ..... 344, 361
sulfadiazine 45
sulfamethoxazole-trimethoprim 28, 46, 47
SULFAMYLON 344, 362
sulfasalazine 46, 227, 287, 308, 314
sulfatrim pediatric 28, 46, 47
sulfurated lime 364
sulindac 160, 171
sumatriptan 173
sumatriptan succinate 173
SUMAXIN 345, 361
SUMAXIN CP 344, 361
sunitinib malate 60
SUNLENCA 28, 34
SUNOSI 177
SUPREP BOWEL PREP KIT 229
SUTAB 229
syeda 253, 263, 277
SYMBICORT 79, 241
SYMDEKO 328, 329
SYMFI 36, 37
SYMPAZAN 147, 149
SYMPROIC 225, 233
SYMTUZA 37, 38, 320
SYNALAR 219, 355
SYNAPRYN FUSEPAQ 163
SYNAREL 266
SYNDROS 226, 233
SYNJARDY 247, 280
SYNJARDY XR 247, 280, 281
TABLOID 60
TABRADOL FUSEPAQ 74
TABRECTA 60
TACLONEX 350, 355, 368
tacrolimus 285, 316, 358, 368
tadalafil 120, 121, 334

tadalafil (pah) 120, 121, 334, 338
TADLIQ 120, 121, 334, 338
TAFINLAR 60
tafluprost (pf) 223
TAGRISSO 60
take action 245, 253, 277
TAKHZYRO 94, 316
TALZENNA 60
tamoxifen citrate 60, 256
tamsulosin hcl 78
TANLOR 74
tapentadol hcl 163
TAPERDEX 12-DAY 219, 241
TAPERDEX 6-DAY 219, 241
TAPERDEX 7-DAY 219, 241
tarina 24 fe 253, 263, 277
tarina fe 1/20 eq 253, 263, 278
TARPEYO 242
tasimelteon 144, 156
tavaborole 363
TAVALISSE 82
TAVNEOS 286, 302, 303
taysofy 253, 264, 278
tazarotene 361, 368
TAZAROTENE 361, 368
TAZORAC 361, 368
TECHLITE LANCETS 26G 190
TECHLITE PLUS PEN NEEDLES 191
TEGLUTIK 126, 151
TEGRETOL 135, 140
TEGRETOL-XR 136, 140
TEKTURNA 121
telmisartan 97, 98
telmisartan-amlodipine ... 98, 113
telmisartan-hctz 98, 204
temazepam 149
TEMBEXA 42
temozolomide 60
TENCON 129, 147, 159
TENIVAC 64
tenofovir disoproxil fumarate 37
TEPMETKO 60
terazosin hcl 76, 96, 97, 102
terbinafine hcl 23
terbutaline sulfate 79, 337
terconazole 349
teriflunomide 285, 314
TERIPARATIDE 268, 298
terrell 155
TESTIM 243, 245
testosterone 243, 245
testosterone cypionate .243, 245
TESTOSTERONE CYPIONATE 243, 245
testosterone enanthate 243, 245
tetrabenazine 176
tetracaine hcl 222, 295
tetracycline hcl .. 27, 47, 227, 345
TEXACORT 219, 242, 355
TEZRULY 76, 96
TEZSPIRE 331, 335
THALITONE 96, 122, 205
THALOMID 60, 314
THEO-24 .115, 169, 198, 339, 370
theophylline 115, 169, 199, 339, 370
theophylline er 115, 169, 199, 339, 370
thioridazine hcl 167
thiothixene 175
THROMBIN-JMI 89
THROMBIN-JMI EPISTAXIS 89
THROMBOGEN 89
THYQUIDITY 283
thyroid 283
tiadylt er . 104, 105, 106, 112, 125
tiagabine hcl 136, 154
TIAZAC ... 104, 105, 106, 112, 125
TIBSOVO 60
ticagrelor 93
TIGLUTIK 126, 151
TIKOSYN 111
tilia fe 253, 264, 278
timolol hemihydrate 75, 102, 110, 213
timolol maleate .. 75, 102, 108, 111, 119, 142, 213
timolol maleate (once-daily) 75, 102, 110, 213
timolol maleate ocudose 75, 102, 110, 213
timolol maleate pf 76, 102, 111, 213
TIMOPTIC OCUDOSE 76, 103, 111, 213
tinidazole 28
tiopronin 320
TIROSINT 284
TIROSINT-SOL 284
TISSEEL 350, 368
TIVICAY 35
TIVICAY PD 35
tizanidine hcl 74
TOBI NEBULIZER 23, 210
TOBI PODHALER 23, 210
TOBRADEX 23, 210, 219
TOBRADEX ST 23, 211, 219
tobramycin 24, 211
tobramycin-dexamethasone 24, 211, 219
TOBREX 24, 211
TODAY SPONGE 322
tofacitinib citrate 291, 308
tofacitinib citrate er 291, 308
TOLAK 60, 340, 368
tolcapone 150
tolterodine tartrate 369
tolterodine tartrate er 369
tolvaptan 205
tolvaptan (hyponatremia) 205
TONMYA 74, 153
TOPAMAX 136, 142
TOPAMAX SPRINKLE 136, 142
TOPFINE INSULIN PEN NEEDLE 191
TOPICORT 355
topiramate 136, 142
toremifene citrate 60, 256
torpenz 60, 288
torsemide 95, 116, 199
TOSYMRA 173
TOUJEO MAX SOLOSTAR 268
TOUJEO SOLOSTAR 268
tovet 355
TPOXX 29
TRACLEER 125, 330, 338
TRADJENTA 255
tramadol hcl 164
TRAMADOL HCL (ER BIPHASIC) 163
tramadol hcl (er biphasic) 163
tramadol hcl er 163
tramadol-acetaminophen 129, 159, 164
trandolapril 99, 100
trandolapril-verapamil hcl er 100, 106
tranexamic acid 89
tranylcypromine sulfate 157
travoprost (bak free) 223
trazodone hcl 174
TRELEGY ELLIPTA 72, 80, 219, 242, 328
TREMFYA 287, 358, 368
TREMFYA ONE-PRESS 287, 358, 368
TREMFYA PEN 287, 358

TREMFYA-CD/UC INDUCTION 287, 358
tretinoin 60, 61, 350
tretinoin microsphere 60, 350
tretinoin microsphere pump 61, 350
TRETTEN 89
TREXALL .. 61, 287, 308, 314, 316
TREZIX 129, 159, 164, 169
triamcinolone acetonide 242, 355, 356
triamterene 95, 121, 201
triamterene-hctz 201, 204
triazolam 149
TRICITRASOL 82
tricitrates 195
triderm 242, 356
trientine hcl 236
tri-estarylla 253, 264, 278
trifluoperazine hcl 167
trifluridine 212
trihexyphenidyl hcl 72, 132
TRIJARDY XR 247, 256, 281
TRIKAFTA 328, 329, 330
tri-legest fe 253, 264, 278
TRILEPTAL 136, 155
tri-linyah 253, 264, 278
trilitas 361, 368
tri-lo-estarylla 253, 264, 278
tri-lo-marzia 253, 264, 278
tri-lo-mili 253, 264, 278
tri-lo-sprintec 253, 264, 278
trimethobenzamide hcl 226
trimethoprim 47
tri-mili 253, 264, 278
trimipramine maleate 175
TRINATE 91, 372, 375
TRINTELLIX 174
TRIPLE PMB 211, 219, 221
TRIPLE PMK 211, 219, 221
tri-sprintec 253, 264, 278
TRISTART DHA 91, 203, 320, 372, 375
TRIUMEQ 35, 37
TRIUMEQ PD 35, 37
TRI-VI-FLOR 178, 180, 302, 372, 373, 375, 376
TRI-VI-FLORO 178, 180, 302, 372, 373, 375, 376
TRI-VITAMIN WITH FLUORIDE 178, 180, 302, 372
tri-vite/fluoride 178, 180, 302, 372, 373, 375, 376
tri-vylibra 254, 264, 278
tri-vylibra lo 254, 264, 278
trospium chloride 369
trospium chloride er 369
TRUE COMFORT SAFETY PEN NEEDLE 191
TRUE COVER 322
TRUE FOLIC ACID 375
TRUE METRIX LEVEL 1 191
TRUE METRIX LEVEL 2 191
TRUE METRIX LEVEL 3 191
TRULANCE 224, 233
TRULICITY 267
TRUMENBA 67
TRUQAP 61
TRUVADA 37, 42
TRYNGOLZA 101, 242, 297
TRYPTYR 220
TRYVIO 330
TUKYSA 61
TURALIO 61
turpentine 349
turqoz 254, 264, 278
TUXARIN ER 20, 21, 326
TWIIST REFILL KIT 191
TWIIST REFILL KIT/INFUSION SET 191
TWIIST STARTER KIT 191
TWINRIX 67
TWIRLA 254, 264, 278
TWYNEO 350, 362
TYBLUME 254, 264, 278
tydemy 254, 264, 278, 375
TYMLOS 269, 298
TYRVAYA 68, 220
TYVASO 125, 335, 338
TYVASO DPI MAINTENANCE KIT 125, 335, 338
TYVASO DPI TITRATION KIT 125, 335, 338
TYVASO REFILL KIT 125, 335, 338
TYVASO STARTER KIT 125, 335, 338
UBRELVY 150
UCERIS 242
UDENYCA 85
ULTANE 155
ULTRA-CARE SAFETY LANCETS 30G 191
UNIFINE OTC PEN NEEDLES 191
UNIFINE PROTECT PEN NEEDLE 191
UNISTRIP CONTROL 191
unithroid 284
UPNEEQ 223
UPTRAVI 338, 339
UPTRAVI TITRATION 339
URAMAXIN 95, 199, 222, 361
urea 95, 199, 222, 223, 361
URELLE 47, 72, 130, 320
uretron d/s 48, 72, 130, 320
UROCIT-K 10 195
UROCIT-K 15 195
UROGESIC-BLUE 48, 72, 320
ursodiol 230
URSODIOL+SYRSPEND SF .. 230
VAFSEO 85
valacyclovir hcl 42
VALCHLOR 340, 368
valganciclovir hcl 42
valproic acid 136, 140, 142, 143, 154
valsartan 97, 98
valsartan-hydrochlorothiazide 98, 204
VALTOCO 10 MG DOSE 147
VALTOCO 15 MG DOSE 147
VALTOCO 20 MG DOSE 147
VALTOCO 5 MG DOSE 148
valtya 1/35 ..... 254, 264, 278
valtya 1/50 ..... 254, 264, 278
VANCOCIN 31
vancomycin hcl 32
VANCOMYCIN+SYRSPEND SF 32
VANFLYTA 61
VANRAFIA 308, 330
VAQTA 67
vardenafil hcl 120, 121
varenicline tartrate 68, 73
varenicline tartrate (starter) 68, 73
varenicline tartrate(continue) 68, 73
VARIVAX 67
VAXELIS 64, 67
VAXNEUVANCE 67
VCF VAGINAL CONTRACEPTIVE 322
VECAMYL 122
velivet 254, 264, 278

VELPHORO 200
VELTASSA 200
VEMLIDY 42
VENCLEXTA 61
VENCLEXTA STARTING PACK 61
VENELEX 368
VENLAFAXINE BESYLATE ER 172
venlafaxine hcl 172
venlafaxine hcl er 172
VEOZAH 151
verapamil hcl 104, 105, 106, 112, 125
verapamil hcl er 104, 105, 106, 112, 125
VEREGEN 361, 369
VERIFINE INSULIN PEN NEEDLE 191
VERIFINE INSULIN SYRINGE 191
VERIFINE PLUS PEN NEEDLE 191
VERIFINE SAFE LANCET MINI 21G 191
VERIFINE SAFE LANCET MINI 23G 191
VERIFINE SAFE LANCET MINI 28G 191
VERIFINE SAFE LANCET MINI 30G 192
VERIFINE SHARPS CONTAINER 192
VERISAFE SAFETY STERILE NEEDLE 192
VERKAZIA 212, 220, 285
VERQUVO 108, 125
VERSACLOZ 146
VERSAPENN (AG) ANHYDROUS 323
VERSAPENN (AL) ANHYD LIPID 323
VERZENIO 61
VESICARE 370
vestura 254, 264, 278
VFEND 30
VIBERZI 225, 233
vienva 254, 264, 278
vigabatrin 136, 154
VIGADRONE 136, 154
VIGAFYDE 154
VIGAMOX 45, 211
VIJOICE 320
vilazodone hcl 174
VILEVEV MB 48, 72, 130, 320
VIMPAT 136, 155
VIOKACE 207, 230
viorele 254, 264, 278
VIRACEPT 38
VIREAD 37
VISTOGARD 18, 296
VITAFOL FE+ 91, 203, 320, 372, 375
VITAFOL-OB+DHA 91, 203, 320, 372, 375
VITAMIN C BRIGHTENING SERUM 349
vitamin d (ergocalciferol) 376
VITATHELY WITH GINGER 92, 372, 375
VITRAKVI 61
VIVAGUARD INO CONTROL SOLUTION 192
VIVAGUARD LANCETS 30G . 192
VIVAGUARD LANCING DEVICE 192
VIVAGUARD SAFETY LANCETS 28G 192
VIVJOA 30
VOCABRIA 35
volnea 254, 264, 278
VONJO 61
VONVENDI 89
VOQUEZNA 234, 235
VOQUEZNA DUAL PAK ... 24, 234
VOQUEZNA TRIPLE PAK 25, 43, 234
VORANIGO 62
voriconazole 30
VORTEX VALVE CHAMBER-PEDI MASK 192
VORTEX VALVED HOLDING CHAMBER 192
VOSEVI 33, 34
VOWST 233, 321
VOXZOGO 321
VOYDEYA 303
VOYXACT 285
VP FC KIT 74, 363, 369
VP GKL KIT 346, 363, 369
VRAYLAR 146
VTAMA 345, 350, 369
VUSION 347, 349, 356
VYBRIQUE 120, 334
vyfemla 254, 264, 278
VYKAT XR 130, 131
VYLEESI 151, 236
vylibra 254, 264, 278
VYNDAMAX 106, 151, 321
VYSCOXA 151
VYTORIN 108, 116
VYVANSE 128
VYVGART HYTRULO 292
WAINUA 297
WAKIX 177
warfarin sodium 82
WAYRILZ 82
WEGOVY 131, 267
WEGOVY HD 131, 267
WELIREG 62
wera 254, 264, 278
WESCAP-PN DHA 92, 203, 321, 372, 375
WESNATE DHA 92, 321, 373, 375
WESTGEL DHA 92, 203, 321, 373, 375
WEZLANA 290
wheat germ oil 376
WIDE-SEAL DIAPHRAGM 60 322
WIDE-SEAL DIAPHRAGM 65 322
WIDE-SEAL DIAPHRAGM 70 322
WIDE-SEAL DIAPHRAGM 75 322
WIDE-SEAL DIAPHRAGM 80 322
WIDE-SEAL DIAPHRAGM 85 322
WIDE-SEAL DIAPHRAGM 90 322
WIDE-SEAL DIAPHRAGM 95 322
WILATE 89
WINREVAIR 335
wixela inhub 80, 219, 242, 328
wymzya fe 254, 264, 278
XACIATO 40, 345
xarah fe 254, 264, 279
XARELTO 83
XARELTO STARTER PACK 83
XATMEP ... 62, 287, 308, 314, 316
XCOPRI 136, 155
XDEMVY 211
XELPROS 223
xelria fe 254, 265, 279
XELSTRYM 128
XENICAL 233
XEPI 345
XERMELO 225
XIFAXAN 45
XIIDRA 212, 220
XIRUN 349, 361
XOFLUZA (40 MG DOSE) .. 29, 31
XOFLUZA (80 MG DOSE) .. 29, 31
XOLAIR 289, 336

XOLREMDI 85
XOPENEX HFA 80, 337
XOSPATA 62
XPHOZAH 200, 233
XPOVIO (100 MG ONCE WEEKLY) 62
XPOVIO (40 MG ONCE WEEKLY) 62
XPOVIO (40 MG TWICE WEEKLY) 62
XPOVIO (60 MG ONCE WEEKLY) 62
XPOVIO (60 MG TWICE WEEKLY) 62
XPOVIO (80 MG ONCE WEEKLY) 62
XPOVIO (80 MG TWICE WEEKLY) 62
XROMI 62
XTAMPZA ER 164
XTANDI 62
xulane 254, 265, 279
XYNTHA 89
XYNTHA SOLOFUSE 89
xyvona 164
XYWAV 151
YASMIN 28 ..... 254, 265, 279
YAZ 254, 265, 279
YESINTEK 290, 291
YEZTUGO 34
YORVIPATH 269
your choice 245, 254, 279
yulithira 62, 63, 288
YUPELRI 72, 325
YUTREPIA 125, 335
yuvafem 265, 299
ZACARE 349, 362
ZACLIR CLEANSING 363
zafemy 254, 265, 279
zafirlukast 331
zaleplon 144, 157
ZANAFLEX 74
ZARONTIN 175
ZARXIO 85
ZAVZPRET 150
ZEJULA 63
ZELAPAR 156, 157
ZELBORAF 63
ZELSUVMI 347, 369
zelvysia 206, 321
ZEMBRACE SYMTOUCH 173
ZEMPLAR 376
zenatane 361, 369
ZENPEP 207, 230
ZEPBOUND 131, 267
ZEPOSIA 314
ZEPOSIA 7-DAY STARTER PACK 314
ZEPOSIA STARTER KIT 314
ZESTRIL 99, 100
ZIAGEN 37
zidovudine 37, 38
ZILBRYSQ 286, 303
zileuton er 332
ZILXI 27, 47, 211, 345
ZIOPTAN 223
ziprasidone hcl 140, 146
ZIPSOR 160
ZIRGAN 42, 212
ZITHROMAX 43
ZITHROMAX TRI-PAK 43
ZITHROMAX Z-PAK 43
ZITUVIMET 247, 256
ZITUVIMET XR 247, 256
ZITUVIO 256
ZOKINVY 206, 207, 321
ZOLINZA 63
zolmitriptan 173
ZOLPIDEM TARTRATE 144, 157
zolpidem tartrate 144, 157
zolpidem tartrate er 144, 157
ZOMIG 173
ZONEGRAN 136, 156
ZONISADE 136, 156
zonisamide 136, 156
ZONTIVITY 93
ZORYVE 333, 359, 363, 369
zovia 1/35 (28) 254, 265, 279
ZOVIRAX 42, 347
ZTALMY 137, 154
ZTLIDO 295, 346
ZUBSOLV 165, 166
zumandimine 254, 265, 279
ZURNAI 165
ZURZUVAE 137
ZYCUBO 203
ZYDELIG 63
ZYLET 211, 219
ZYPITAMAG 116