SHARP HEALTH PLAN
make life better.

2021 Formulary

List of covered prescription drugs

This drug list applies to all Individual HMO products and the following Small Group HMO products: Sharp Platinum 90 Performance HMO, Sharp Platinum 90 Performance HMO AI-AN, Sharp Platinum 90 Premier HMO, Sharp Platinum 90 Premier HMO AI-AN, Sharp Gold 80 Performance HMO, Sharp Gold 80 Performance HMO AI-AN, Sharp Gold 80 Premier HMO, Sharp Gold 80 Premier HMO AI-AN, Sharp Silver 70 Performance HMO, Sharp Silver 70 Performance HMO AI-AN, Sharp Silver 70 Premier HMO, Sharp Silver 70 Premier HMO AI-AN, Sharp Silver 73 Performance HMO, Sharp Silver 73 Premier HMO, Sharp Silver 87 Performance HMO, Sharp Silver 87 Premier HMO, Sharp Silver 94 Performance HMO, Sharp Silver 94 Premier HMO, Sharp Bronze 60 Performance HMO, Sharp Bronze 60 Performance HMO AI-AN, Sharp Bronze 60 Premier HDHP HMO, Sharp Bronze 60 Premier HDHP HMO AI-AN, Sharp Minimum Coverage Performance HMO, Sharp $0 Cost Share Performance HMO AI-AN, Sharp $0 Cost Share Premier HMO AI-AN, Sharp Silver 70 Off Exchange Performance HMO, Sharp Silver 70 Off Exchange Premier HMO, Sharp Performance Platinum 90 HMO 0/15 + Child Dental, Sharp Premier Platinum 90 HMO 0/20 + Child Dental, Sharp Performance Gold 80 HMO 350 /25 + Child Dental, Sharp Premier Gold 80 HMO 250/35 + Child Dental, Sharp Performance Silver 70 HMO 2250/50 + Child Dental, Sharp Premier Silver 70 HMO 2250/55 + Child Dental, Sharp Premier Silver 70 HDHP HMO 2500/20% + Child Dental, Sharp Performance Bronze 60 HMO 6300/65 + Child Dental, Sharp Premier Bronze 60 HDHP HMO 7000/0 + Child Dental, Sharp Performance Platinum 90 HMO 0/15 + Child Dental (INF), Sharp Premier Platinum 90 HMO 0/20 + Child Dental (INF), Sharp Performance Gold 80 HMO 350/25 + Child Dental (INF), Sharp Premier Gold 80 HMO 250/35 + Child Dental (INF), Sharp Performance Silver 70 HMO 2250/50 + Child Dental (INF), Sharp Premier Silver 70 HMO 2250/55 + Child Dental (INF), Sharp Premier Silver 70 HDHP HMO 2500/20% + Child Dental (INF), Sharp Performance Bronze 60 HMO 6300/65 + Child Dental (INF), Sharp Premier Bronze 60 HDHP HMO 7000/0 + Child Dental (INF), Sharp Performance Gold 80 HMO 350/25 + Child Dental, Sharp Premier Silver 70 HDHP 2500/20% + Child Dental, Sharp Platinum 90 HMO 0/15/10% + Child Dental (Pr/V/C), Sharp Platinum 90 HMO 0/20/250 + Child Dental (Pe/V/C), Sharp Gold 80 HMO 350/25/20% + Child Dental (Pr/V/C), Sharp Gold 80 HMO 250/35/600 + Child Dental (Pe/V/C), Sharp Silver 70 HMO 2250/50/30% + Child Dental (Pr/V/C- 30%), Sharp Silver 70 HMO 2250/55/30% + Child Dental (Pe/V/C-300), Sharp Silver 70 HDHP HMO 2500/20%/20% + Child Dental (Pe/V/C), Sharp Bronze 60 HMO 6300/65/40% + Child Dental (Pr/V/C), Sharp Bronze 60 HDHP HMO 7000/0/0 + Child Dental (Pe/V/C)

List of covered prescription drugs for **Individual, family & employer-sponsored coverage through Covered California and Individual and family coverage directly from Sharp Health Plan**

An electronic version of this Prescription Drug List is available on the Sharp Health Plan website, by visiting sharphealthplan.com/search-drug-list

You can find specific cost sharing information in your plan's coverage documents by logging in to your Sharp Connect account on our website by visiting sharphealthplan.com/login

This document is subject to change and all previous versions are no longer in effect. Last updated 12/01/21.

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Introduction

December 2021

This document contains a list of the federal Food and Drug Administration (FDA) approved drugs covered for Sharp Health Plan Members under the pharmacy outpatient prescription drug benefit, and is also known as the Formulary. The outpatient prescription drug benefit covers outpatient drugs provided to Members through a network retail, specialty or mail order pharmacy. Drugs covered under the pharmacy benefit are generally oral or topical medications, unless otherwise listed on the Formulary. The presence of a drug on the Formulary does not guarantee that it will be prescribed by your Prescribing Provider for a particular medical condition. Refer to the end of this Introduction for information about drug benefit exclusions for the outpatient prescription drug benefit.

If you have questions regarding your outpatient prescription drug benefit, please call our Customer Service department at 1-855-298-4252.

A Medical Benefit drug is a drug that is physician administered or is self-injectable. Medical Benefit drugs are covered under the Medical Benefit. Refer to the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook for specific information about the Cost Shares, exclusions and limitations for these drugs covered under your Medical Benefit:

1. Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU), provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office or self-injectable drugs.
3. FDA-approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by, or under direct supervision of, a physician.
4. Immunization or immunological agents, including, but not limited to: biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, lancets and lancet puncture devices. (Insulin, glucagon and insulin syringes are covered under the outpatient prescription drug benefit.)
6. Items that are approved by the FDA as a medical device. Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

DEFINITIONS

Defined terms are capitalized throughout this Formulary and have the meaning set forth below throughout this Formulary and in the Glossary section of your Member Handbook.

"Appeal" is a written or oral request, by or on behalf of a Member, to re-evaluate a specific determination made by Sharp Health Plan or any of its delegated entities (e.g., Plan Providers).

"Brand-Name Drug" is a drug that is marketed under a proprietary, trademark protected name. The Brand Name Drug shall be listed in all CAPITAL letters.

"Coinsurance" is a percentage of the cost of a Covered Benefit (for example, 20%) that an Enrollee pays after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

"Copayment" is a fixed dollar amount (for example, $20) that an Enrollee pays for a Covered Benefit after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

"Deductible" is the amount an Enrollee pays for certain Covered Benefits before Sharp Health Plan begins payment for all or part of the cost of the Covered Benefit under the terms of the policy.

"Drug Tier" is a group of Prescription Drugs that corresponds to a specified cost sharing tier in Sharp Health Plan's Prescription Drug coverage. The tier in which a Prescription Drug is placed determines the Enrollee's portion of the cost for the drug.

"Enrollee" is a person enrolled in Sharp Health Plan who is entitled to receive services from the Plan. All references to Enrollees in this Formulary template shall also include Subscribers as defined in this section below. An Enrollee is also referred to as a Member.

"Exception Request" is a request for coverage of a Prescription Drug. If an Enrollee, his or her designee, or prescribing health care provider submits an Exception Request for coverage of a Prescription Drug, Sharp Health Plan must cover the Prescription Drug when the drug is determined to be Medically Necessary to treat the Enrollee's condition. Drugs and supplies that fall within one of the outpatient prescription drug benefit exclusions described in the Member Handbook are not eligible for an Exception Request.

"Exigent Circumstances" are when an Enrollee is suffering from a health condition that may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, or when an Enrollee is undergoing a current course of treatment using a Nonformulary Drug.

"Formulary" is the complete list of drugs preferred for use and eligible for coverage under a Sharp Health Plan product, and includes all drugs covered under the outpatient prescription drug benefit of the Sharp Health Plan product. Formulary is also known as a Prescription Drug list,

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

"Grievance" is a written or oral expression of dissatisfaction regarding Sharp Health Plan, a provider and/or a pharmacy, including quality of care concerns.

"Nonformulary Drug" is a Prescription Drug that is not listed on Sharp Health Plan's Formulary.

"Out-of-Pocket Cost" are Copayments, Coinsurance, and the applicable Deductible, plus all costs for health care services that are not covered by Sharp Health Plan.

"Prescribing Provider" is a health care provider authorized to write a Prescription to treat a medical condition for a Sharp Health Plan Enrollee.

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

"Prescription Drug" is a drug that is prescribed by the Enrollee's Prescribing Provider and requires a Prescription under applicable law.

"Prior Authorization" is Sharp Health Plan's requirement that the Enrollee or the Enrollee's Prescribing Provider obtain the Sharp Health Plan's Authorization for a Prescription Drug before Sharp Health Plan will cover the drug. Sharp Health Plan shall grant a Prior Authorization when it is Medically Necessary for the Enrollee to obtain the drug.

"Step Therapy" is a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health Plan may require the Enrollee to try one or

more drugs to treat the Enrollee's medical condition before Sharp Health Plan will cover a particular drug for the condition pursuant to a Step Therapy request. If the Enrollee's Prescribing Provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.

"Subscriber" means the person who is responsible for payment to Sharp Health Plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

How often does the Formulary change?

The Sharp Health Plan Formulary is developed to identify safe and effective drugs for Members while maintaining affordable benefits. The Formulary and Drug Coverage Requirements and Limits are updated regularly by the Pharmacy and Therapeutics (P&T) Committee, which meets quarterly. The Formulary and the Drug Coverage Requirements and Limits are subject to change monthly as new clinical information and new drugs become available. The P&T Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. The P&T Committee frequently consults with other medical experts for input to the Committee.

The P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications
- Relevant utilization experience
- Physician recommendations

Will I be notified of a Formulary change?

Sharp Health Plan will provide sixty (60) days written notice of a Formulary change to negatively affected Members. The notice will include the date the Member will be impacted by the change. Some examples of Formulary changes that will result in a notice to the member include, but are not limited to:

- A drug or dosage form is moved to a higher Drug Tier that results in an increase in cost sharing
- A drug or dosage form is removed from the Formulary
- Drug Coverage Requirements or Limits for a drug are added or changed

Changes to the Formulary that may occur without prior written notice to the Member include:

- A drug is removed from the Formulary because it is removed from the market by either the drug manufacturer or the FDA
- A drug is added to the Formulary
- A drug is moved to a lower Drug Tier
- A Drug Coverage Requirement or Limit is removed from a drug
- A generic drug is drug is added to the Formulary and the Brand Name drug is moved to a higher Drug Tier or removed from the Formulary

The drug formulary can be accessed by current and prospective Members. To view the most current Formulary, please visit sharphealthplan.com/search-drug-list.

How do I locate a Prescription Drug on the Formulary?

Covered Prescription Drugs are listed alphabetically by Generic name and Brand-Name in the alphabetical Index.

Within the Formulary, drugs are listed alphabetically under the column titled "Prescription Drug Name" by its Brand or

Generic name under the therapeutic category and class to which it belongs. If a generic for a Brand Name Drug is not available or is not covered, the Generic Drug name will not be listed separately by its generic name.

You can find a Prescription Drug on the formulary by looking for its Generic or Brand-Name alphabetically in the Index, or by looking for it in the Formulary, where it is listed alphabetically under the therapeutic category and class to which it belongs. Sharp Health Plan uses the Medispan classification system for therapeutic category and class. Medi-Span® maintains the Master Drug Data Base of drug information for professionals in the health sciences. The Master Drug Data Base provides pricing and descriptive drug information on name brand, generic, prescription and OTC medications, and herbal products and is updated daily.

How do I know if the drug listed on the Formulary is a Brand or Generic Drug?

Brand-Name Drugs are listed in all CAPITALS followed by the generic name in parentheses in (***lowercase bold italics***).

If a Generic equivalent for a Brand-Name Drug is available and is covered, and both the Brand-Name Drug and the Generic equivalents are covered, the Generic Drug will be listed separately from the Brand-Name Drug in all ***lowercase bold italics.***

When a Generic Drug is marketed under a Brand-Name, the Brand-Name will be listed in all capital letters after the Generic name in parentheses with the first letter of each word capitalized.

Here is how this is listed on the Formulary:

Drug Type	Listing on the Formulary
Brand-Name Drug and Generic-Name	FIBRICOR TAB 35MG ***(fenofibric acid)***
Generic-Name that is covered on the Formulary	***fenofibric acid tab 35mg***
Generic Drug marketed with a Brand-Name	(Amiodarone Hcl Tab 100mg) PACERONE

Some drugs are commercially available as both a Brand-Name and a Generic-Name. Contracted pharmacies are required to dispense the Generic version of the drug, unless Prior Authorization for the Brand-Name Drug is obtained from Sharp Health Plan.

The Brand-Name listed in this document is for reference only and is not an indication that the Brand-Name Drug is covered by Sharp Health Plan, unless Sharp Health Plan has Authorized the Brand-Name Drug due to medical necessity or specifically noted.

What is a Drug Tier?

Each covered drug is assigned to a Drug Tier. The Drug Tier is a group of drugs that indicates what your Copayment or Coinsurance is for each drug. A Deductible may also apply. For information about your Copayments, Coinsurance and/or Deductible, please consult your benefits information available online by visiting sharphealthplan.com/login and log in to your *SharpConnect* account. When you create a *SharpConnect* account, you can easily access your benefit information online 24 hours a day, 7 days a week.

A preferred drug is a drug that the Pharmacy and Therapeutics Committee has determined provides greater value than its alternatives when considering clinical effectiveness, safety and overall value.

The Drug Tier is marked throughout this document by one of the following symbols:

Symbol	Drug Tier	Description

1	Tier 1	Most Generic drugs and low-cost preferred Brand-Name drugs.
2	Tier 2	Non-preferred Generic drugs, preferred Brand-Name drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.
3	Tier 3	Non-preferred Brand-Name drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	Tier 4	Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) for a one-month (30-day) supply.
PV	PV	Select drugs covered with no Copayment, including certain generic and over-the-counter contraceptives for women.
MB	MB	Drugs covered under the Medical Benefit. Please refer to your Medical Benefit coverage information.

Are There Any Coverage Requirements or Limits?

Some covered Generic and Brand-Name Drugs have coverage requirements or limits on coverage. Symbols are used to identify drugs with a Coverage Requirement or Limit. The following symbols are used in this Formulary:

Symbol	Meaning	Description
PA	Prior Authorization	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria. See "What is Prior Authorization?" below for additional information.
PA**	Prior Authorization if Step Therapy is not met	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria, if Step Therapy criteria has not been met.
QL	Quantity Limit	Coverage is limited to a specific quantity per Prescription and/or time period. Prior Authorization is required for other quantities.
ST	Step Therapy	Coverage depends on previous use of another drug. Prior Authorization may be required. See "What Is Step Therapy?" below for additional information.
MO	Mail Order	A maintenance drug that is available for up to a 90-day supply and is eligible to be filled through mail order.
SP	Specialty	A specialty drug that must be filled by a pharmacy in the Sharp Health Plan Specialty Pharmacy network and is limited to a 30-day supply per fill.
OAC	Oral Anti-Cancer	An orally administered anticancer medication. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance does not exceed two hundred fifty dollars ($250) for an individual Prescription of up to a 30-day supply.

What is Prior Authorization?

Drugs with a PA symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization. Your Prescribing Provider must request Prior Authorization, or approval for coverage, from Sharp Health Plan by calling our Customer Service department, submitting a fax request, or submitting an electronic Prior Authorization Form. Once all the needed supporting information has been received, the Prior Authorization request will be either approved or denied based on our clinical policies within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. Exigent Circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a Nonformulary Drug. Sharp Health Plan will provide coverage for the Prescription, including refills, for the duration of the Prescription for non-urgent requests, and for the duration of the exigency for requests based on Exigent Circumstances. If Sharp Health Plan fails to respond to a completed Prior Authorization request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted.

If Sharp Health Plan denies a request for Prior Authorization, the Member, an Authorized Representative, or the Prescribing Provider can file an Appeal or Grievance. Information about this process is described in the section of the Formulary called, "You Have the Right to Appeal."

If Sharp Health Plan approved a Prior Authorization request for your medication and medical condition, Sharp Health Plan will not discontinue or limit coverage if your Prescribing Provider continues to prescribe it for the same medical condition, provided the drug is appropriately prescribed and is safe and effective for treating your medical condition.

What is PA**?

Drugs with a PA** symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization based on specific clinical criteria, if Step Therapy has not been met. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying the alternative drug. In these instances, your doctor may request a Prior Authorization by following the Prior Authorization process described above.

What is Quantity Limit?

Drugs with a QL symbol in the Coverage Requirements and Limits column of the Formulary are subject to Quantity Limits. Quantity Limits exist when drugs are limited to a determined number of doses based on criteria, including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximum approved dose. A Member's Prescribing Provider may submit a request for a quantity of medication that exceeds the Quantity Limit by following the Prior Authorization request procedure stated above. Medical Necessity for the quantity requested must be provided. Once all the needed supporting information has been received, the Prior Authorization request will be either approved or denied within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances.

What is Step Therapy?

Drugs with a ST symbol in the Coverage Requirements and Limits column of the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain drugs. This means that to receive coverage, you may need to first try a proven, cost-effective drug. Remember, treatment decisions are always between you and your doctor. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying the alternative drug. In these instances, your doctor may request a Step Therapy Exception Request by following the Prior Authorization as described above. If Sharp Health Plan fails to respond to a completed Step Therapy request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted.

If you have moved from another insurance plan to Sharp Health Plan and are taking a medication that your previous insurer covered, Sharp Health Plan will not require you to follow Step Therapy in order to obtain the medication. Your

doctor may need to submit a request to Sharp Health Plan in order to provide you with this continuity of coverage.

What Is MO?

Drugs with a MO symbol in the Coverage Requirements and Limits column of the Formulary are classified as Maintenance Drugs and can be filled for a 90-day supply at a retail location or at Mail Order.

What is a Specialty Drug?

Drugs with a SP symbol in the Coverage Requirements and Limits column of the Formulary are Specialty drugs. A Specialty drug is a drug that the FDA or the manufacturer states must be distributed through a Specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that the Pharmacy and Therapeutics Committee determines to be a Specialty medication.

What is an Oral Anti-Cancer Drug?

Drugs with an OAC symbol in the Coverage Requirements and Limits column of the Formulary are Oral Anti-Cancer drugs. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance for these drugs does not exceed two hundred fifty dollars ($250) for an individual Prescription of up to a 30-day supply.

What if a Drug Is Not Listed on the Formulary? What is a Formulary Exception?

Drugs that are not listed on the Formulary are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a Nonformulary Drug. In these instances, your Prescribing Provider may request a Formulary Exception, by following the Prior Authorization Request process described above. Once all the needed supporting information has been received, the Exception Request will be either approved or denied based on medical necessity within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. If Sharp Health Plan denies an Exception Request, the Member, an Authorized Representative, or the Provider can file an Appeal with Sharp Health Plan. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Tier 1 Cost Share. When approved, Sharp Health Plan shall provide coverage of the Nonformulary non-urgent request for the duration of the Prescription, including refills. Sharp Health Plan shall provide coverage, including refills, pursuant to a request based on Exigent Circumstances for the duration of the exigency. Nonformulary Drugs that are approved for coverage and meet the Tier 4 description will be subject to the Tier 4 Cost Share.

Where Can I Fill My Prescription Drug?

To find a pharmacy in our network, use our Pharmacy Locator tool. First, register for an account at www.caremark.com. The Pharmacy Locator tool is available after you log into your account and will allow you to search for a pharmacy that meets your needs. For example, you can search for a pharmacy close to your home, one that is open 24 hours a day, or one that offers drive-thru service.

Specialty drugs can be filled at CVS Specialty Pharmacy and will be mailed to you. Visit www.CVSspecialty.com to enroll. You can also take your Specialty drug prescription to a CVS retail pharmacy. Your Prescription will be sent to CVS Specialty Pharmacy to be filled. You may return to your local CVS pharmacy to pick up your Prescription.

Mail order medications can be filled at CVS/caremark. You can enroll with CVS/caremark by visiting info.caremark.com/mailservice.

What is Therapeutic Interchange?

Sharp Health Plan employs therapeutic interchange as part of its prescription drug benefit. Therapeutic interchange is

the practice of replacing (with the Prescribing Provider's approval) a Prescription Drug originally prescribed for a patient with a Prescription Drug that is its therapeutic equivalent. Using therapeutic interchange may offer advantages, such as value through improved convenience, affordability, improved outcomes or fewer side effects. Two or more drugs are considered therapeutically equivalent if they can be expected to produce similar levels of clinical effectiveness and sound medical outcomes in patients. If, during the Prior Authorization process, the requested medication has a preferred therapeutic equivalent on the Sharp Health Plan Formulary, a request to consider the preferred drug(s) may be conveyed to the Prescribing Provider. The Prescribing Provider may choose to use therapeutic interchange and select a pharmaceutical that does not require Prior Authorization or Step Therapy.

What is Generic Substitution?

The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents. When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless Sharp Health Plan has authorized the Brand-Name Drug due to medical necessity. If the brand-name drug is Medically Necessary and Prior Authorization is obtained from Sharp Health Plan, you must pay the Cost Share for the corresponding tier.

You Have the Right to Appeal

If you do not agree with a coverage decision, you, your Authorized Representative or your doctor may request an Appeal. You must submit your request within 180 days from the postmark date of the denial notice.

Appeals Due to Denial of Coverage for a Nonformulary Drug

If an exception request for coverage of a Nonformulary drug is denied, you, your Authorized Representative or your doctor may request an external Exception Request review. Sharp Health Plan will ensure that a decision is made within 72 hours in routine circumstances or 24 hours in urgent circumstances.

All Other Appeals

If a decision is made to delay, deny or modify coverage of a Formulary Drug, you, your Authorized Representative or your doctor may request an Appeal. A decision will be made within 30 days in routine circumstances or 72 hours in urgent circumstances.

For all types of Appeals, the circumstance may be considered urgent if the routine decision-making process might seriously jeopardize your life or health, or when you are experiencing severe pain.

Please refer to your Member Handbook for more information on the Appeal process.

Questions

If you have any questions, please contact Customer Care by calling 1-855-298-4252. If you or somebody who you are helping have questions about Sharp Health Plan, you have the right to obtain assistance and information in your language without any cost to you.

Exclusions and Limitations to the Outpatient Prescription Drug Benefit

The services and supplies listed below are exclusions and limitations to your Outpatient Prescription Drug Benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by a person or entity other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency Medical Condition or urgent care condition.

2. Drugs prescribed by non-Plan Providers and not authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an Emergency Medical Condition.
3. Over-the-counter medications or supplies, even if written on Prescription, except as specifically identified as covered in this Formulary. This exclusion does not apply to over-the-counter products that Sharp Health Plan must cover as a "preventive care" benefit under federal law with a Prescription or if the prescription legend drug is Medically Necessary due to a documented failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.
4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over-the-counter medications or other non-prescription items/supplies.
6. Vitamins (other than pediatric or prenatal vitamins listed in this Formulary).
7. Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are not excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.)
8. Herbal, nutritional and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
10. Drugs prescribed by a dentist or when prescribed for a dental treatment.
11. Drugs and supplies prescribed in connection with a service or supply that is not a Covered Benefit, unless required to treat a complication that arises as a result of the service or supply.
12. Travel and/or required work-related immunizations.
13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States, unless they are furnished in connection with Urgent Care Services or Emergency Services.
15. Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. Members must be enrolled in a Sharp Health Plan-approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug.
16. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer-reviewed journal.
17. Replacement of lost, stolen, or destroyed medications.
18. Compounded medications, unless determined to be Medically Necessary and Prior Authorization is obtained.
19. Brand-Name Drugs when a generic equivalent is available. Some drugs are commercially available as both a brand-name version and a generic version. It is the policy of Sharp Health Plan that when a Generic Drug is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. If a generic version of a drug is available, the brand-name version will require Prior Authorization. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless Prior Authorization for the Brand-Name Drug is obtained.
20. Any Prescription Drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the Prescription Drug.

The exclusions listed above do not apply to:

1. Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.
2. Drugs listed in this Formulary.

3. Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at $0 Cost Sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see your Formulary and your Member Handbook under Family Planning and Preventive Care Services.

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html.**

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese)
注意 : 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 (Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն (Armenian):
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید (TTY:711) 1-800-359-2002 با. باشد می فراهم.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

ةيبرعلا :(Arabic)
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. تصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002(TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।कॉल करें।

ภาษาไทย (Thai):
เรียน: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION		
COX-2 INHIBITORS		
celecoxib caps 50mg, 100mg, 200mg	1	MO
GOUT - DRUGS TO TREAT GOUT		
allopurinol tabs 100mg, 300mg	1	MO
colchicine tabs .6mg	1	
colchicine w/ probenecid tab 0.5-500 mg	1	MO
febuxostat tabs 40mg, 80mg	1	ST, MO; PA**
probenecid tabs 500mg	1	MO
NON-OPIOID ANALGESICS		
(Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs / 25 days)
butalbital-acetaminophen-caffeine cap 50-300-40 mg	1	QL (48 caps / 25 days)
butalbital-acetaminophen-caffeine cap 50-325-40 mg	1	QL (48 caps / 25 days)
butalbital-acetaminophen-caffeine tab 50-325-40 mg	1	QL (48 tabs / 25 days)
butalbital-aspirin-caffeine cap 50-325-40 mg	1	QL (48 caps / 25 days)
NSAIDS - DRUGS TO TREAT PAIN AND INFLAMMATION		
diclofenac potassium tabs 50mg	1	MO
diclofenac sodium tb24 100mg; tbec 25mg, 50mg, 75mg	1	MO
etodolac caps 200mg, 300mg; tabs 400mg, 500mg; tb24 400mg, 500mg, 600mg	1	MO
fenoprofen calcium tabs 600mg	3	MO
flurbiprofen tabs 50mg, 100mg	1	MO
ibuprofen susp 100mg/5ml	1	
ibuprofen tabs 400mg, 600mg, 800mg	1	MO
ketoprofen caps 50mg, 75mg	1	MO
ketorolac tromethamine soln 15mg/ml, 30mg/ml	MB	
ketorolac tromethamine tabs 10mg	1	QL (20 tabs / 25 days)
meclofenamate sodium caps 50mg, 100mg	1	MO
mefenamic acid caps 250mg	1	MO
meloxicam tabs 7.5mg, 15mg	1	MO
nabumetone tabs 500mg, 750mg	1	MO
naproxen tabs 250mg, 375mg, 500mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxaprozin tabs 600mg	1	MO
piroxicam caps 10mg, 20mg	1	MO
sulindac tabs 150mg, 200mg	1	MO
tolmetin sodium caps 400mg; tabs 600mg	1	MO
NSAIDS, COMBINATIONS		
diclofenac w/ misoprostol tab delayed release 50-0.2 mg	1	MO
diclofenac w/ misoprostol tab delayed release 75-0.2 mg	1	MO
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	QL (3 units / day)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	QL (3 units / day)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	QL (3 units / day)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	QL (2 units / day)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	QL (3 tabs / day)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	QL (3 tabs / day)
ZUBSOLV SUB 0.7-0.18 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units / day)
ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units / day)
ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units / day)
ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units / day)
ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (2 units / day)
ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (1 unit / day)
OPIOID ANALGESICS - DRUGS TO TREAT PAIN		
acetaminophen w/ codeine soln 120-12 mg/5ml	1	ST, QL (2700 ml / 25 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
acetaminophen w/ codeine tab 300-15 mg	1	ST, QL (400 tabs / 25 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-30 mg	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-60 mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg	1	QL (48 caps / 25 days)
butorphanol tartrate soln 1mg/ml, 2mg/ml	MB	
butorphanol tartrate soln 10mg/ml	1	QL (2 bottles / 25 days)
codeine sulfate tabs 30mg	1	ST, QL (42 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
codeine sulfate tabs 60mg	3	ST, QL (42 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
fentanyl pt72 12mcg/hr, 25mcg/hr	1	ST, QL (10 patches / 25 days)
fentanyl pt72 50mcg/hr, 75mcg/hr, 100mcg/hr	1	ST, PA; High Strength Requires PA
fentanyl citrate lpop 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	1	PA, QL (120 lozenges / 25 days)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	ST, QL (2700 ml / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-acetaminophen tab 5-325 mg	1	ST, QL (240 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 7.5-325 mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 10-325 mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 10-200 mg	1	ST, QL (50 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl soln 2mg/ml	MB	
hydromorphone hcl tabs 2mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tabs 4mg	1	ST, QL (150 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tabs 8mg	1	ST, QL (60 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tb24 8mg, 12mg, 16mg	1	ST, QL (30 tabs / 25 days)
hydromorphone hcl tb24 32mg	1	ST, PA; High Strength Requires PA
methadone hcl conc 10mg/ml	1	QL (30 ml / 25 days); (indicated for opioid addiction)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Methadone Hcl Conc 10mg/ml) METHADONE HYDROCHLORIDE I	1	ST, QL (60 mL / 25 days); (generic of Methadone Intensol, indicated for pain)
methadone hcl soln 5mg/5ml	1	ST, QL (450 ml / 25 days)
methadone hcl soln 10mg/5ml	1	ST, QL (300 mL / 25 days)
methadone hcl tabs 5mg	1	ST, QL (90 tabs / 25 days)
methadone hcl tabs 10mg	1	ST, QL (60 tabs / 25 days)
methadone hcl tbso 40mg	1	QL (9 tabs / 25 days)
(Methadone Hcl Tbso 40mg) METHADOSE	1	QL (9 tabs / 25 days)
morphine sulfate cp24 10mg, 20mg, 30mg	1	ST, QL (60 caps / 25 days)
morphine sulfate cp24 50mg, 60mg, 80mg	1	ST, QL (30 caps / 25 days)
morphine sulfate cp24 100mg; tbcr 60mg, 100mg, 200mg	1	ST, PA; High Strength Requires PA
morphine sulfate soln 4mg/ml, 10mg/ml	MB	
morphine sulfate soln 10mg/5ml	1	ST, QL (900 ml / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate soln 20mg/5ml	1	ST, QL (675 mL / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate soln 100mg/5ml	1	ST, QL (135 mL / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate supp 5mg, 10mg	1	ST, QL (180 suppositories / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
morphine sulfate supp 20mg	1	ST, QL (120 supp / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate supp 30mg	1	ST, QL (90 supp / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tabs 15mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tabs 30mg	1	ST, QL (90 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tbcr 15mg, 30mg	1	ST, QL (90 tabs / 25 days)
morphine sulfate beads cp24 30mg, 45mg, 60mg, 75mg, 90mg	1	ST, QL (30 caps / 25 days)
morphine sulfate beads cp24 120mg	1	ST, PA; High Strength Requires PA
nalbuphine hcl soln 10mg/ml, 20mg/ml	MB	
NUCYNTA TABS 50mg ***(tapentadol hcl)***	2	ST, QL (120 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA TABS 75mg ***(tapentadol hcl)***	2	ST, QL (90 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA TABS 100mg ***(tapentadol hcl)***	2	ST, QL (60 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA ER TB12 50mg, 100mg ***(tapentadol hcl)***	3	ST, QL (60 tabs / 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NUCYNTA ER TB12 150mg, 200mg, 250mg ***(tapentadol hcl)***	3	ST, PA; High Strength Requires PA
oxycodone hcl caps 5mg	1	ST, QL (180 caps / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl conc 100mg/5ml	1	ST, QL (90 mL / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl soln 5mg/5ml	1	ST, QL (900 ml / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl t12a 10mg, 15mg, 20mg, 30mg	1	ST, QL (60 tabs / 25 days)
oxycodone hcl t12a 40mg, 60mg, 80mg	1	ST, PA; High Strength Requires PA
oxycodone hcl tabs 5mg, 10mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 15mg	1	ST, QL (120 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 20mg	1	ST, QL (90 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 30mg	1	ST, QL (60 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone w/ acetaminophen tab 2.5-325 mg	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 2.5-325 mg) ENDOCET	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 5-325 mg	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 5-325 mg) ENDOCET	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 7.5-325 mg	1	ST, QL (240 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 7.5-325 mg) ENDOCET	1	ST, QL (240 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 10-325 mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 10-325 mg) ENDOCET	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone-aspirin tab 4.8355-325 mg	1	ST, QL (360 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone-ibuprofen tab 5-400 mg	1	ST, QL (28 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tabs 5mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tabs 10mg	1	ST, QL (90 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tb12 5mg, 7.5mg, 10mg, 15mg	1	ST, QL (60 tabs / 25 days)
oxymorphone hcl tb12 20mg, 30mg, 40mg	1	ST, PA; High Strength Requires PA
tramadol hcl tabs 50mg	1	ST, QL (180 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
tramadol hcl tb24 100mg	1	ST, QL (30 tabs / 25 days)
tramadol hcl tb24 200mg, 300mg	1	ST, PA; High Strength Requires PA
tramadol-acetaminophen tab 37.5-325 mg	1	ST, QL (40 tabs / 25 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
XTAMPZA ER C12A 9mg, 13.5mg, 18mg, 27mg ***(oxycodone)***	2	ST, QL (60 caps / 25 days)
XTAMPZA ER C12A 36mg ***(oxycodone)***	2	ST, PA; High Strength Requires Prior Auth
OPIOID PARTIAL AGONISTS		
BELBUCA FILM 75mcg, 150mcg, 300mcg, 450mcg ***(buprenorphine hcl)***	2	ST, QL (60 films / 25 days)
BELBUCA FILM 600mcg, 750mcg, 900mcg ***(buprenorphine hcl)***	2	ST, PA; High Strength Requires Prior Auth
buprenorphine ptwk 5mcg/hr, 7.5mcg/hr, 10mcg/hr	1	ST, QL (4 patches / 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
buprenorphine ptwk 15mcg/hr, 20mcg/hr	1	ST, PA; High Strength Requires Prior Auth
buprenorphine hcl soln .3mg/ml	MB	
buprenorphine hcl subl 2mg, 8mg	1	QL (90 tabs / 25 days); Must obtain approval after the first 30 day supply
SUBLOCADE SOSY 100mg/0.5ml, 300mg/1.5ml ***(buprenorphine)***	MB	
SALICYLATES		
(Aspirin Chew 81mg) GOODSENSE ASPIRIN	PV	QL (100 tabs / 30 days); $0 copay for members age 50-59 or age 12-59 years at risk for preeclampsia, otherwise not covered
(Aspirin Tbec 81mg) ASPIRIN ENTERIC COATED AD	PV	QL (100 tabs / 30 days); $0 copay for members age 50-59 or age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tabs 500mg	1	MO
ANESTHETICS - DRUGS FOR NUMBING		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) soln .5%, 1%, 2%	MB	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTI-BACTERIALS - MISCELLANEOUS		
amikacin sulfate soln 1gm/4ml, 500mg/2ml	MB	
fosfomycin tromethamine pack 3gm	1	
gentamicin sulfate soln 40mg/ml	MB	
neomycin sulfate tabs 500mg	1	
paromomycin sulfate caps 250mg	1	
SULFADIAZINE TABS 500mg	3	
tinidazole tabs 250mg, 500mg	1	
tobramycin nebu 300mg/4ml	4	SP, PA, QL (224 mL / 28 days), MO
tobramycin nebu 300mg/5ml	4	SP, PA, QL (280 mL / 28 days), MO
tobramycin sulfate soln 40mg/ml, 80mg/2ml; solr 1.2gm	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTI-INFECTIVES - MISCELLANEOUS		
ALINIA SUSR 100mg/5ml ***(nitazoxanide)***	3	QL (540mL / 25 days)
atovaquone susp 750mg/5ml	1	
aztreonam solr 1gm, 2gm	MB	
CAYSTON SOLR 75mg ***(aztreonam lysine)***	4	SP, PA, QL (84 vials / 28 days)
clindamycin hcl caps 75mg, 150mg, 300mg	1	
clindamycin palmitate hydrochloride solr 75mg/5ml	1	
clindamycin phosphate soln 9gm/60ml, 300mg/2ml, 600mg/4ml, 9000mg/60ml	MB	
dapsone tabs 25mg, 100mg	1	MO
EMVERM CHEW 100mg ***(mebendazole)***	3	QL (12 tabs / 365 days)
ertapenem sodium solr 1gm	MB	
ivermectin tabs 3mg	1	
linezolid soln 600mg/300ml	MB	
linezolid susr 100mg/5ml; tabs 600mg	1	
linezolid in sodium chloride iv soln 600 mg/300ml-0.9%	MB	
meropenem solr 1gm, 500mg	MB	
methenamine hippurate tabs 1gm	1	
metronidazole caps 375mg; tabs 250mg, 500mg	1	
metronidazole in nacl 0.79% iv soln 500 mg/100ml	MB	
nitazoxanide tabs 500mg	1	QL (20 tabs / 25 days)
nitrofurantoin susp 25mg/5ml	1	PA; High Risk Medications require PA for members age 70 and older
nitrofurantoin macrocrystal caps 25mg, 50mg, 100mg	1	PA; High Risk Medications require PA for members age 70 and older
nitrofurantoin monohyd macro caps 100mg	1	PA; High Risk Medications require PA for members age 70 and older
pentamidine isethionate solr 300mg	1	
pentamidine isethionate solr 300mg	MB	
polymyxin b sulfate solr 500000unit	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
praziquantel tabs 600mg	1	QL (24 tabs / 365 days)
PRIMSOL SOLN 50mg/5ml ***(trimethoprim hcl)***	2	
pyrimethamine tabs 25mg	3	PA
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
trimethoprim tabs 100mg	1	
vancomycin hcl caps 125mg, 250mg	1	QL (80 caps / 10 days)
vancomycin hcl solr 1gm, 5gm, 10gm, 500mg, 750mg	MB	
XIFAXAN TABS 200mg ***(rifaximin)***	2	QL (9 tabs / 25 days)
XIFAXAN TABS 550mg ***(rifaximin)***	2	PA, MO
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
amphotericin b solr 50mg	MB	
BIO-STATIN CAPS 500000unit, 1000000unit ***(nystatin)***	2	
CRESEMBA CAPS 186mg ***(isavuconazonium sulfate)***	3	
fluconazole susr 10mg/ml, 40mg/ml; tabs 50mg, 100mg, 150mg, 200mg	1	
griseofulvin microsize susp 125mg/5ml; tabs 500mg	1	
griseofulvin ultramicrosize tabs 125mg, 250mg	1	
itraconazole caps 100mg; soln 10mg/ml	1	PA
NOXAFIL SUSP 40mg/ml ***(posaconazole)***	2	PA, MO
nystatin tabs 500000unit	1	
(*nystatin Oral Powder*) BIO-STATIN	1	
posaconazole tbec 100mg	3	PA, MO
terbinafine hcl tabs 250mg	1	
voriconazole susr 40mg/ml; tabs 50mg, 200mg	2	PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl tab 62.5-25 mg	1	
atovaquone-proguanil hcl tab 250-100 mg	1	
chloroquine phosphate tabs 250mg, 500mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COARTEM TAB 20-120MG ***(artemether-lumefantrine)***	3	
mefloquine hcl tabs 250mg	1	MO
primaquine phosphate tabs 26.3mg	1	
quinine sulfate caps 324mg	1	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate soln 20mg/ml	1	SP, QL (900 mL / 30 days), MO
abacavir sulfate tabs 300mg	1	SP, QL (60 tabs / 30 days), MO
APTIVUS CAPS 250mg ***(tipranavir)***	2	SP, QL (120 caps / 30 days), MO
APTIVUS SOLN 100mg/ml ***(tipranavir)***	2	SP, QL (285 mL / 28 days), MO
atazanavir sulfate caps 150mg, 300mg	1	SP, QL (30 caps / 30 days), MO
atazanavir sulfate caps 200mg	1	SP, QL (60 caps / 30 days), MO
CRIXIVAN CAPS 200mg ***(indinavir sulfate)***	2	SP, QL (450 caps / 30 days), MO
CRIXIVAN CAPS 400mg ***(indinavir sulfate)***	2	SP, QL (180 caps / 30 days), MO
didanosine cpdr 200mg, 250mg, 400mg	1	SP, QL (30 caps / 30 days), MO
EDURANT TABS 25mg ***(rilpivirine hcl)***	2	SP, QL (60 tabs / 30 days), MO
efavirenz caps 50mg, 200mg	1	SP, QL (90 caps / 30 days), MO
efavirenz tabs 600mg	1	SP, QL (30 tabs / 30 days), MO
emtricitabine caps 200mg	1	SP, QL (30 caps / 30 days), MO
EMTRIVA SOLN 10mg/ml ***(emtricitabine)***	2	SP, QL (680 ml / 28 days), MO
etravirine tabs 100mg	1	SP, QL (120 tabs / 30 days), MO
etravirine tabs 200mg	1	SP, QL (60 tabs / 30 days), MO
fosamprenavir calcium tabs 700mg	1	SP, QL (120 tabs / 30 days), MO
FUZEON SOLR 90mg ***(enfuvirtide)***	MB	MO
INTELENCE TABS 25mg, 100mg ***(etravirine)***	2	SP, QL (120 tabs / 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INTELENCE TABS 200mg ***(etravirine)***	2	SP, QL (60 tabs / 30 days), MO
INVIRASE TABS 500mg ***(saquinavir mesylate)***	2	SP, QL (120 tabs / 30 days), MO
ISENTRESS CHEW 25mg, 100mg ***(raltegravir potassium)***	2	SP, QL (180 tabs / 30 days), MO
ISENTRESS PACK 100mg ***(raltegravir potassium)***	2	SP, QL (60 packets / 30 days), MO
ISENTRESS TABS 400mg ***(raltegravir potassium)***	2	SP, QL (120 tabs / 30 days), MO
ISENTRESS HD TABS 600mg ***(raltegravir potassium)***	2	SP, QL (60 tabs / 30 days), MO
lamivudine soln 10mg/ml	1	SP, QL (900 ml / 30 days), MO
lamivudine tabs 150mg	1	SP, QL (60 tabs / 30 days), MO
lamivudine tabs 300mg	1	SP, QL (30 tabs / 30 days), MO
LEXIVA SUSP 50mg/ml ***(fosamprenavir calcium)***	2	SP, QL (1575 mL / 28 days), MO
nevirapine susp 50mg/5ml	1	SP, QL (1200 mL / 30 days), MO
nevirapine tabs 200mg	1	SP, QL (60 tabs / 30 days), MO
nevirapine tb24 100mg	1	SP, QL (90 tabs / 30 days), MO
nevirapine tb24 400mg	1	SP, QL (30 tabs / 30 days), MO
NORVIR PACK 100mg ***(ritonavir)***	2	SP, QL (360 packets / 30 days), MO
NORVIR SOLN 80mg/ml ***(ritonavir)***	2	SP, QL (480 mL / 30 days), MO
PREZISTA SUSP 100mg/ml ***(darunavir ethanolate)***	2	SP, QL (400 ml / 30 days), MO
PREZISTA TABS 75mg ***(darunavir ethanolate)***	2	SP, QL (300 tabs / 30 days), MO
PREZISTA TABS 150mg ***(darunavir ethanolate)***	2	SP, QL (180 tabs / 30 days), MO
PREZISTA TABS 600mg ***(darunavir ethanolate)***	2	SP, QL (60 tabs / 30 days), MO
PREZISTA TABS 800mg ***(darunavir ethanolate)***	2	SP, QL (30 tabs / 30 days), MO
RETROVIR IV INFUSION SOLN 10mg/ml ***(zidovudine)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
REYATAZ PACK 50mg ***(atazanavir sulfate)***	2	SP, QL (180 packets / 30 days), MO
ritonavir tabs 100mg	1	SP, QL (360 tabs / 30 days), MO
SELZENTRY SOLN 20mg/ml ***(maraviroc)***	2	SP, QL (1840 mL / 30 days), MO
SELZENTRY TABS 25mg ***(maraviroc)***	2	SP, QL (240 tabs / 30 days), MO
SELZENTRY TABS 75mg, 150mg ***(maraviroc)***	2	SP, QL (60 tabs / 30 days), MO
SELZENTRY TABS 300mg ***(maraviroc)***	2	SP, QL (120 tabs / 30 days), MO
stavudine caps 15mg, 20mg, 30mg, 40mg	1	SP, QL (60 caps / 30 days), MO
tenofovir disoproxil fumarate tabs 300mg	1	SP, QL (30 tabs / 30 days), MO
TIVICAY TABS 10mg ***(dolutegravir sodium)***	2	SP, QL (240 tabs / 30 days), MO
TIVICAY TABS 25mg, 50mg ***(dolutegravir sodium)***	2	SP, QL (60 tabs / 30 days), MO
TIVICAY PD TBSO 5mg ***(dolutegravir sodium)***	2	SP, QL (360 tabs / 30 days), MO
TROGARZO SOLN 200mg/1.33ml ***(ibalizumab-uiyk)***	MB	MO
TYBOST TABS 150mg ***(cobicistat)***	2	SP, QL (30 tabs / 30 days), MO
VIDEX EC CPDR 125mg ***(didanosine)***	2	SP, QL (30 caps / 30 days), MO
VIDEX PEDIATRIC SOLR 2gm ***(didanosine)***	2	SP, QL (1200 ml / 30 days), MO
VIRACEPT TABS 250mg ***(nelfinavir mesylate)***	2	SP, QL (300 tabs / 30 days), MO
VIRACEPT TABS 625mg ***(nelfinavir mesylate)***	2	SP, QL (120 tabs / 30 days), MO
VIREAD POWD 40mg/gm ***(tenofovir disoproxil fumarate)***	2	SP, QL (240 gm / 30 days), MO
VIREAD TABS 150mg, 200mg, 250mg ***(tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs / 30 days), MO
zidovudine caps 100mg	1	SP, QL (180 caps / 30 days), MO
zidovudine syrp 50mg/5ml	1	SP, QL (1800 ml / 30 days), MO
zidovudine tabs 300mg	1	SP, QL (60 tabs / 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg	1	SP, QL (30 tabs / 30 days), MO
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg	1	SP, QL (60 tabs / 30 days), MO
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs / 30 days), MO
CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs / 30 days), MO
DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs / 30 days), MO; $0 Copay for PrEP
DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)***	2	SP, QL (30 tabs / 30 days), MO
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	1	SP, QL (30 tabs / 30 days), MO
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	1	SP, QL (30 tabs / 30 days), MO
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	1	SP, QL (30 tabs / 30 days), MO
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	1	SP, QL (30 tabs / 30 days), MO
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	1	SP, QL (30 tabs / 30 days), MO
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	1	SP, QL (30 tabs / 30 days), MO
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	1	SP, QL (30 tabs / 30 days), MO; $0 Copay for PrEP
EVOTAZ TAB 300-150 ***(atazanavir sulfate-cobicistat)***	2	SP, QL (30 tabs / 30 days), MO
GENVOYA TAB ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)***	2	SP, QL (30 tabs / 30 days), MO
KALETRA TAB 100-25MG ***(lopinavir-ritonavir)***	2	SP, QL (240 tabs / 30 days), MO
KALETRA TAB 200-50MG ***(lopinavir-ritonavir)***	2	SP, QL (120 tabs / 30 days), MO
lamivudine-zidovudine tab 150-300 mg	1	SP, QL (60 tabs / 30 days), MO
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	1	SP, QL (390 mL / 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lopinavir-ritonavir tab 100-25 mg	1	SP, QL (240 tabs / 30 days), MO
lopinavir-ritonavir tab 200-50 mg	1	SP, QL (120 tabs / 30 days), MO
ODEFSEY TAB ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs / 30 days), MO
PREZCOBIX TAB 800-150 ***(darunavir-cobicistat)***	2	SP, QL (30 tabs / 30 days), MO
TEMIXYS TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs / 30 days), MO
TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)***	2	SP, QL (30 tabs / 30 days), MO
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine caps 250mg	1	
ethambutol hcl tabs 100mg, 400mg	1	
isoniazid soln 100mg/ml	MB	
isoniazid syrp 50mg/5ml; tabs 100mg, 300mg	1	MO
PASER PACK 4gm ***(aminosalicylic acid)***	3	
PRIFTIN TABS 150mg ***(rifapentine)***	2	
pyrazinamide tabs 500mg	1	
rifabutin caps 150mg	1	
RIFAMATE CAP ***(isoniazid & rifampin)***	2	
rifampin caps 150mg, 300mg	1	
rifampin solr 600mg	MB	
RIFATER TAB ***(isoniazid-rifampin w/ pyrazinamide)***	2	
SIRTURO TABS 20mg, 100mg ***(bedaquiline fumarate)***	4	PA
TRECATOR TABS 250mg ***(ethionamide)***	2	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir caps 200mg; susp 200mg/5ml; tabs 400mg, 800mg	1	
adefovir dipivoxil tabs 10mg	4	SP, MO
BARACLUDE SOLN .05mg/ml ***(entecavir)***	3	SP, QL (630 mL / 30 days), MO
cidofovir soln 75mg/ml	MB	
entecavir tabs .5mg, 1mg	4	SP, QL (30 tabs / 30 days), MO
EPIVIR HBV SOLN 5mg/ml ***(lamivudine (hbv))***	2	SP, MO
famciclovir tabs 125mg, 250mg, 500mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lamivudine (hbv) tabs 100mg	1	SP, MO
oseltamivir phosphate caps 30mg	1	QL (40 caps / 90 days)
oseltamivir phosphate caps 45mg, 75mg	1	QL (20 caps / 90 days)
oseltamivir phosphate susr 6mg/ml	1	QL (360 mL / 90 days)
RELENZA DISKHALER AEPB 5mg/blister ***(zanamivir)***	2	QL (2 inhalers / 90 days)
ribavirin solr 6gm	MB	
rimantadine hydrochloride tabs 100mg	1	
valacyclovir hcl tabs 500mg, 1000mg	1	
valganciclovir hcl solr 50mg/ml	4	PA, QL (1000 mL / 30 days), MO
valganciclovir hcl tabs 450mg	4	PA, QL (120 tabs / 30 days), MO
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor caps 250mg, 500mg; susr 125mg/5ml, 250mg/5ml, 375mg/5ml	1	
cefadroxil caps 500mg; susr 250mg/5ml, 500mg/5ml; tabs 1gm	1	
cefazolin sodium solr 1gm	MB	
cefdinir caps 300mg; susr 125mg/5ml, 250mg/5ml	1	
cefditoren pivoxil tabs 200mg, 400mg	1	
cefepime hcl solr 1gm, 2gm	MB	
cefixime caps 400mg; susr 100mg/5ml, 200mg/5ml	1	
cefpodoxime proxetil susr 50mg/5ml, 100mg/5ml; tabs 100mg, 200mg	1	
cefprozil susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	1	
(Ceftazidime Solr 1gm) TAZICEF	MB	
ceftazidime solr 2gm	MB	
ceftriaxone sodium solr 1gm, 2gm, 10gm, 250mg, 500mg	MB	
cefuroxime axetil tabs 250mg, 500mg	1	
cephalexin caps 250mg, 500mg, 750mg; susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	1	
SUPRAX CHEW 100mg, 200mg; SUSR 500mg/5ml ***(cefixime)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin pack 1gm; susr 100mg/5ml, 200mg/5ml; tabs 250mg, 500mg, 600mg	1	
clarithromycin susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg; tb24 500mg	1	
DIFICID SUSR 40mg/ml; TABS 200mg ***(fidaxomicin)***	2	PA
erythromycin base cpep 250mg; tabs 250mg, 500mg	1	
(Erythromycin Base Tbec 250mg, 333mg, 500mg) ERY-TAB	1	
erythromycin ethylsuccinate susr 200mg/5ml, 400mg/5ml; tabs 400mg	1	
(Erythromycin Stearate Tabs 250mg) ERYTHROCIN STEARATE	1	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO SUSR 500mg/5ml ***(ciprofloxacin)***	3	
ciprofloxacin hcl tabs 100mg, 250mg, 500mg, 750mg	1	
levofloxacin soln 25mg/ml	MB	
levofloxacin soln 25mg/ml; tabs 250mg, 500mg, 750mg	1	
moxifloxacin hcl tabs 400mg	1	
ofloxacin tabs 300mg, 400mg	1	
HEPATITIS C		
EPCLUSA TAB 200-50MG ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 tabs / 28 days)
EPCLUSA TAB 400-100 ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 tabs / 28 days)
HARVONI PAK ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 pellets / 28 days)
HARVONI PAK 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 pellets / 28 days)
HARVONI TAB 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 tabs / 28 days)
HARVONI TAB 90-400MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 tabs / 28 days)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml ***(peginterferon alfa-2a)***	MB	
ribavirin (hepatitis c) caps 200mg; tabs 200mg	1	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SOVALDI PACK 150mg, 200mg ***(sofosbuvir)***	4	SP, ST, PA, QL (28 pellets / 28 days)
SOVALDI TABS 200mg, 400mg ***(sofosbuvir)***	4	SP, ST, PA, QL (28 tabs / 28 days)
VOSEVI TAB ***(sofosbuvir-velpatasvir-voxilaprevir)***	4	SP, PA, QL (28 tabs / 28 days)
PENICILLINS - DRUGS TO TREAT INFECTIONS		
amoxicillin caps 250mg, 500mg; chew 125mg, 250mg; susr 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; tabs 500mg, 875mg	1	
amoxicillin & k clavulanate chew tab 200-28.5 mg	1	
amoxicillin & k clavulanate chew tab 400-57 mg	1	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	1	
amoxicillin & k clavulanate tab 250-125 mg	1	
amoxicillin & k clavulanate tab 500-125 mg	1	
amoxicillin & k clavulanate tab 875-125 mg	1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	1	
ampicillin caps 500mg	1	
ampicillin sodium solr 1gm, 2gm	MB	
dicloxacillin sodium caps 250mg, 500mg	1	
(Penicillin G Potassium Solr 20mu) PFIZERPEN	MB	
penicillin g potassium solr 5000000unit, 20000000unit	MB	
penicillin g sodium solr 5000000unit	MB	
penicillin v potassium solr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	MB	
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	MB	
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	MB	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
demeclocycline hcl tabs 150mg, 300mg	1	
doxycycline (monohydrate) caps 50mg, 100mg; susr 25mg/5ml; tabs 50mg, 75mg, 150mg	1	
(Doxycycline (Monohydrate) Tabs 100mg) AVIDOXY	1	
doxycycline hyclate caps 50mg, 100mg; tabs 100mg; tbec 75mg, 150mg	1	
(Doxycycline Hyclate Caps 100mg) MORGIDOX 1X100MG	1	
doxycycline hyclate solr 100mg	MB	
(Doxycycline Hyclate Solr 100mg) DOXY 100	MB	
minocycline hcl caps 50mg, 75mg, 100mg; tabs 50mg, 75mg, 100mg	1	
tetracycline hcl caps 250mg, 500mg	1	
VIBRAMYCIN SYRP 50mg/5ml ***(doxycycline calcium)***	3	
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
ANTICONVULSANTS - MISC.		
BRIVIACT SOLN 10mg/ml; TABS 10mg, 25mg, 50mg, 75mg, 100mg ***(brivaracetam)***	3	MO
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
neostigmine methylsulfate soln 10mg/10ml	MB	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
busulfan soln 6mg/ml	MB	
carmustine solr 100mg	MB	
cyclophosphamide caps 25mg, 50mg	1	OAC
cyclophosphamide solr 1gm, 2gm, 500mg	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dacarbazine solr 100mg, 200mg	MB	
EMCYT CAPS 140mg ***(estramustine phosphate sodium)***	4	OAC
GLEOSTINE CAPS 10mg, 40mg, 100mg ***(lomustine)***	4	OAC
GLIADEL WAF 7.7MG ***(carmustine in polifeprosan)***	MB	
ifosfamide soln 1gm/20ml, 3gm/60ml; solr 1gm	MB	
LEUKERAN TABS 2mg ***(chlorambucil)***	2	OAC
melphalan tabs 2mg	1	OAC
melphalan hcl solr 50mg	MB	
TEMODAR SOLR 100mg ***(temozolomide)***	MB	
temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg	4	SP, PA; OAC
ANTHRACYCLINES		
daunorubicin hcl soln 20mg/4ml	MB	
doxorubicin hcl soln 2mg/ml	MB	
(Doxorubicin Hcl Solr 10mg, 50mg) ADRIAMYCIN	MB	
doxorubicin hcl liposomal inj 2mg/ml	MB	
epirubicin hcl soln 50mg/25ml, 200mg/100ml	MB	
idarubicin hcl soln 5mg/5ml, 10mg/10ml, 20mg/20ml	MB	
ANTIBIOTICS		
bleomycin sulfate solr 15unit, 30unit	MB	
mitomycin solr 5mg, 20mg, 40mg	MB	
ANTIMETABOLITES		
ALIMTA SOLR 100mg, 500mg ***(pemetrexed disodium)***	MB	
azacitidine susr 100mg	MB	
capecitabine tabs 150mg	4	SP, PA, QL (120 tabs / 30 days); OAC
capecitabine tabs 500mg	4	SP, PA, QL (300 tabs / 30 days); OAC
cladribine soln 10mg/10ml	MB	
clofarabine soln 1mg/ml	MB	
cytarabine soln 20mg/ml, 100mg/ml	MB	
decitabine solr 50mg	MB	
floxuridine solr .5gm	MB	
fludarabine phosphate soln 50mg/2ml; solr 50mg	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluorouracil soln 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	MB	
gemcitabine hcl soln 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; solr 1gm, 2gm, 200mg	MB	
mercaptopurine tabs 50mg	1	OAC
methotrexate sodium soln 1gm/40ml, 50mg/2ml, 250mg/10ml; solr 1gm	MB	
NIPENT SOLR 10mg ***(pentostatin)***	MB	
TABLOID TABS 40mg ***(thioguanine)***	2	OAC
ANTIMITOTIC, TAXOIDS		
ABRAXANE INJ 100MG ***(paclitaxel protein-bound particles)***	MB	
docetaxel conc 20mg/ml, 80mg/4ml, 160mg/8ml; soln 20mg/2ml, 80mg/8ml, 160mg/16ml	MB	
paclitaxel conc 30mg/5ml, 100mg/16.7ml, 150mg/25ml, 300mg/50ml	MB	
ANTIMITOTIC, VINCA ALKALOIDS		
vinblastine sulfate soln 1mg/ml	MB	
vincristine sulfate soln 1mg/ml	MB	
vinorelbine tartrate soln 10mg/ml, 50mg/5ml	MB	
BIOLOGIC RESPONSE MODIFIERS		
ERBITUX SOLN 100mg/50ml, 200mg/100ml ***(cetuximab)***	MB	
ERIVEDGE CAPS 150mg ***(vismodegib)***	4	SP, PA, QL (30 caps / 30 days); OAC
FARYDAK CAPS 10mg, 15mg, 20mg ***(panobinostat lactate)***	4	SP, PA, QL (6 caps / 21 days); OAC
GAZYVA SOLN 1000mg/40ml ***(obinutuzumab)***	MB	
IBRANCE CAPS 75mg, 100mg, 125mg ***(palbociclib)***	4	SP, PA, QL (21 caps / 28 days); OAC
IBRANCE TABS 75mg, 100mg, 125mg ***(palbociclib)***	4	SP, PA, QL (21 tabs / 28 days); OAC
KADCYLA SOLR 100mg, 160mg ***(ado-trastuzumab emtansine)***	MB	
KEYTRUDA SOLN 100mg/4ml ***(pembrolizumab)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (21 tabs / 28 days); 200 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (42 tabs / 28 days); 400 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (63 tabs / 28 days); 600 mg dose; OAC
LYNPARZA TABS 100mg, 150mg ***(olaparib)***	4	SP, PA, QL (120 tabs / 30 days); OAC
RYDAPT CAPS 25mg ***(midostaurin)***	4	SP, PA, QL (224 caps / 28 days); OAC
ZEJULA CAPS 100mg ***(niraparib tosylate)***	4	SP, PA, QL (90 caps / 30 days); OAC
ZOLINZA CAPS 100mg ***(vorinostat)***	4	SP, PA, QL (120 caps / 30 days); OAC
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate tabs 250mg	4	SP, PA, QL (120 tabs / 30 days); OAC
abiraterone acetate tabs 500mg	4	SP, PA, QL (60 tabs / 30 days); OAC
anastrozole tabs 1mg	1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
bicalutamide tabs 50mg	1	OAC
DEPO-PROVERA SUSP 400mg/ml ***(medroxyprogesterone acetate (antineoplastic))***	MB	
ELIGARD KIT 7.5mg ***(leuprolide acetate)***	MB	
ELIGARD KIT 22.5mg ***(leuprolide acetate (3 month))***	MB	
ELIGARD KIT 30mg ***(leuprolide acetate (4 month))***	MB	
ELIGARD KIT 45mg ***(leuprolide acetate (6 month))***	MB	
ERLEADA TABS 60mg ***(apalutamide)***	4	SP, PA, QL (120 tabs / 30 days); OAC
exemestane tabs 25mg	1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
flutamide caps 125mg	1	OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fulvestrant soln 250mg/5ml	MB	
letrozole tabs 2.5mg	1	MO; OAC
leuprolide acetate kit 1mg/0.2ml	MB	
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg ***(leuprolide acetate (cpp))***	MB	
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg ***(leuprolide acetate (cpp) (3 month))***	MB	
LYSODREN TABS 500mg ***(mitotane)***	2	OAC
megestrol acetate susp 40mg/ml; tabs 20mg, 40mg	1	OAC
megestrol acetate (appetite) susp 625mg/5ml	1	MO; OAC
nilutamide tabs 150mg	1	OAC
NUBEQA TABS 300mg ***(darolutamide)***	4	SP, PA, QL (120 tabs / 30 days); OAC
tamoxifen citrate tabs 10mg, 20mg	1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
toremifene citrate tabs 60mg	1	MO; OAC
XTANDI CAPS 40mg ***(enzalutamide)***	4	SP, PA, QL (120 caps / 30 days); OAC
XTANDI TABS 40mg ***(enzalutamide)***	4	SP, PA, QL (120 tabs / 30 days); OAC
XTANDI TABS 80mg ***(enzalutamide)***	4	SP, PA, QL (60 tabs / 30 days); OAC
YONSA TABS 125mg ***(abiraterone acetate)***	4	SP, PA, QL (120 tabs / 30 days); OAC
KINASE INHIBITORS		
AFINITOR TABS 10mg ***(everolimus)***	4	SP, PA, QL (30 tabs / 30 days); OAC
AFINITOR DISPERZ TBSO 2mg, 5mg ***(everolimus)***	4	SP, PA, QL (60 tabs / 30 days); OAC
AFINITOR DISPERZ TBSO 3mg ***(everolimus)***	4	SP, PA, QL (90 tabs / 30 days); OAC
ALECENSA CAPS 150mg ***(alectinib hcl)***	4	SP, PA, QL (240 caps / 30 days); OAC
BOSULIF TABS 100mg ***(bosutinib)***	4	SP, PA, QL (90 tabs / 30 days); OAC
BOSULIF TABS 400mg, 500mg ***(bosutinib)***	4	SP, PA, QL (30 tabs / 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CABOMETYX TABS 20mg, 40mg, 60mg ***(cabozantinib s-malate)***	4	SP, PA, QL (30 tabs / 30 days); OAC
CALQUENCE CAPS 100mg ***(acalabrutinib)***	4	PA, QL (60 caps / 30 days); OAC
CAPRELSA TABS 100mg ***(vandetanib)***	4	PA, QL (60 tabs / 30 days); OAC
CAPRELSA TABS 300mg ***(vandetanib)***	4	PA, QL (30 tabs / 30 days); OAC
COMETRIQ KIT 20mg ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit / 28 days); OAC
COMETRIQ KIT 100MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit / 28 days); OAC
COMETRIQ KIT 140MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit / 28 days); OAC
erlotinib hcl tabs 25mg	4	SP, PA, QL (60 tabs / 30 days); OAC
erlotinib hcl tabs 100mg, 150mg	4	SP, PA, QL (30 tabs / 30 days); OAC
everolimus tabs 2.5mg, 5mg, 7.5mg	4	SP, PA, QL (30 tabs / 30 days); OAC
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg ***(ponatinib hcl)***	4	PA, QL (30 tabs / 30 days); OAC
IDHIFA TABS 50mg, 100mg ***(enasidenib mesylate)***	4	SP, PA, QL (30 tabs / 30 days); OAC
imatinib mesylate tabs 100mg	4	SP, PA, QL (90 tabs / 30 days); OAC
imatinib mesylate tabs 400mg	4	SP, PA, QL (60 tabs / 30 days); OAC
IMBRUVICA CAPS 70mg ***(ibrutinib)***	4	PA, QL (30 caps / 30 days); OAC
IMBRUVICA CAPS 140mg ***(ibrutinib)***	4	PA, QL (90 caps / 30 days); OAC
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg ***(ibrutinib)***	4	PA, QL (30 tabs / 30 days); OAC
INLYTA TABS 1mg ***(axitinib)***	4	SP, PA, QL (240 tabs / 30 days); OAC
INLYTA TABS 5mg ***(axitinib)***	4	SP, PA, QL (120 tabs / 30 days); OAC
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg ***(ruxolitinib phosphate)***	4	SP, PA, QL (60 tabs / 30 days); OAC
lapatinib ditosylate tabs 250mg	4	SP, PA, QL (180 tabs / 30 days); OAC
LENVIMA 4 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (30 caps / 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LENVIMA 8 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps / 30 days); OAC
LENVIMA 10 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	4	SP, PA, QL (30 caps / 30 days); OAC
LENVIMA 12MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps / 30 days); OAC
LENVIMA 20 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps / 30 days); OAC
LENVIMA CAP 14 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps / 30 days); OAC
LENVIMA CAP 18 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps / 30 days); OAC
LENVIMA CAP 24 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps / 30 days); OAC
LORBRENA TABS 25mg ***(lorlatinib)***	4	SP, PA, QL (90 tabs / 30 days); OAC
LORBRENA TABS 100mg ***(lorlatinib)***	4	SP, PA, QL (30 tabs / 30 days); OAC
MEKINIST TABS 2mg ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (30 tabs / 30 days); OAC
MEKINIST TABS .5mg ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (90 tabs / 30 days); OAC
NEXAVAR TABS 200mg ***(sorafenib tosylate)***	4	SP, PA, QL (120 tabs / 30 days); OAC
SPRYCEL TABS 20mg ***(dasatinib)***	4	SP, PA, QL (90 tabs / 30 days); OAC
SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg ***(dasatinib)***	4	SP, PA, QL (30 tabs / 30 days); OAC
STIVARGA TABS 40mg ***(regorafenib)***	4	SP, PA, QL (84 tabs / 28 days); OAC
sunitinib malate caps 12.5mg, 25mg, 37.5mg, 50mg	4	SP, PA, QL (30 caps / 30 days); OAC
SUTENT CAPS 12.5mg, 25mg, 37.5mg, 50mg ***(sunitinib malate)***	4	SP, PA, QL (30 caps / 30 days); OAC
TAFINLAR CAPS 50mg, 75mg ***(dabrafenib mesylate)***	4	SP, PA, QL (120 caps / 30 days); OAC
TUKYSA TABS 50mg, 150mg ***(tucatinib)***	4	PA, QL (120 tabs / 30 days); OAC
VITRAKVI CAPS 25mg ***(larotrectinib sulfate)***	4	SP, PA, QL (180 caps / 30 days); OAC
VITRAKVI CAPS 100mg ***(larotrectinib sulfate)***	4	SP, PA, QL (60 caps / 30 days); OAC
VITRAKVI SOLN 20mg/ml ***(larotrectinib sulfate)***	4	SP, PA, QL (300 mL / 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VOTRIENT TABS 200mg ***(pazopanib hcl)***	4	SP, PA, QL (120 tabs / 30 days); OAC
XALKORI CAPS 200mg, 250mg ***(crizotinib)***	4	SP, PA, QL (120 caps / 30 days); OAC
ZELBORAF TABS 240mg ***(vemurafenib)***	4	SP, PA, QL (240 tabs / 30 days); OAC
ZYDELIG TABS 100mg, 150mg ***(idelalisib)***	4	SP, PA, QL (60 tabs / 30 days); OAC
ZYKADIA TABS 150mg ***(ceritinib)***	4	SP, PA, QL (90 tabs / 30 days); OAC
MISCELLANEOUS		
arsenic trioxide soln 10mg/10ml, 12mg/6ml	MB	
bexarotene caps 75mg	4	SP, PA; OAC
DROXIA CAPS 200mg, 300mg, 400mg ***(hydroxyurea (sickle cell disease))***	2	MO; OAC
hydroxyurea caps 500mg	1	OAC
MATULANE CAPS 50mg ***(procarbazine hcl)***	2	OAC
mitoxantrone hcl conc 2mg/ml	MB	
ODOMZO CAPS 200mg ***(sonidegib phosphate)***	4	SP, PA, QL (30 caps / 30 days); OAC
ONCASPAR SOLN 750unit/ml ***(pegaspargase)***	MB	
PHOTOFRIN SOLR 75mg ***(porfimer sodium)***	MB	
QUADRAMET SOLN 1850mbq/ml ***(samarium sm 153 lexidronam)***	MB	
TICE BCG SUSR 50mg ***(bcg live intravesical)***	MB	
tretinoin (chemotherapy) caps 10mg	1	OAC
VISTOGARD PACK 10gm ***(uridine triacetate (emergency treatment))***	4	QL (20 packets / 5 days); OAC
PLATINUM-BASED AGENTS		
carboplatin soln 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	MB	
(Carboplatin Soln 1000mg/100ml) PARAPLATIN	MB	
cisplatin soln 50mg/50ml, 100mg/100ml, 200mg/200ml	MB	
oxaliplatin soln 50mg/10ml, 100mg/20ml; solr 50mg, 100mg	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PROTECTIVE AGENTS		
dexrazoxane hcl solr 250mg, 500mg	MB	
leucovorin calcium solr 50mg, 100mg, 200mg, 350mg, 500mg	MB	
leucovorin calcium tabs 5mg, 10mg, 15mg, 25mg	1	OAC
mesna soln 100mg/ml	MB	
MESNEX TABS 400mg ***(mesna)***	4	OAC
TOPOISOMERASE INHIBITORS		
etoposide caps 50mg	1	OAC
(Etoposide Soln 1gm/50ml, 100mg/5ml, 500mg/25ml) TOPOSAR	MB	
etoposide soln 100mg/5ml	MB	
irinotecan hcl soln 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	MB	
TENIPOSIDE SOLN 10mg/ml	MB	
topotecan hcl solr 4mg	MB	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA TABS 10mg, 50mg ***(venetoclax)***	4	PA, QL (120 / 30 days); OAC
VENCLEXTA TABS 100mg ***(venetoclax)***	4	PA, QL (180 / 30 days); OAC
VENCLEXTA TAB START PK ***(venetoclax)***	4	PA, QL (1 pack / 28 days); OAC
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-40 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-40 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
benazepril & hydrochlorothiazide tab 5-6.25 mg	1	MO
benazepril & hydrochlorothiazide tab 10-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-25 mg	1	MO
captopril & hydrochlorothiazide tab 25-15 mg	1	MO
captopril & hydrochlorothiazide tab 25-25 mg	1	MO
captopril & hydrochlorothiazide tab 50-15 mg	1	MO
captopril & hydrochlorothiazide tab 50-25 mg	1	MO
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	MO
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-25 mg	1	MO
quinapril-hydrochlorothiazide tab 10-12.5 mg	1	MO
quinapril-hydrochlorothiazide tab 20-12.5 mg	1	MO
quinapril-hydrochlorothiazide tab 20-25 mg	1	MO
trando/verap tab 2-180 er	1	MO
trando/verap tab 2-240 er	1	MO
trando/verap tab 4-240 er	1	MO
trandolapril-verapamil hcl tab er 1-240 mg	1	MO
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl tabs 5mg, 10mg, 20mg, 40mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
captopril tabs 12.5mg, 25mg, 50mg, 100mg	1	MO
enalapril maleate tabs 2.5mg, 5mg, 10mg, 20mg	1	MO
fosinopril sodium tabs 10mg, 20mg, 40mg	1	MO
lisinopril tabs 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	MO
moexipril hcl tabs 7.5mg, 15mg	1	MO
perindopril erbumine tabs 2mg, 4mg, 8mg	1	MO
quinapril hcl tabs 5mg, 10mg, 20mg, 40mg	1	MO
ramipril caps 1.25mg, 2.5mg, 5mg, 10mg	1	MO
trandolapril tabs 1mg, 2mg, 4mg	1	MO
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
eplerenone tabs 25mg, 50mg	1	MO
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
doxazosin mesylate tabs 1mg, 2mg, 4mg, 8mg	1	MO
prazosin hcl caps 1mg, 2mg, 5mg	1	MO
terazosin hcl caps 1mg, 2mg, 5mg, 10mg	1	MO
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	1	MO
amlodipine besylate-valsartan tab 5-160 mg	1	MO
amlodipine besylate-valsartan tab 5-320 mg	1	MO
amlodipine besylate-valsartan tab 10-160 mg	1	MO
amlodipine besylate-valsartan tab 10-320 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	1	MO
irbesartan-hydrochlorothiazide tab 150-12.5 mg	1	MO
irbesartan-hydrochlorothiazide tab 300-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
telmisartan-amlodipine tab 40-5 mg	1	MO
telmisartan-amlodipine tab 40-10 mg	1	MO
telmisartan-amlodipine tab 80-5 mg	1	MO
telmisartan-amlodipine tab 80-10 mg	1	MO
telmisartan-hydrochlorothiazide tab 40-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-25 mg	1	MO
valsartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-25 mg	1	MO
valsartan-hydrochlorothiazide tab 320-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 320-25 mg	1	MO
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil tabs 4mg, 8mg, 16mg, 32mg	1	MO
eprosartan mesylate tabs 600mg	1	MO
irbesartan tabs 75mg, 150mg, 300mg	1	MO
losartan potassium tabs 25mg, 50mg, 100mg	1	MO
olmesartan medoxomil tabs 5mg, 20mg, 40mg	1	MO
telmisartan tabs 20mg, 40mg, 80mg	1	MO
valsartan tabs 40mg, 80mg, 160mg, 320mg	1	MO
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
(Amiodarone Hcl Tabs 100mg, 200mg) PACERONE	1	MO
amiodarone hcl tabs 200mg, 400mg	1	MO
disopyramide phosphate caps 100mg, 150mg	1	MO
dofetilide caps 125mcg, 250mcg, 500mcg	1	SP, PA, MO
flecainide acetate tabs 50mg, 100mg, 150mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lidocaine hcl (cardiac) sosy 50mg/5ml, 100mg/5ml	MB	
mexiletine hcl caps 150mg, 200mg, 250mg	1	MO
MULTAQ TABS 400mg ***(dronedarone hcl)***	3	PA, MO
NORPACE CR CP12 100mg, 150mg ***(disopyramide phosphate)***	2	MO
procainamide hcl soln 100mg/ml	MB	
propafenone hcl cp12 225mg, 325mg, 425mg; tabs 150mg, 225mg, 300mg	1	MO
sotalol hcl tabs 80mg, 120mg, 160mg, 240mg	1	MO
(Sotalol Hcl Tabs 80mg, 120mg, 160mg, 240mg) SORINE	1	MO
sotalol hcl (afib/afl) tabs 80mg, 120mg, 160mg	1	MO
ANTILIPEMICS, BILE ACID RESINS		
cholestyramine pack 4gm; powd 4gm/dose	1	MO
cholestyramine light pack 4gm; powd 4gm/dose	1	MO
(Cholestyramine Light Powd 4gm/dose) PREVALITE	1	MO
colestipol hcl gran 5gm; pack 5gm; tabs 1gm	1	MO
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR		
ezetimibe tabs 10mg	1	MO
ANTILIPEMICS, FIBRATES		
choline fenofibrate cpdr 45mg, 135mg	1	MO
fenofibrate caps 150mg; tabs 48mg, 54mg, 145mg, 160mg	1	MO
fenofibrate micronized caps 43mg, 67mg, 134mg, 200mg	1	MO
gemfibrozil tabs 600mg	1	MO
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg	1	MO
ezetimibe-simvastatin tab 10-20 mg	1	MO
ezetimibe-simvastatin tab 10-40 mg	1	MO
ezetimibe-simvastatin tab 10-80 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
atorvastatin calcium tabs 10mg, 20mg	1	MO; $0 copay for members age 40 through 75
atorvastatin calcium tabs 40mg, 80mg	1	MO
fluvastatin sodium caps 20mg, 40mg; tb24 80mg	1	MO; $0 copay for members age 40 through 75
lovastatin tabs 10mg, 20mg, 40mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tabs 10mg, 20mg, 40mg, 80mg	1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tabs 5mg, 10mg	1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tabs 20mg, 40mg	1	MO
simvastatin tabs 5mg, 10mg, 20mg, 40mg	1	MO; $0 copay for members age 40 through 75
simvastatin tabs 80mg	1	ST, MO; PA**
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
niacin (antihyperlipidemic) tbcr 500mg, 750mg, 1000mg	1	MO
ANTILIPEMICS, OMEGA-3 FATTY ACIDS		
omega-3-acid ethyl esters cap 1 gm	1	MO
VASCEPA CAPS .5gm, 1gm ***(icosapent ethyl)***	2	MO
ANTILIPEMICS, PCSK9 INHIBITORS		
PRALUENT SOAJ 75mg/ml, 150mg/ml ***(alirocumab)***	MB	MO
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg	1	MO
atenolol & chlorthalidone tab 100-25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	MO
metoprolol & hydrochlorothiazide tab 50-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-50 mg	1	MO
propranolol & hydrochlorothiazide tab 40-25 mg	1	MO
propranolol & hydrochlorothiazide tab 80-25 mg	1	MO
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl caps 200mg, 400mg	1	MO
atenolol tabs 25mg, 50mg, 100mg	1	MO
betaxolol hcl tabs 10mg, 20mg	1	MO
bisoprolol fumarate tabs 5mg, 10mg	1	MO
BYSTOLIC TABS 2.5mg, 5mg, 10mg, 20mg ***(nebivolol hcl)***	3	MO
carvedilol tabs 3.125mg, 6.25mg, 12.5mg, 25mg	1	MO
carvedilol phosphate cp24 10mg, 20mg, 40mg, 80mg	1	MO
labetalol hcl tabs 100mg, 200mg, 300mg	1	MO
metoprolol succinate tb24 25mg, 50mg, 100mg, 200mg	1	MO
metoprolol tartrate tabs 25mg, 50mg, 100mg	1	MO
nadolol tabs 20mg, 40mg, 80mg	1	MO
nebivolol hcl tabs 2.5mg, 5mg, 10mg, 20mg	1	MO
pindolol tabs 5mg, 10mg	1	MO
propranolol hcl cp24 60mg, 80mg, 120mg, 160mg; soln 20mg/5ml, 40mg/5ml; tabs 10mg, 20mg, 40mg, 60mg, 80mg	1	MO
timolol maleate tabs 5mg, 10mg, 20mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS		
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-80 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-80 mg	1	MO
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
amlodipine besylate tabs 2.5mg, 5mg, 10mg	1	MO
CARDIZEM LA TB24 120mg ***(diltiazem hcl coated beads)***	3	MO
diltiazem hcl cp12 60mg, 90mg, 120mg; tabs 30mg, 60mg, 90mg, 120mg	1	MO
(Diltiazem Hcl Cp24 120mg, 180mg, 240mg) DILT-XR	1	MO
diltiazem hcl soln 25mg/5ml, 125mg/25ml	MB	
(Diltiazem Hcl Coated Beads Cp24 120mg, 180mg, 240mg, 300mg) CARTIA XT	1	MO
diltiazem hcl coated beads cp24 120mg, 180mg, 240mg, 300mg, 360mg	1	MO
(Diltiazem Hcl Coated Beads Tb24 180mg, 240mg, 300mg, 360mg, 420mg) MATZIM LA	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Diltiazem Hcl Extended Release Beads Cp24 120mg, 180mg, 240mg, 300mg, 360mg) TAZTIA XT	1	MO
diltiazem hcl extended release beads cp24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	MO
felodipine tb24 2.5mg, 5mg, 10mg	1	MO
isradipine caps 2.5mg, 5mg	1	MO
nicardipine hcl caps 20mg, 30mg	1	MO
nifedipine tb24 30mg, 60mg, 90mg	1	MO
nimodipine caps 30mg	1	
nisoldipine tb24 8.5mg, 17mg, 20mg, 25.5mg, 30mg, 34mg, 40mg	1	MO
verapamil hcl cp24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; tabs 40mg, 80mg, 120mg; tbcr 120mg, 180mg, 240mg	1	MO
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
digoxin soln .05mg/ml; tabs 125mcg, 250mcg	1	MO
(Digoxin Tabs 125mcg, 250mcg) DIGOX	1	MO
LANOXIN TABS 62.5mcg ***(digoxin)***	2	MO
DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS		
aliskiren fumarate tabs 150mg, 300mg	1	MO
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide cp12 500mg; tabs 125mg, 250mg	1	MO
ALDACTAZIDE TAB 50/50 ***(spironolactone & hydrochlorothiazide)***	2	MO
amiloride & hydrochlorothiazide tab 5-50 mg	1	MO
amiloride hcl tabs 5mg	1	MO
bumetanide tabs .5mg, 1mg, 2mg	1	MO
chlorothiazide tabs 250mg, 500mg	1	MO
chlorthalidone tabs 25mg, 50mg	1	MO
DIURIL SUSP 250mg/5ml ***(chlorothiazide)***	3	MO
ethacrynic acid tabs 25mg	3	MO
furosemide soln 8mg/ml, 10mg/ml; tabs 20mg, 40mg, 80mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
furosemide soln 10mg/ml	MB	
hydrochlorothiazide caps 12.5mg; tabs 12.5mg, 25mg, 50mg	1	MO
indapamide tabs 1.25mg, 2.5mg	1	MO
methazolamide tabs 25mg, 50mg	1	MO
metolazone tabs 2.5mg, 5mg, 10mg	1	MO
spironolactone tabs 25mg, 50mg, 100mg	1	MO
spironolactone & hydrochlorothiazide tab 25-25 mg	1	MO
torsemide tabs 5mg, 10mg, 20mg, 100mg	1	MO
triamterene caps 50mg, 100mg	1	MO
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 75-50 mg	1	MO
MISCELLANEOUS		
clonidine ptwk .1mg/24hr, .2mg/24hr, .3mg/24hr	1	MO
clonidine hcl tabs .1mg, .2mg, .3mg	1	MO
ENTRESTO TAB 24-26MG ***(sacubitril-valsartan)***	2	MO
ENTRESTO TAB 49-51MG ***(sacubitril-valsartan)***	2	MO
ENTRESTO TAB 97-103MG ***(sacubitril-valsartan)***	2	MO
guanfacine hcl tabs 1mg, 2mg	1	MO
hydralazine hcl tabs 10mg, 25mg, 50mg, 100mg	1	MO
methyldopa tabs 250mg, 500mg	1	MO
midodrine hcl tabs 2.5mg, 5mg, 10mg	1	
minoxidil tabs 2.5mg, 10mg	1	MO
phenoxybenzamine hcl caps 10mg	4	PA, QL (360 caps / 25 days)
ranolazine tb12 500mg, 1000mg	1	ST, MO; PA**
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
DILATRATE SR CPCR 40mg ***(isosorbide dinitrate)***	3	MO
isosorbide dinitrate tabs 5mg, 10mg, 20mg, 30mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
isosorbide mononitrate tabs 10mg, 20mg; tb24 30mg, 60mg, 120mg	1	MO
NITRO-BID OINT 2% ***(nitroglycerin)***	3	MO
NITRO-DUR PT24 .3mg/hr, .8mg/hr ***(nitroglycerin)***	2	MO
(Nitroglycerin Pt24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr) MINITRAN	1	MO
nitroglycerin pt24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; soln .4mg/spray; subl .3mg, .4mg, .6mg	1	MO
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg ***(riociguat)***	4	SP, PA, QL (90 tabs / 30 days), MO
ambrisentan tabs 5mg, 10mg	4	SP, PA, QL (30 tabs / 30 days), MO
bosentan tabs 62.5mg, 125mg	4	SP, PA, QL (60 tabs / 30 days), MO
OPSUMIT TABS 10mg ***(macitentan)***	4	SP, PA, QL (30 tabs / 30 days), MO
ORENITRAM TBCR .125mg, .25mg, 1mg, 2.5mg, 5mg ***(treprostinil diolamine)***	4	SP, PA, MO
REMODULIN SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml ***(treprostinil)***	MB	
sildenafil citrate (pulmonary hypertension) soln 10mg/12.5ml	MB	
sildenafil citrate (pulmonary hypertension) tabs 20mg	4	SP, PA, QL (90 tabs / 30 days), MO
tadalafil (pulmonary hypertension) tabs 20mg	4	SP, PA, QL (60 tabs / 30 days), MO
TRACLEER TBSO 32mg ***(bosentan)***	4	SP, PA, QL (112 tabs / 28 days), MO
TYVASO STARTER SOLN .6mg/ml ***(treprostinil)***	4	SP, PA, QL (28 ampules / 28 days), MO
UPTRAVI SOLR 1800mcg ***(selexipag)***	MB	
UPTRAVI TABS 200mcg ***(selexipag)***	4	SP, PA, QL (140 tabs / 28 days), MO
UPTRAVI TABS 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg ***(selexipag)***	4	SP, PA, QL (60 tabs / 30 days), MO
UPTRAVI TAB 200/800 ***(selexipag)***	4	SP, PA, QL (1 pack / 28 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VENTAVIS SOLN 10mcg/ml, 20mcg/ml ***(iloprost)***	4	SP, PA, QL (270 ampules / 30 days), MO
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam tabs .25mg, .5mg, 1mg, 2mg; tbdp .25mg, .5mg, 1mg, 2mg	1	QL (150 tabs / 25 days)
ALPRAZOLAM INTENSOL CONC 1mg/ml ***(alprazolam)***	2	QL (300 mL / 25 days)
lorazepam conc 2mg/ml	1	QL (150 mL / 25 days)
lorazepam tabs .5mg, 1mg, 2mg	1	QL (150 tabs / 25 days)
meprobamate tabs 200mg, 400mg	1	
oxazepam caps 10mg, 15mg, 30mg	1	QL (120 caps / 25 days)
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
APTIOM TABS 200mg, 400mg, 600mg, 800mg ***(eslicarbazepine acetate)***	3	PA, MO
carbamazepine chew 100mg; cp12 100mg, 200mg, 300mg; susp 100mg/5ml; tabs 200mg; tb12 100mg, 200mg, 400mg	1	MO
(Carbamazepine Tabs 200mg) EPITOL	1	MO
CELONTIN CAPS 300mg ***(methsuximide)***	3	MO
clobazam susp 2.5mg/ml; tabs 10mg, 20mg	1	PA, MO
clonazepam tabs .5mg, 1mg, 2mg	1	
clorazepate dipotassium tabs 3.75mg, 7.5mg, 15mg	1	QL (180 tabs / 25 days)
(Diazepam Conc 5mg/ml) DIAZEPAM INTENSOL	1	QL (240 mL / 25 days)
diazepam soln 5mg/5ml	1	QL (1200 mL / 25 days)
diazepam soln 5mg/ml	MB	
diazepam tabs 2mg, 5mg, 10mg	1	QL (120 tabs / 25 days)
DILANTIN CAPS 30mg ***(phenytoin sodium extended)***	3	MO
divalproex sodium csdr 125mg; tb24 250mg, 500mg; tbec 125mg, 250mg, 500mg	1	MO
ethosuximide caps 250mg; soln 250mg/5ml	1	MO
felbamate susp 600mg/5ml; tabs 400mg, 600mg	1	MO
fosphenytoin sodium soln 100mgpe/2ml, 500mgpe/10ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FYCOMPA SUSP .5mg/ml; TABS 2mg, 4mg, 6mg, 8mg, 10mg, 12mg ***(perampanel)***	2	MO
gabapentin caps 100mg, 300mg, 400mg; soln 250mg/5ml; tabs 600mg, 800mg	1	MO
lamotrigine chew 5mg, 25mg; tabs 25mg, 100mg, 150mg, 200mg; tb24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg; tbdp 25mg, 50mg, 100mg, 200mg	1	MO
lamotrigine kit 25mg	1	
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	1	
levetiracetam soln 100mg/ml; tabs 250mg, 500mg, 750mg, 1000mg; tb24 500mg, 750mg	1	MO
levetiracetam soln 500mg/5ml	MB	
levetiracetam in sodium chloride iv soln 500 mg/100ml	MB	
levetiracetam in sodium chloride iv soln 1000 mg/100ml	MB	
levetiracetam in sodium chloride iv soln 1500 mg/100ml	MB	
oxcarbazepine susp 60mg/ml; tabs 150mg, 300mg, 600mg	1	MO
PEGANONE TABS 250mg ***(ethotoin)***	3	MO
phenobarbital elix 20mg/5ml; tabs 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	1	MO
phenytoin chew 50mg; susp 125mg/5ml	1	MO
phenytoin sodium soln 50mg/ml	MB	
phenytoin sodium extended caps 100mg, 200mg, 300mg	1	MO
pregabalin caps 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg; soln 20mg/ml	1	ST, MO; PA**
primidone tabs 50mg, 250mg	1	MO
tiagabine hcl tabs 2mg, 4mg, 12mg, 16mg	1	MO
topiramate cpsp 15mg, 25mg; tabs 25mg, 50mg, 100mg, 200mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
valproate sodium soln 100mg/ml	MB	
valproate sodium soln 250mg/5ml	1	MO
valproic acid caps 250mg	1	MO
vigabatrin pack 500mg	4	SP, PA, QL (180 packets / 30 days), MO
vigabatrin tabs 500mg	4	SP, PA, QL (180 tabs / 30 days), MO
VIMPAT SOLN 10mg/ml; TABS 50mg, 100mg, 150mg, 200mg ***(lacosamide)***	3	MO
VIMPAT SOLN 200mg/20ml ***(lacosamide)***	MB	
zonisamide caps 25mg, 50mg, 100mg	1	MO
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride tabs 5mg, 10mg, 23mg; tbdp 5mg, 10mg	1	MO
ergoloid mesylates tabs 1mg	1	MO
galantamine hydrobromide cp24 8mg, 16mg, 24mg; soln 4mg/ml; tabs 4mg, 8mg, 12mg	1	MO
memantine hcl cp24 7mg, 14mg, 21mg, 28mg; soln 2mg/ml; tabs 5mg, 10mg	1	PA, MO; PA applies for members less than 30 years of age
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	1	PA; PA applies for members less than 30 years of age
NAMENDA XR CAP TITRATIO ***(memantine hcl)***	2	PA; PA applies for members less than 30 years of age
rivastigmine pt24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	1	PA, MO
rivastigmine tartrate caps 1.5mg, 3mg, 4.5mg, 6mg	1	PA, MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
amitriptyline hcl tabs 10mg	1	QL (150 tabs / 25 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 25mg	1	QL (60 tabs / 25 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 50mg	1	QL (30 tabs / 25 days), MO; QL applies to members age 65 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amitriptyline hcl tabs 75mg, 100mg, 150mg	1	PA, MO; High strength requires PA for members age 70 and older
amoxapine tabs 25mg, 50mg, 100mg	1	QL (90 tabs / 25 days), MO; QL applies to members age 65 and older
amoxapine tabs 150mg	1	QL (60 tabs / 25 days), MO; QL applies to members age 65 and older
bupropion hcl tabs 75mg, 100mg; tb12 100mg, 150mg, 200mg; tb24 150mg, 300mg	1	MO
citalopram hydrobromide soln 10mg/5ml; tabs 10mg, 20mg, 40mg	1	MO
desipramine hcl tabs 10mg, 25mg, 50mg	1	QL (90 tabs / 25 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 75mg	1	QL (60 tabs / 25 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 100mg, 150mg	1	QL (30 tabs / 25 days), MO; QL applies to members age 65 and older
desvenlafaxine succinate tb24 25mg, 50mg, 100mg	1	ST, QL (30 tabs / 25 days), MO; (generic of Pristiq) PA**
doxepin hcl caps 10mg, 25mg, 50mg	1	QL (90 caps / 25 days), MO; QL applies to members age 65 and older
doxepin hcl caps 75mg	1	QL (60 caps / 25 days), MO; QL applies to members age 65 and older
doxepin hcl caps 100mg, 150mg	1	QL (30 caps / 25 days), MO; QL applies to members age 65 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
doxepin hcl conc 10mg/ml	1	QL (450 mL / 25 days), MO; QL applies to members age 65 and older
duloxetine hcl cpep 20mg, 30mg, 60mg	1	MO
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr ***(selegiline)***	3	PA, MO
escitalopram oxalate soln 5mg/5ml; tabs 5mg, 10mg, 20mg	1	MO
FETZIMA CP24 20mg, 40mg, 80mg, 120mg ***(levomilnacipran hcl)***	3	ST, QL (30 caps / 25 days), MO; PA**
FETZIMA CAP TITRATIO ***(levomilnacipran hcl)***	3	ST, QL (30 caps / 25 days); PA**
fluoxetine hcl caps 10mg, 20mg, 40mg; cpdr 90mg; soln 20mg/5ml	1	MO
fluoxetine hcl tabs 10mg, 20mg	1	MO; (generic Sarafem not covered)
imipramine hcl tabs 10mg, 25mg	1	QL (120 tabs / 25 days), MO; QL applies to members age 65 and older
imipramine hcl tabs 50mg	1	QL (60 tabs / 25 days), MO; QL applies to members age 65 and older
imipramine pamoate caps 75mg, 100mg	1	QL (30 caps / 25 days), MO; QL applies to members age 65 and older
imipramine pamoate caps 125mg, 150mg	1	PA, MO; High strength requires PA for members age 70 and older
maprotiline hcl tabs 25mg, 50mg, 75mg	1	MO
MARPLAN TABS 10mg ***(isocarboxazid)***	3	MO
mirtazapine tabs 7.5mg, 15mg, 30mg, 45mg; tbdp 15mg, 30mg, 45mg	1	MO
nefazodone hcl tabs 50mg, 100mg, 150mg, 200mg, 250mg	1	MO
nortriptyline hcl caps 10mg	1	QL (150 caps / 25 days), MO; QL applies to members age 65 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
nortriptyline hcl caps 25mg	1	QL (60 caps / 25 days), MO; QL applies to members age 65 and older
nortriptyline hcl caps 50mg	1	QL (30 caps / 25 days), MO; QL applies to members age 65 and older
nortriptyline hcl caps 75mg	1	PA, MO; High strength requires PA for members age 65 and older
nortriptyline hcl soln 10mg/5ml	1	QL (750 mL / 25 days), MO; QL applies to members age 65 and older
paroxetine hcl tabs 10mg, 20mg, 30mg, 40mg; tb24 12.5mg, 25mg, 37.5mg	1	MO
phenelzine sulfate tabs 15mg	1	MO
protriptyline hcl tabs 5mg	1	QL (90 tabs / 25 days), MO; QL applies to members age 65 and older
protriptyline hcl tabs 10mg	1	QL (60 tabs / 25 days), MO; QL applies to members age 65 and older
sertraline hcl conc 20mg/ml; tabs 25mg, 50mg, 100mg	1	MO
tranylcypromine sulfate tabs 10mg	1	MO
trazodone hcl tabs 50mg, 100mg, 150mg, 300mg	1	MO
trimipramine maleate caps 25mg, 50mg	1	QL (60 caps / 25 days), MO; QL applies to members age 65 and older
trimipramine maleate caps 100mg	1	QL (30 caps / 25 days), MO; QL applies to members age 65 and older
venlafaxine hcl cp24 37.5mg, 75mg, 150mg; tabs 25mg, 37.5mg, 50mg, 75mg, 100mg; tb24 37.5mg, 75mg, 150mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VIIBRYD TABS 10mg, 20mg, 40mg ***(vilazodone hcl)***	3	ST, MO; PA**
VIIBRYD KIT STARTER ***(vilazodone hcl)***	3	ST; PA**
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl caps 100mg; soln 50mg/5ml; tabs 100mg	1	MO
APOKYN SOCT 30mg/3ml ***(apomorphine hydrochloride)***	MB	
benztropine mesylate soln 1mg/ml	MB	
benztropine mesylate tabs .5mg, 1mg, 2mg	1	MO
bromocriptine mesylate caps 5mg; tabs 2.5mg	1	MO
carbidopa tabs 25mg	1	MO
carbidopa & levodopa orally disintegrating tab 10-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-250 mg	1	MO
carbidopa & levodopa tab 10-100 mg	1	MO
carbidopa & levodopa tab 25-100 mg	1	MO
carbidopa & levodopa tab 25-250 mg	1	MO
carbidopa & levodopa tab er 25-100 mg	1	MO
carbidopa & levodopa tab er 50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	MO
entacapone tabs 200mg	1	MO
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr ***(rotigotine)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
pramipexole dihydrochloride tabs .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg; tb24 .375mg, .75mg, 1.5mg, 2.25mg, 3mg, 3.75mg, 4.5mg	1	MO
rasagiline mesylate tabs .5mg, 1mg	1	MO
ropinirole hydrochloride tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	1	MO
selegiline hcl caps 5mg; tabs 5mg	1	MO
tolcapone tabs 100mg	1	MO
trihexyphenidyl hcl soln .4mg/ml; tabs 2mg, 5mg	1	MO
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
aripiprazole soln 1mg/ml; tabs 2mg, 5mg, 10mg, 15mg, 20mg, 30mg; tbdp 10mg, 15mg	1	MO
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml, 1064mg/3.9ml ***(aripiprazole lauroxil)***	MB	MO
ARISTADA INITIO PRSY 675mg/2.4ml ***(aripiprazole lauroxil)***	MB	
asenapine maleate subl 2.5mg, 5mg, 10mg	1	MO
chlorpromazine hcl soln 25mg/ml, 50mg/2ml	MB	
chlorpromazine hcl tabs 10mg, 25mg, 50mg, 100mg, 200mg	1	MO
clozapine tabs 25mg, 50mg, 100mg, 200mg; tbdp 12.5mg, 25mg, 100mg, 150mg, 200mg	1	
fluphenazine decanoate soln 25mg/ml	MB	
fluphenazine hcl conc 5mg/ml; elix 2.5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg	1	MO
fluphenazine hcl soln 2.5mg/ml	MB	
haloperidol tabs .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	1	MO
haloperidol decanoate soln 50mg/ml, 100mg/ml	MB	
haloperidol lactate conc 2mg/ml	1	MO
haloperidol lactate soln 5mg/ml	MB	
LATUDA TABS 20mg, 40mg, 60mg, 80mg, 120mg ***(lurasidone hcl)***	2	ST, MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
loxapine succinate caps 5mg, 10mg, 25mg, 50mg	1	MO
olanzapine solr 10mg	MB	
olanzapine tabs 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg; tbdp 5mg, 10mg, 15mg, 20mg	1	MO
paliperidone tb24 1.5mg, 3mg, 6mg, 9mg	1	MO
perphenazine tabs 2mg, 4mg, 8mg, 16mg	1	MO
quetiapine fumarate tabs 25mg, 50mg, 100mg, 200mg, 300mg, 400mg; tb24 50mg, 150mg, 200mg, 300mg, 400mg	1	MO
REXULTI TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg ***(brexpiprazole)***	3	ST, MO; PA**
risperidone soln 1mg/ml; tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg; tbdp .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	1	MO
thioridazine hcl tabs 10mg, 25mg, 50mg, 100mg	1	MO
thiothixene caps 1mg, 2mg, 5mg, 10mg	1	MO
trifluoperazine hcl tabs 1mg, 2mg, 5mg, 10mg	1	MO
ziprasidone hcl caps 20mg, 40mg, 60mg, 80mg	1	MO
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
amphetamine-dextroamphetamine cap er 24hr 5 mg	1	QL (90 caps / 25 days), MO
amphetamine-dextroamphetamine cap er 24hr 10 mg	1	QL (90 caps / 25 days), MO
amphetamine-dextroamphetamine cap er 24hr 15 mg	1	QL (30 caps / 25 days), MO
amphetamine-dextroamphetamine cap er 24hr 20 mg	1	QL (30 caps / 25 days), MO
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	QL (30 caps / 25 days), MO
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	QL (30 caps / 25 days), MO
amphetamine-dextroamphetamine tab 5 mg	1	QL (90 tabs / 25 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (90 tabs / 25 days), MO
amphetamine-dextroamphetamine tab 10 mg	1	QL (90 tabs / 25 days), MO
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (90 tabs / 25 days), MO
amphetamine-dextroamphetamine tab 15 mg	1	QL (60 tabs / 25 days), MO
amphetamine-dextroamphetamine tab 20 mg	1	QL (60 tabs / 25 days), MO
amphetamine-dextroamphetamine tab 30 mg	1	QL (30 tabs / 25 days), MO
atomoxetine hcl caps 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg	1	MO
dexmethylphenidate hcl cp24 5mg, 10mg, 15mg, 20mg	1	QL (60 caps / 25 days), MO
dexmethylphenidate hcl cp24 25mg, 30mg, 35mg, 40mg	1	QL (30 caps / 25 days), MO
dexmethylphenidate hcl tabs 2.5mg, 5mg	1	QL (120 tabs / 25 days), MO
dexmethylphenidate hcl tabs 10mg	1	QL (60 tabs / 25 days), MO
dextroamphetamine sulfate cp24 5mg, 10mg	1	QL (120 caps / 25 days), MO
dextroamphetamine sulfate cp24 15mg	1	QL (60 caps / 25 days), MO
dextroamphetamine sulfate soln 5mg/5ml	1	QL (1,200 mL / 25 days), MO
(Dextroamphetamine Sulfate Tabs 2.5mg, 7.5mg) ZENZEDI	1	QL (120 tabs / 25 days), MO
dextroamphetamine sulfate tabs 5mg, 10mg	1	QL (120 tabs / 25 days), MO
(Dextroamphetamine Sulfate Tabs 15mg, 20mg) ZENZEDI	1	QL (60 tabs / 25 days), MO
(Dextroamphetamine Sulfate Tabs 30mg) ZENZEDI	1	QL (30 tabs / 25 days), MO
guanfacine hcl (adhd) tb24 1mg, 2mg, 3mg, 4mg	1	MO
methamphetamine hcl tabs 5mg	1	QL (150 tabs / 25 days), MO
methylphenidate hcl chew 2.5mg, 5mg, 10mg	1	QL (180 chew tabs / 25 days), MO
methylphenidate hcl cp24 20mg, 30mg; cpcr 10mg, 20mg, 30mg	1	QL (60 caps / 25 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cp24 40mg, 60mg; cpcr 40mg, 50mg, 60mg	1	QL (30 caps / 25 days), MO
methylphenidate hcl soln 5mg/5ml	1	QL (1800 mL / 25 days), MO
methylphenidate hcl soln 10mg/5ml	1	QL (900 mL / 25 days), MO
methylphenidate hcl tabs 5mg, 10mg	1	QL (180 tabs / 25 days), MO
methylphenidate hcl tabs 20mg; tbcr 10mg, 20mg	1	QL (90 tabs / 25 days), MO
methylphenidate hcl tbcr 18mg, 27mg, 36mg	1	QL (60 tabs / 25 days), MO
methylphenidate hcl tbcr 54mg	1	QL (30 tabs / 25 days), MO
VYVANSE CAPS 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)***	2	QL (60 caps / 25 days), MO
VYVANSE CAPS 40mg, 50mg, 60mg, 70mg ***(lisdexamfetamine dimesylate)***	2	QL (30 caps / 25 days), MO
VYVANSE CHEW 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)***	2	QL (60 tabs / 25 days), MO
VYVANSE CHEW 40mg, 50mg, 60mg ***(lisdexamfetamine dimesylate)***	2	QL (30 tabs / 25 days), MO
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg ***(suvorexant)***	2	ST; PA**
eszopiclone tabs 1mg, 2mg, 3mg	1	QL (15 tabs / 25 days)
HETLIOZ CAPS 20mg ***(tasimelteon)***	4	PA, QL (30 caps / 30 days), MO
ramelteon tabs 8mg	1	QL (15 tabs / 25 days)
temazepam caps 7.5mg, 15mg, 22.5mg, 30mg	1	QL (15 caps / 25 days)
zaleplon caps 5mg, 10mg	1	QL (15 caps / 25 days)
zolpidem tartrate tabs 5mg, 10mg; tbcr 6.25mg, 12.5mg	1	QL (15 tabs / 25 days)
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SOAJ 70mg/ml, 140mg/ml ***(erenumab-aooe)***	MB	MO
AJOVY SOAJ 225mg/1.5ml; SOSY 225mg/1.5ml ***(fremanezumab-vfrm)***	MB	MO
almotriptan malate tabs 6.25mg, 12.5mg	1	QL (12 tabs / 25 days)
dihydroergotamine mesylate soln 1mg/ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
eletriptan hydrobromide tabs 20mg, 40mg	1	QL (12 tabs / 25 days)
EMGALITY SOAJ 120mg/ml; SOSY 100mg/ml, 120mg/ml ***(galcanezumab-gnlm)***	MB	MO
ergotamine w/ caffeine tab 1-100 mg	3	
frovatriptan succinate tabs 2.5mg	1	QL (18 tabs / 25 days)
naratriptan hcl tabs 1mg, 2.5mg	1	QL (12 tabs / 25 days)
rizatriptan benzoate tabs 5mg, 10mg; tbdp 5mg, 10mg	1	QL (18 tabs / 25 days)
sumatriptan soln 5mg/act	1	QL (24 sprays / 25 days)
sumatriptan soln 20mg/act	1	QL (12 sprays / 25 days)
sumatriptan succinate soaj 4mg/0.5ml; soct 4mg/0.5ml	1	QL (18 syringes / 25 days)
sumatriptan succinate soaj 6mg/0.5ml; soct 6mg/0.5ml; sosy 6mg/0.5ml	1	QL (12 units / 25 days)
sumatriptan succinate soln 6mg/0.5ml	1	QL (12 vials / 25 days)
sumatriptan succinate tabs 25mg, 50mg, 100mg	1	QL (12 tabs / 25 days)
zolmitriptan soln 2.5mg, 5mg	1	QL (12 sprays / 25 days)
zolmitriptan tabs 2.5mg, 5mg; tbdp 2.5mg, 5mg	1	QL (12 tabs / 25 days)
MISCELLANEOUS		
buspirone hcl tabs 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
clomipramine hcl caps 25mg, 50mg	1	QL (150 caps / 25 days), MO; QL applies to members age 65 and older
clomipramine hcl caps 75mg	1	QL (90 caps / 25 days), MO; QL applies to members age 65 and older
EVRYSDI SOLR .75mg/ml ***(risdiplam)***	4	PA, QL (2 bottles / 24 days), MO
fluvoxamine maleate cp24 100mg, 150mg; tabs 25mg, 50mg, 100mg	1	MO
GUANIDINE HCL TABS 125mg	3	
LITHIUM SOLN 8meq/5ml	3	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lithium carbonate caps 150mg, 300mg, 600mg; tabs 300mg; tbcr 300mg, 450mg	1	MO
NUEDEXTA CAP 20-10MG ***(dextromethorphan hbr-quinidine sulfate)***	2	PA, MO
pimozide tabs 1mg, 2mg	1	MO
pyridostigmine bromide soln 60mg/5ml; tabs 60mg; tbcr 180mg	1	
riluzole tabs 50mg	1	MO
tetrabenazine tabs 12.5mg	4	SP, PA, QL (120 tabs / 30 days), MO
tetrabenazine tabs 25mg	4	SP, PA, QL (60 tabs / 30 days), MO
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO TABS 7mg, 14mg ***(teriflunomide)***	4	SP, PA, QL (30 tabs / 30 days), MO
AVONEX PSKT 30mcg/0.5ml ***(interferon beta-1a)***	MB	MO
AVONEX PEN AJKT 30mcg/0.5ml ***(interferon beta-1a)***	MB	MO
BETASERON KIT .3mg ***(interferon beta-1b)***	MB	MO
COPAXONE SOSY 20mg/ml, 40mg/ml ***(glatiramer acetate)***	MB	MO
dalfampridine tb12 10mg	4	SP, PA, QL (60 tabs / 30 days), MO
dimethyl fumarate cpdr 120mg	4	SP, PA, QL (14 caps / 28 days), MO
dimethyl fumarate cpdr 240mg	4	SP, PA, QL (60 caps / 30 days), MO
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	4	SP, PA, QL (1 kit / 30 days)
GILENYA CAPS .5mg ***(fingolimod hcl)***	4	SP, PA, QL (30 caps / 30 days), MO
(Glatiramer Acetate Sosy 20mg/ml) GLATOPA	MB	MO
glatiramer acetate sosy 40mg/ml	MB	MO
PLEGRIDY SOPN 125mcg/0.5ml; SOSY 125mcg/0.5ml ***(peginterferon beta-1a)***	MB	MO
PLEGRIDY INJ STARTER ***(peginterferon beta-1a)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PLEGRIDY PEN INJ STARTER ***(peginterferon beta-1a)***	MB	
REBIF SOSY 22mcg/0.5ml, 44mcg/0.5ml ***(interferon beta-1a)***	MB	MO
REBIF REBIDO INJ TITRATN ***(interferon beta-1a)***	MB	MO
REBIF REBIDOSE SOAJ 22mcg/0.5ml, 44mcg/0.5ml ***(interferon beta-1a)***	MB	MO
REBIF TITRTN INJ PACK ***(interferon beta-1a)***	MB	MO
TYSABRI CONC 300mg/15ml ***(natalizumab)***	MB	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
baclofen tabs 5mg, 10mg, 20mg	1	
carisoprodol tabs 350mg	1	PA
chlorzoxazone tabs 500mg	1	PA; High Risk Medications require PA for members age 70 and older
cyclobenzaprine hcl tabs 5mg, 10mg	1	PA; High Risk Medications require PA for members age 70 and older
dantrolene sodium caps 25mg, 50mg, 100mg	1	
metaxalone tabs 800mg	1	PA; High Risk Medications require PA for members age 70 and older
methocarbamol tabs 500mg, 750mg	1	PA; High Risk Medications require PA for members age 70 and older
orphenadrine citrate soln 30mg/ml	MB	
orphenadrine citrate tb12 100mg	1	PA; High Risk Medications require PA for members age 70 and older
tizanidine hcl tabs 2mg, 4mg	1	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil tabs 50mg	1	PA, QL (60 tabs / 25 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
armodafinil tabs 150mg, 200mg, 250mg	1	PA, QL (30 tabs / 25 days), MO
modafinil tabs 100mg, 200mg	1	PA, QL (60 tabs / 25 days), MO
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium tbec 333mg	1	PA, MO
bupropion hcl (smoking deterrent) tb12 150mg	PV	$0 limited to 2 treatment cycles/year
CHANTIX TABS .5mg, 1mg ***(varenicline tartrate)***	PV	$0 limited to 2 treatment cycles/year
CHANTIX CONTINUING MONTH TABS 1mg ***(varenicline tartrate)***	PV	$0 limited to 2 treatment cycles/year
CHANTIX PAK 0.5& 1MG ***(varenicline tartrate)***	PV	$0 limited to 2 treatment cycles/year
disulfiram tabs 250mg, 500mg	1	MO
naloxone hcl soct .4mg/ml; soln .4mg/ml, 4mg/10ml; sosy 2mg/2ml	MB	
naltrexone hcl tabs 50mg	1	Must obtain approval after the first 30 day supply
NARCAN LIQD 4mg/0.1ml ***(naloxone hcl)***	2	
(Nicotine Pt24 7mg/24hr) NICOTINE STEP 3	PV	$0 limited to 2 treatment cycles/year
nicotine pt24 7mg/24hr, 14mg/24hr, 21mg/24hr	PV	$0 limited to 2 treatment cycles/year
(Nicotine Pt24 7mg/24hr, 14mg/24hr, 21mg/24hr) SM NICOTINE TRANSDERMAL S	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex gum 2mg, 4mg; lozg 2mg	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4mg; Lozg 4mg) GOODSENSE NICOTINE POLACR	PV	$0 limited to 2 treatment cycles/year
NICOTROL INHALER INHA 10mg ***(nicotine)***	PV	QL (max 168 days / year); $0 limited to 2 treatment cycles/year
NICOTROL NS SOLN 10mg/ml ***(nicotine)***	PV	QL (max 168 days / year); $0 limited to 2 treatment cycles/year
VARENICLINE TARTRATE TABS .5mg, 1mg	PV	$0 limited to 2 treatment cycles/year
VIVITROL SUSR 380mg ***(naltrexone)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
INTRAROSA INST 6.5mg ***(prasterone vaginal)***	3	MO
methyltestosterone caps 10mg	1	PA, MO
testosterone gel 10mg/act, 25mg/2.5gm	1	PA, MO
testosterone cypionate soln 100mg/ml, 200mg/ml	MB	MO
testosterone enanthate soln 200mg/ml	MB	MO
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tabs 25mg, 50mg, 100mg	1	MO
miglitol tabs 25mg, 50mg, 100mg	1	MO
ANTIDIABETICS, AMYLIN ANALOGS		
SYMLINPEN 60 SOPN 1500mcg/1.5ml ***(pramlintide acetate)***	3	ST, MO; PA**
SYMLINPEN 120 SOPN 2700mcg/2.7ml ***(pramlintide acetate)***	3	ST, MO; PA**
ANTIDIABETICS, BIGUANIDE		
metformin hcl tabs 500mg, 850mg, 1000mg; tb24 500mg, 750mg	1	MO
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
glipizide-metformin hcl tab 2.5-250 mg	1	MO
glipizide-metformin hcl tab 2.5-500 mg	1	MO
glipizide-metformin hcl tab 5-500 mg	1	MO
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 INHIBITORS		
alogliptin benzoate tabs 6.25mg, 12.5mg, 25mg	1	ST, MO; PA**
JANUVIA TABS 25mg, 50mg, 100mg ***(sitagliptin phosphate)***	2	ST, MO; PA**
ANTIDIABETICS, DOPAMINE RECEPTOR AGONISTS		
CYCLOSET TABS .8mg ***(bromocriptine mesylate (diabetes))***	3	MO
ANTIDIABETICS, DPP-4 INHIBITOR COMBINATIONS		
alogliptin-metformin hcl tab 12.5-500 mg	1	ST, MO; PA**
alogliptin-metformin hcl tab 12.5-1000 mg	1	ST, MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
JANUMET TAB 50-500MG ***(sitagliptin-metformin hcl)***	2	ST, MO; PA**
JANUMET TAB 50-1000 ***(sitagliptin-metformin hcl)***	2	ST, MO; PA**
JANUMET XR TAB 50-500MG ***(sitagliptin-metformin hcl)***	2	ST, MO; PA**
JANUMET XR TAB 50-1000 ***(sitagliptin-metformin hcl)***	2	ST, MO; PA**
JANUMET XR TAB 100-1000 ***(sitagliptin-metformin hcl)***	2	ST, MO; PA**
JENTADUETO TAB XR ***(linagliptin-metformin hcl)***	3	ST, MO; PA**
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
OZEMPIC SOPN 2mg/1.5ml, 4mg/3ml ***(semaglutide)***	2	ST, MO; PA**
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml ***(dulaglutide)***	2	ST, MO; PA**
VICTOZA SOPN 18mg/3ml ***(liraglutide)***	2	ST, MO; PA**
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA INJ 100/33 ***(insulin glargine-lixisenatide)***	2	MO; PA**
XULTOPHY INJ 100/3.6 ***(insulin degludec-liraglutide)***	2	MO; PA**
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN SOPN 100unit/ml ***(insulin glargine)***	2	MO
FIASP FLEX INJ TOUCH ***(insulin aspart (with niacinamide))***	2	MO
FIASP INJ 100/ML ***(insulin aspart (with niacinamide))***	2	MO
FIASP PENFIL INJ U-100 ***(insulin aspart (with niacinamide))***	2	MO
HUMULIN INJ 70/30 ***(insulin nph isophane & reg (human))***	3	MO
HUMULIN INJ 70/30KWP ***(insulin nph isophane & reg (human))***	3	MO
HUMULIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))***	3	MO
HUMULIN N KWIKPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))***	3	MO
HUMULIN R SOLN 100unit/ml ***(insulin regular (human))***	3	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml ***(insulin regular (human))***	2	MO
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml ***(insulin regular (human))***	2	MO
LEVEMIR SOLN 100unit/ml ***(insulin detemir)***	2	MO
LEVEMIR FLEXTOUCH SOPN 100unit/ml ***(insulin detemir)***	2	MO
NOVOLIN INJ 70/30 ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered
NOVOLIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN N FLEXPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN R SOLN 100unit/ml ***(insulin regular (human))***	2	MO; RELION not covered
NOVOLIN R FLEXPEN SOPN 100unit/ml ***(insulin regular (human))***	2	MO; RELION not covered
NOVOLOG SOLN 100unit/ml ***(insulin aspart)***	2	MO
NOVOLOG FLEXPEN SOPN 100unit/ml ***(insulin aspart)***	2	MO
NOVOLOG MIX INJ 70/30 ***(insulin aspart protamine & aspart (human))***	2	MO
NOVOLOG MIX INJ FLEXPEN ***(insulin aspart protamine & aspart (human))***	2	MO
NOVOLOG PENFILL SOCT 100unit/ml ***(insulin aspart)***	2	MO
TRESIBA SOLN 100unit/ml ***(insulin degludec)***	2	MO
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml ***(insulin degludec)***	2	MO
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl tabs 15mg, 30mg, 45mg	1	MO
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl tab 15-500 mg	1	MO
pioglitazone hcl-metformin hcl tab 15-850 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride tab 30-2 mg	1	MO
pioglitazone hcl-glimepiride tab 30-4 mg	1	MO
ANTIDIABETICS, MEGLITINIDE		
nateglinide tabs 60mg, 120mg	1	MO
repaglinide tabs .5mg, 1mg, 2mg	1	MO
ANTIDIABETICS, SODIUM-GLUC CO-TRANSPOR2 INHIB (SGLT2) COMBO		
SYNJARDY TAB ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY TAB 5-500MG ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY TAB 12.5-500 ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY XR TAB ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY XR TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY XR TAB 10-1000 ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
SYNJARDY XR TAB 25-1000 ***(empagliflozin-metformin hcl)***	2	ST, MO; PA**
XIGDUO XR TAB 2.5-1000 ***(dapagliflozin-metformin hcl)***	2	ST, MO; PA**
XIGDUO XR TAB 5-500MG ***(dapagliflozin-metformin hcl)***	2	ST, MO; PA**
XIGDUO XR TAB 5-1000MG ***(dapagliflozin-metformin hcl)***	2	ST, MO; PA**
XIGDUO XR TAB 10-500MG ***(dapagliflozin-metformin hcl)***	2	ST, MO; PA**
XIGDUO XR TAB 10-1000 ***(dapagliflozin-metformin hcl)***	2	ST, MO; PA**
ANTIDIABETICS, SODIUM-GLUC CO-TRANSPOR2 INHIB (SGLT2)/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI TAB 10-5 MG ***(empagliflozin-linagliptin)***	2	ST, MO; PA**
GLYXAMBI TAB 25-5 MG ***(empagliflozin-linagliptin)***	2	ST, MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER2(SGLT2) INHIB		
FARXIGA TABS 5mg, 10mg ***(dapagliflozin propanediol)***	2	ST, MO; PA**
JARDIANCE TABS 10mg, 25mg ***(empagliflozin)***	2	ST, MO; PA**
ANTIDIABETICS, SULFONYLUREA		
glimepiride tabs 1mg, 2mg, 4mg	1	MO
glipizide tabs 5mg, 10mg; tb24 2.5mg, 5mg, 10mg	1	MO
BISPHOSPHONATES - DRUGS TO TREAT BONE LOSS		
alendronate sodium soln 70mg/75ml; tabs 5mg, 10mg, 35mg, 70mg	1	MO
FOSAMAX + D TAB 70-2800 ***(alendronate sodium-cholecalciferol)***	3	ST, MO; PA**
FOSAMAX + D TAB 70-5600 ***(alendronate sodium-cholecalciferol)***	3	ST, MO; PA**
ibandronate sodium soln 3mg/3ml	MB	
ibandronate sodium tabs 150mg	1	MO
pamidronate disodium soln 30mg/10ml	MB	
risedronate sodium tabs 5mg, 35mg, 150mg; tbec 35mg	1	MO
risedronate sodium tabs 30mg	1	
zoledronic acid conc 4mg/5ml; soln 5mg/100ml	MB	
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl tabs 30mg, 60mg	4	SP, PA, QL (60 tabs / 30 days), MO
cinacalcet hcl tabs 90mg	4	SP, PA, QL (120 tabs / 30 days), MO
CHELATING AGENTS		
CHEMET CAPS 100mg ***(succimer)***	3	
deferiprone tabs 500mg	4	SP, PA, MO
FERRIPROX SOLN 100mg/ml; TABS 1000mg ***(deferiprone)***	4	PA, MO
FERRIPROX TWICE-A-DAY TABS 1000mg ***(deferiprone)***	4	PA, MO
penicillamine tabs 250mg	1	SP, PA
(Sodium Polystyrene Sulfonate Susp 15gm/60ml) SPS	1	
sodium polystyrene sulfonate susp 15gm/60ml, 30gm/120ml	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)***	PV	QL (1 / 300 days), MO
BALCOLTRA TAB 0.1-20 ***(levonorgestrel-ethinyl estradiol-ferrous bisglycinate)***	PV	MO
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml ***(medroxyprogesterone acetate (contraceptive))***	MB	
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) AZURETTE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) KARIVA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VIORELE	PV	MO
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) CAZIANT	PV	MO
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) APRI	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) EMOQUETTE	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ENSKYCE	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) RECLIPSEN	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) GIANVI	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LORYNA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) NIKKI	PV	MO
drospirenone-ethinyl estradiol tab 3-0.03 mg	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) OCELLA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZARAH	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ELLA TABS 30mg ***(ulipristal acetate)***	PV	
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) KELNOR 1/35	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35E	PV	MO
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	PV	MO
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	PV	QL (13 / 300 days), MO
KYLEENA IUD 19.5mg ***(levonorgestrel (iud))***	MB	
(Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg) FAYOSIM	PV	MO
(Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg) RIVELSA	PV	MO
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) AMETHIA	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) ASHLYNA	PV	MO
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) INTROVALE	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) JOLESSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AVIANE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) DELYLA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) FALMINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LESSINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LUTERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) ORSYTHIA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) SRONYX	PV	MO
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ALTAVERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CHATEAL	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KURVELO	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) LEVORA 0.15/30-28	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) MARLISSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) PORTIA-28	PV	MO
(Levonorgestrel (Emergency Oc) Tabs 1.5mg) TAKE ACTION	PV	
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) ENPRESSE-28	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) TRIVORA-28	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
LILETTA IUD 19.5mcg/day ***(levonorgestrel (iud))***	MB	
LO LOESTRIN TAB 1-10-10 ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))***	PV	MO
medroxyprogesterone acetate (contraceptive) susp 150mg/ml; susy 150mg/ml	MB	
MIRENA IUD 20mcg/24hr ***(levonorgestrel (iud))***	MB	
NATAZIA TAB ***(estradiol valerate-dienogest)***	PV	MO
NEXPLANON IMPL 68mg ***(etonogestrel)***	MB	
NEXTSTELLIS TAB 3-14.2MG ***(drospirenone-estetrol)***	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) XULANE	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) VYFEMLA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NECON 0.5/35-28	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NORTREL 0.5/35 (28)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) WERA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) ALYACEN 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) CYCLAFEM 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) DASETTA 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NORTREL 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) PIRMELLA 1/35	PV	MO
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg	PV	MO
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg	PV	MO
norethindrone (contraceptive) tabs .35mg	PV	MO
(Norethindrone (Contraceptive) Tabs .35mg) CAMILA	PV	MO
(Norethindrone (Contraceptive) Tabs .35mg) ERRIN	PV	MO
(Norethindrone (Contraceptive) Tabs .35mg) HEATHER	PV	MO
(Norethindrone (Contraceptive) Tabs .35mg) NORA-BE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) TILIA FE	PV	MO
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) JUNEL 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) JUNEL 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LARIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) MICROGESTIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) JUNEL FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) JUNEL FE 1.5/30	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) MIBELAS 24 FE	PV	MO
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) GEMMILY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) JUNEL FE 24	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) ALYACEN 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) CYCLAFEM 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) DASETTA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NORTREL 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) PIRMELLA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) ARANELLE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) LEENA	PV	MO
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MONO-LINYAH	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) PREVIFEM	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) SPRINTEC 28	PV	MO
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	PV	MO
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-LINYAH	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-SPRINTEC	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) CRYSELLE-28	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) ELINEST	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) LOW-OGESTREL	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg) OGESTREL	PV	MO
PARAGARD IUD T380A ***(copper (iud))***	MB	
SKYLA IUD 13.5mg ***(levonorgestrel (iud))***	MB	
SLYND TABS 4mg ***(drospirenone)***	PV	MO
TWIRLA DIS 120-30 ***(levonorgestrel-ethinyl estradiol)***	PV	MO
TYBLUME CHW 0.1-0.02 ***(levonorgestrel & eth estradiol)***	PV	MO
ENDOMETRIOSIS		
danazol caps 50mg, 100mg, 200mg	1	
ORILISSA TABS 150mg, 200mg ***(elagolix sodium)***	2	
SYNAREL SOLN 2mg/ml ***(nafarelin acetate)***	4	PA
ENZYME REPLACEMENTS - DRUGS TO TREAT ENZYME DEFICIENCIES		
CARBAGLU TABS 200mg ***(carglumic acid)***	4	PA, MO
CERDELGA CAPS 84mg ***(eliglustat tartrate)***	4	SP, PA, QL (60 caps / 30 days), MO
CYSTADANE POW ***(betaine)***	4	PA, MO
CYSTAGON CAPS 50mg, 150mg ***(cysteamine bitartrate)***	4	SP, PA, MO
nitisinone caps 2mg, 5mg, 10mg	4	SP, PA, MO
ORFADIN CAPS 20mg; SUSP 4mg/ml ***(nitisinone)***	4	PA, MO
sapropterin dihydrochloride pack 100mg, 500mg; tabs 100mg	4	SP, PA, MO
sodium phenylbutyrate powd 3gm/tsp	4	SP, PA, QL (600g / 30 days), MO
sodium phenylbutyrate tabs 500mg	4	SP, PA, QL (1200 tabs / 30 days), MO
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
CLIMARA PRO DIS WEEKLY ***(estradiol-levonorgestrel)***	2	MO
DEPO-ESTRADIOL OIL 5mg/ml ***(estradiol cypionate)***	MB	
DIVIGEL GEL .25mg/0.25gm, .5mg/0.5gm, .75mg/0.75gm, 1mg/gm, 1.25mg/1.25gm ***(estradiol)***	3	PA, MO; High Risk Medications require PA for members age 70 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DUAVEE TAB 0.45-20 ***(conjugated estrogens-bazedoxifene)***	2	MO
ELESTRIN GEL .06% ***(estradiol)***	3	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol pttw .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; ptwk .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr; tabs .5mg, 1mg, 2mg	1	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	MO
estradiol & norethindrone acetate tab 1-0.5 mg	1	MO
(Estradiol & Norethindrone Acetate Tab 1-0.5 mg) MIMVEY	1	MO
estradiol vaginal crea .1mg/gm	1	MO
(Estradiol Vaginal Tabs 10mcg) YUVAFEM	1	MO
estradiol valerate oil 20mg/ml, 40mg/ml	MB	
ESTROGEL GEL .06% ***(estradiol)***	3	PA, MO; High Risk Medications require PA for members age 70 and older
EVAMIST SOLN 1.53mg/spray ***(estradiol)***	3	PA, MO; High Risk Medications require PA for members age 70 and older
MENEST TABS .3mg, .625mg, 1.25mg ***(esterified estrogens)***	3	PA, MO; High Risk Medications require PA for members age 70 and older
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) JINTELI	1	MO
PREMARIN CREA .625mg/gm ***(estrogens, conjugated vaginal)***	3	MO
PREMARIN TABS .3mg, .45mg, .625mg, .9mg, 1.25mg ***(estrogens, conjugated)***	3	PA, MO; High Risk Medications require PA for members age 70 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
cortisone acetate tabs 25mg	1	
DEPO-MEDROL SUSP 20mg/ml ***(methylprednisolone acetate)***	MB	
dexamethasone elix .5mg/5ml; soln .5mg/5ml; tabs .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	1	
DEXAMETHASONE INTENSOL CONC 1mg/ml ***(dexamethasone)***	2	
dexamethasone sodium phosphate soln 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	MB	
fludrocortisone acetate tabs .1mg	1	MO
hydrocortisone tabs 5mg, 10mg, 20mg	1	
MEDROL TABS 2mg ***(methylprednisolone)***	2	
methylprednisolone tabs 4mg, 8mg, 16mg, 32mg; tbpk 4mg	1	
methylprednisolone acetate susp 40mg/ml, 80mg/ml	MB	
methylprednisolone sod succ solr 125mg, 1000mg	MB	
prednisolone soln 15mg/5ml	1	
prednisolone sodium phosphate soln 5mg/5ml, 10mg/5ml, 15mg/5ml, 20mg/5ml, 25mg/5ml; tbdp 10mg, 15mg, 30mg	1	
prednisone soln 5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg; tbpk 5mg, 10mg	1	
PREDNISONE INTENSOL CONC 5mg/ml ***(prednisone)***	2	
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg ***(hydrocortisone sod succinate)***	MB	
SOLU-MEDROL SOLR 2gm ***(methylprednisolone sod succ)***	MB	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
glucagon (rdna) kit 1mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
HUMATROPE SOLR 6mg, 12mg, 24mg ***(somatropin)***	MB	MO
HUMATROPE COMBO PACK SOLR 5mg ***(somatropin)***	MB	MO
MISCELLANEOUS		
cabergoline tabs .5mg	1	
calcitonin (salmon) soln 200unit/act	1	MO
INCRELEX SOLN 40mg/4ml ***(mecasermin)***	MB	MO
octreotide acetate soln 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; sosy 50mcg/ml, 100mcg/ml, 500mcg/ml	MB	MO
OSPHENA TABS 60mg ***(ospemifene)***	2	MO
PROLIA SOSY 60mg/ml ***(denosumab)***	MB	
raloxifene hcl tabs 60mg	1	MO; $0 copay ages 35 and older for the primary prevention of breast cancer
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml ***(pasireotide diaspartate)***	MB	MO
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml ***(lanreotide acetate)***	MB	
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg ***(pegvisomant)***	MB	MO
tolvaptan tabs 15mg, 30mg	4	SP, PA
TYMLOS SOPN 3120mcg/1.56ml ***(abaloparatide)***	MB	MO
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
calcium acetate (phosphate binder) caps 667mg; tabs 667mg	1	MO
FOSRENOL PACK 750mg, 1000mg ***(lanthanum carbonate)***	3	MO
PHOSLYRA SOLN 667mg/5ml ***(calcium acetate (phosphate binder))***	2	MO
sevelamer carbonate pack .8gm, 2.4gm; tabs 800mg	1	MO
VELPHORO CHEW 500mg ***(sucroferric oxyhydroxide)***	3	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
CRINONE GEL 4% ***(progesterone (vaginal))***	2	
CRINONE GEL 8% ***(progesterone (vaginal))***	2	PA
LUPANETA KIT 3.75-5 ***(leuprolide acetate & norethindrone acetate)***	MB	
LUPANETA KIT 11.25-5 ***(leuprolide acetate & norethindrone acetate)***	MB	
medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg	1	MO
norethindrone acetate tabs 5mg	1	MO
progesterone caps 100mg, 200mg	1	MO
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
(Levothyroxine Sodium Tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg) LEVOXYL	1	MO
levothyroxine sodium tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	MO
(Levothyroxine Sodium Tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 200mcg, 300mcg) UNITHROID	1	MO
liothyronine sodium tabs 5mcg, 25mcg, 50mcg	1	MO
methimazole tabs 5mg, 10mg	1	MO
propylthiouracil tabs 50mg	1	MO
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg ***(levothyroxine sodium)***	2	MO
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
desmopressin acetate soln 4mcg/ml	MB	
desmopressin acetate tabs .1mg, .2mg	1	MO
desmopressin acetate spray soln .01%	1	MO
desmopressin acetate spray refrigerated soln .01%	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ENDOCRINE AND METABOLIC AGENTS - MISC.		
METABOLIC MODIFIERS		
MYALEPT SOLR 11.3mg ***(metreleptin)***	MB	MO
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
BAXDELA TABS 450mg ***(delafloxacin meglumine)***	3	
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
atropine sulfate sosy .25mg/5ml, 1mg/10ml	MB	
CUVPOSA SOLN 1mg/5ml ***(glycopyrrolate)***	2	MO
dicyclomine hcl caps 10mg; soln 10mg/5ml; tabs 20mg	1	
dicyclomine hcl soln 10mg/ml	MB	
glycopyrrolate soln 1mg/5ml, 4mg/20ml	MB	
glycopyrrolate tabs 1mg, 2mg	1	
(Hyoscyamine Sulfate Subl .125mg) SYMAX-SL	1	MO
(Hyoscyamine Sulfate Subl .125mg; Tabs .125mg) OSCIMIN	1	MO
hyoscyamine sulfate subl .125mg; tabs .125mg; tbdp .125mg	1	MO
(Hyoscyamine Sulfate Tbdp .125mg) ED-SPAZ	1	MO
(Hyoscyamine Sulfate Tbdp .125mg) NULEV	1	MO
methscopolamine bromide tabs 2.5mg, 5mg	1	PA; High Risk Medications require PA for members age 70 and older
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
AKYNZEO CAP 300-0.5 ***(netupitant-palonosetron)***	3	QL (2 caps / 21 days)
aprepitant caps 40mg	1	QL (3 caps / 180 days)
aprepitant caps 80mg	1	QL (4 caps / 21 days)
aprepitant caps 125mg	1	QL (2 caps / 21 days)
aprepitant capsule therapy pack 80 & 125 mg	1	QL (2 packs / 21 days)
dronabinol caps 2.5mg, 5mg, 10mg	1	QL (60 caps / 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
granisetron hcl soln 1mg/ml	MB	
granisetron hcl tabs 1mg	1	QL (12 tabs / 21 days)
meclizine hcl tabs 12.5mg, 25mg	1	
metoclopramide hcl soln 5mg/ml	MB	
metoclopramide hcl soln 10mg/10ml; tabs 5mg, 10mg; tbdp 5mg	1	
ondansetron tbdp 4mg, 8mg	1	QL (18 tabs / 21 days)
ondansetron hcl soln 4mg/2ml, 40mg/20ml	MB	
ondansetron hcl soln 4mg/5ml	1	QL (200 mL / 21 days)
ondansetron hcl tabs 4mg, 8mg	1	QL (18 tabs / 21 days)
ondansetron hcl tabs 24mg	1	QL (2 tabs / 21 days)
prochlorperazine supp 25mg	1	
(Prochlorperazine Supp 25mg) COMPRO	1	
prochlorperazine maleate tabs 5mg, 10mg	1	MO
promethazine hcl soln 25mg/ml, 50mg/ml	MB	
promethazine hcl supp 12.5mg, 25mg	1	
(Promethazine Hcl Supp 12.5mg, 25mg, 50mg) PROMETHEGAN	1	
promethazine hcl syrp 6.25mg/5ml; tabs 12.5mg, 25mg, 50mg	1	PA; High Risk Medications require PA for members age 70 and older
SANCUSO PTCH 3.1mg/24hr ***(granisetron)***	2	QL (2 patches / 21 days)
scopolamine pt72 1mg/3days	1	
trimethobenzamide hcl caps 300mg	1	
VARUBI TBPK 90mg ***(rolapitant hcl)***	2	
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
cimetidine tabs 200mg	1	
cimetidine tabs 300mg, 400mg, 800mg	1	MO
cimetidine hcl soln 300mg/5ml	1	MO
famotidine soln 20mg/2ml	MB	
famotidine susr 40mg/5ml; tabs 20mg, 40mg	1	MO
famotidine in nacl 0.9% iv soln 20 mg/50ml	MB	
nizatidine caps 150mg, 300mg; soln 15mg/ml	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ranitidine hcl soln 50mg/2ml	MB	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium caps 750mg	1	
budesonide cpep 3mg	1	
DIPENTUM CAPS 250mg ***(olsalazine sodium)***	3	PA, MO
hydrocortisone (intrarectal) enem 100mg/60ml	1	
mesalamine cp24 .375gm; cpdr 400mg; tbec 1.2gm	1	MO
mesalamine enem 4gm; supp 1000mg; tbec 800mg	1	
sulfasalazine tabs 500mg; tbec 500mg	1	MO
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS CAPS 72mcg, 145mcg, 290mcg ***(linaclotide)***	2	MO
lubiprostone caps 8mcg, 24mcg	1	MO
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl tabs .5mg, 1mg	1	PA, MO
LAXATIVES		
CLENPIQ SOL ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	PV	$0 copay for members age 50 through 74, otherwise not covered
GOLYTELY SOL ***(peg 3350-kcl-sod bicarb-sod chloride-sod sulfate)***	2	
lactulose soln 10gm/15ml	1	MO
(Lactulose (Encephalopathy) Soln 10gm/15ml) ENULOSE	1	MO
(Lactulose (Encephalopathy) Soln 10gm/15ml) GENERLAC	1	MO
OSMOPREP TAB 1.5GM ***(sodium phosphate monobasic-sodium phosphate dibasic)***	3	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm) GAVILYTE-G	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm) GAVILYTE-C	1	
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	PV	$0 copay for members age 50 through 74; Tier 1 for all others

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
(Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm) GAVILYTE-N/FLAVOR PACK	1	
PEG-PREP KIT ***(bisacodyl-peg 3350-pot chloride-sod bicarb-sod chloride)***	PV	$0 copay for members age 50 through 74, otherwise not covered
PLENVU SOL ***(peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid)***	PV	$0 copay for members age 50 through 74, otherwise not covered
PREPOPIK PAK ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	PV	$0 copay for members age 50 through 74, otherwise not covered
SUPREP BOWEL SOL PREP KIT ***(sodium sulfate-potassium sulfate-magnesium sulfate)***	PV	$0 copay for members age 50 through 74; Tier 2 for all others
SUTAB TAB ***(sodium sulfate-magnesium sulfate-potassium chloride)***	PV	$0 copay for members age 50 through 74, otherwise not covered
MISCELLANEOUS		
cromolyn sodium (mastocytosis) conc 100mg/5ml	1	MO
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1	
loperamide hcl caps 2mg	1	
misoprostol tabs 100mcg, 200mcg	1	MO
MOTOFEN TAB 1-0.025 ***(difenoxin w/ atropine)***	3	
MOVANTIK TABS 12.5mg, 25mg ***(naloxegol oxalate)***	2	
SUCRAID SOLN 8500unit/ml ***(sacrosidase)***	3	PA, QL (354 mL / 25 days), MO
sucralfate tabs 1gm	1	MO
ursodiol caps 300mg; tabs 250mg, 500mg	1	MO
PANCREATIC ENZYMES		
CREON CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
CREON CAP 6000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
CREON CAP 12000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CREON CAP 24000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
CREON CAP 36000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
VIOKACE TAB 10440 ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
VIOKACE TAB 20880 ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 5000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 10000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 15000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 20000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 25000 ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 40000 ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
DEXILANT CPDR 30mg, 60mg ***(dexlansoprazole)***	3	ST, QL (90 caps / 365 days), MO; PA**
esomeprazole magnesium cpdr 20mg, 40mg	1	QL (90 caps / 365 days), MO
esomeprazole magnesium pack 10mg	1	QL (90 packets / 365 days), MO; Covered for age less than 1 year only
lansoprazole cpdr 15mg, 30mg	1	QL (90 caps / 365 days), MO
NEXIUM PACK 2.5mg, 5mg ***(esomeprazole magnesium)***	3	QL (90 packets / 365 days), MO; Covered for age less than 1 year only
omeprazole cpdr 10mg, 20mg, 40mg	1	QL (90 caps / 365 days), MO
pantoprazole sodium tbec 20mg, 40mg	1	QL (90 tabs / 365 days), MO
rabeprazole sodium tbec 20mg	1	QL (90 tabs / 365 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
RECTAL,CORTICOSTEROIDS		
(Hydrocortisone (Rectal) Crea 1%) PROCTO-PAK	1	
hydrocortisone (rectal) crea 2.5%	1	
(Hydrocortisone (Rectal) Crea 2.5%) PROCTOZONE-HC	1	
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
alfuzosin hcl tb24 10mg	1	MO
CARDURA XL TB24 4mg, 8mg ***(doxazosin mesylate (bph))***	3	ST, MO; PA**
dutasteride caps .5mg	1	MO
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1	MO
finasteride tabs 5mg	1	MO
silodosin caps 4mg, 8mg	1	MO
tadalafil tabs 2.5mg, 5mg	1	PA, QL (30 tabs / 25 days), MO
tamsulosin hcl caps .4mg	1	MO
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ENCARE SUPP 100mg ***(nonoxynol-9)***	PV	
OPTIONS GYNOL II VAGINAL GEL 3% ***(nonoxynol-9)***	PV	
SHUR-SEAL GEL 2% ***(nonoxynol-9)***	PV	
TODAY SPONGE MISC 1000mg ***(nonoxynol-9)***	PV	
VCF VAGINAL CONTRACEPTIVE FILM 28%; FOAM 12.5%; GEL 4% ***(nonoxynol-9)***	PV	
MISCELLANEOUS		
bethanechol chloride tabs 5mg, 10mg, 25mg, 50mg	1	
ELMIRON CAPS 100mg ***(pentosan polysulfate sodium)***	3	
flavoxate hcl tabs 100mg	1	MO
potassium citrate (alkalinizer) tbcr 15meq, 540mg, 1080mg	1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
darifenacin hydrobromide tb24 7.5mg, 15mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxybutynin chloride syrp 5mg/5ml; tabs 5mg; tb24 5mg, 10mg, 15mg	1	MO
solifenacin succinate tabs 5mg, 10mg	1	MO
tolterodine tartrate cp24 2mg, 4mg; tabs 1mg, 2mg	1	MO
TOVIAZ TB24 4mg, 8mg ***(fesoterodine fumarate)***	2	MO
trospium chloride cp24 60mg; tabs 20mg	1	MO
VAGINAL ANTI-INFECTIVES		
CLEOCIN SUPP 100mg ***(clindamycin phosphate vaginal)***	2	
clindamycin phosphate vaginal crea 2%	1	
GYNAZOLE-1 CREA 2% ***(butoconazole nitrate (one dose))***	3	
metronidazole vaginal gel .75%	1	
(Metronidazole Vaginal Gel .75%) VANDAZOLE	1	
(Miconazole Nitrate Vaginal Supp 200mg) MICONAZOLE 3	1	
terconazole vaginal crea .4%, .8%; supp 80mg	1	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
ELIQUIS TABS 2.5mg, 5mg ***(apixaban)***	2	MO
ELIQUIS STARTER PACK TBPK 5mg ***(apixaban)***	2	
enoxaparin sodium soln 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml	MB	
fondaparinux sodium soln 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	MB	
FRAGMIN SOLN 2500unit/0.2ml, 5000unit/0.2ml, 7500unit/0.3ml, 10000unit/ml, 12500unit/0.5ml, 15000unit/0.6ml, 18000unt/0.72ml, 95000unit/3.8ml ***(dalteparin sodium)***	MB	
heparin sodium (porcine) soln 1000unit/ml, 5000unit/0.5ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PRADAXA CAPS 75mg, 110mg, 150mg ***(dabigatran etexilate mesylate)***	3	MO
warfarin sodium tabs 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	MO
(Warfarin Sodium Tabs 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg) JANTOVEN	1	MO
XARELTO TABS 2.5mg, 10mg, 15mg, 20mg ***(rivaroxaban)***	2	MO
XARELTO STAR TAB 15/20MG ***(rivaroxaban)***	2	
HEMATOPOIETIC GROWTH FACTORS		
ARANESP ALBUMIN FREE SOLN 25mcg/ml, 40mcg/ml, 60mcg/ml, 100mcg/ml, 200mcg/ml, 300mcg/ml; SOSY 10mcg/0.4ml, 25mcg/0.42ml, 40mcg/0.4ml, 60mcg/0.3ml, 100mcg/0.5ml, 150mcg/0.3ml, 200mcg/0.4ml, 300mcg/0.6ml, 500mcg/ml ***(darbepoetin alfa)***	MB	
MIRCERA SOSY 30mcg/0.3ml, 50mcg/0.3ml, 75mcg/0.3ml, 100mcg/0.3ml, 150mcg/0.3ml, 200mcg/0.3ml ***(methoxy polyethylene glycol-epoetin beta)***	MB	
NEULASTA SOSY 6mg/0.6ml ***(pegfilgrastim)***	MB	
NEULASTA ONPRO KIT PSKT 6mg/0.6ml ***(pegfilgrastim)***	MB	
NIVESTYM SOLN 300mcg/ml, 480mcg/1.6ml; SOSY 300mcg/0.5ml, 480mcg/0.8ml ***(filgrastim-aafi)***	MB	
PROMACTA TABS 12.5mg, 25mg ***(eltrombopag olamine)***	4	SP, PA, QL (30 tabs / 30 days), MO
PROMACTA TABS 50mg, 75mg ***(eltrombopag olamine)***	4	SP, PA, QL (60 tabs / 30 days), MO
RETACRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml ***(epoetin alfa-epbx)***	MB	
UDENYCA SOSY 6mg/0.6ml ***(pegfilgrastim-cbqv)***	MB	
MISCELLANEOUS		
anagrelide hcl caps .5mg, 1mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
cilostazol tabs 50mg, 100mg	1	MO
HEMLIBRA SOLN 30mg/ml, 60mg/0.4ml, 105mg/0.7ml, 150mg/ml ***(emicizumab-kxwh)***	MB	MO
icatibant acetate soln 30mg/3ml	MB	
pentoxifylline tbcr 400mg	1	MO
tranexamic acid soln 1000mg/10ml	MB	
tranexamic acid tabs 650mg	1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	1	MO
BRILINTA TABS 60mg, 90mg ***(ticagrelor)***	2	MO
clopidogrel bisulfate tabs 75mg	1	MO
clopidogrel bisulfate tabs 300mg	1	
dipyridamole tabs 25mg, 50mg, 75mg	1	PA, MO; High Risk Medications require PA for members age 70 and older
prasugrel hcl tabs 5mg, 10mg	1	MO
ZONTIVITY TABS 2.08mg ***(vorapaxar sulfate)***	2	MO
HEMATOPOIETIC AGENTS		
FOLIC ACID/FOLATES		
folic acid tabs 1mg	1	MO
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
BIOLOGIC DISEASE-MODIFYING AGENTS		
ACTEMRA SOLN 80mg/4ml, 200mg/10ml, 400mg/20ml ***(tocilizumab)***	MB	
ACTEMRA SOSY 162mg/0.9ml ***(tocilizumab)***	MB	MO
ENBREL SOLN 25mg/0.5ml; SOLR 25mg; SOSY 25mg/0.5ml, 50mg/ml ***(etanercept)***	MB	MO
ENBREL MINI SOCT 50mg/ml ***(etanercept)***	MB	MO
ENBREL SURECLICK SOAJ 50mg/ml ***(etanercept)***	MB	MO
HUMIRA PSKT 10mg/0.1ml, 10mg/0.2ml, 20mg/0.2ml, 20mg/0.4ml, 40mg/0.4ml, 40mg/0.8ml ***(adalimumab)***	MB	MO
HUMIRA PEDIA INJ CROHNS ***(adalimumab)***	MB	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml ***(adalimumab)***	MB	MO
HUMIRA PEN PNKT 40mg/0.4ml ***(adalimumab)***	MB	MO
HUMIRA PEN KIT PS/UV ***(adalimumab)***	MB	MO
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml ***(adalimumab)***	MB	MO
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml ***(adalimumab)***	MB	MO
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml; SOSY 150mg/1.14ml, 200mg/1.14ml ***(sarilumab)***	MB	MO
RINVOQ TB24 15mg ***(upadacitinib)***	4	SP, PA, QL (30 tabs / 30 days), MO; Preferred agent for Rheumatoid Arthritis
SIMPONI SOAJ 50mg/0.5ml, 100mg/ml; SOSY 50mg/0.5ml, 100mg/ml ***(golimumab)***	MB	MO
SIMPONI ARIA SOLN 50mg/4ml ***(golimumab)***	MB	MO
SKYRIZI PSKT 75mg/0.83ml; SOSY 150mg/ml ***(risankizumab-rzaa)***	MB	MO
SKYRIZI PEN SOAJ 150mg/ml ***(risankizumab-rzaa)***	MB	MO
STELARA SOSY 45mg/0.5ml, 90mg/ml ***(ustekinumab)***	MB	MO
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml ***(ixekizumab)***	MB	MO
TREMFYA SOPN 100mg/ml; SOSY 100mg/ml ***(guselkumab)***	MB	MO
XELJANZ SOLN 1mg/ml ***(tofacitinib citrate)***	4	SP, PA, QL (240 mL / 24 days), MO
XELJANZ TABS 5mg ***(tofacitinib citrate)***	4	SP, PA, QL (60 tabs / 30 days), MO; Preferred agent for Rheumatoid Arthritis
XELJANZ TABS 10mg ***(tofacitinib citrate)***	4	SP, PA, QL (60 tabs / 30 days), MO; Preferred agent for Ulcerative Colitis
XELJANZ XR TB24 11mg ***(tofacitinib citrate)***	4	SP, PA, QL (30 tabs / 30 days), MO; Preferred agent for Rheumatoid Arthritis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XELJANZ XR TB24 22mg ***(tofacitinib citrate)***	4	SP, PA, QL (30 tabs / 30 days), MO; Preferred agent for Ulcerative Colitis
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
hydroxychloroquine sulfate tabs 200mg	1	MO
leflunomide tabs 10mg, 20mg	1	MO
methotrexate sodium tabs 2.5mg	1	OAC
OTEZLA TABS 30mg ***(apremilast)***	4	SP, PA, QL (60 tabs / 30 days), MO; Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA TAB 10/20/30 ***(apremilast)***	4	SP, PA, QL (55 tabs / 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
IMMUNOGLOBULIN		
HYQVIA INJ 2.5-200 ***(immune globulin (human)-hyaluronidase (human recombinant))***	MB	
HYQVIA INJ 5-400 ***(immune globulin (human)-hyaluronidase (human recombinant))***	MB	
HYQVIA INJ 10-800 ***(immune globulin (human)-hyaluronidase (human recombinant))***	MB	
HYQVIA INJ 20-1600 ***(immune globulin (human)-hyaluronidase (human recombinant))***	MB	
HYQVIA INJ 30-2400 ***(immune globulin (human)-hyaluronidase (human recombinant))***	MB	
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml ***(interferon gamma-1b)***	MB	MO
ARCALYST SOLR 220mg ***(rilonacept)***	MB	MO
INTRON A SOLN 10mu/ml, 6000000unit/ml; SOLR 10mu, 18mu, 50mu ***(interferon alfa-2b)***	MB	MO
POMALYST CAPS 1mg, 2mg, 3mg, 4mg ***(pomalidomide)***	4	SP, PA, QL (21 caps / 28 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg ***(lenalidomide)***	4	SP, PA, QL (28 caps / 28 days); OAC
REVLIMID CAPS 20mg, 25mg ***(lenalidomide)***	4	SP, PA, QL (21 caps / 28 days); OAC
THALOMID CAPS 50mg, 100mg ***(thalidomide)***	4	SP, PA, QL (28 caps / 28 days), MO; OAC
THALOMID CAPS 150mg, 200mg ***(thalidomide)***	4	SP, PA, QL (56 caps / 28 days), MO; OAC
IMMUNOSUPPRESSANTS		
azathioprine tabs 50mg	1	MO
(Azathioprine Tabs 75mg, 100mg) AZASAN	3	MO
cyclosporine caps 25mg, 100mg	1	SP, MO
cyclosporine soln 50mg/ml	MB	
cyclosporine modified (for microemulsion) caps 25mg, 50mg, 100mg; soln 100mg/ml	1	SP, MO
(Cyclosporine Modified (For Microemulsion) Caps 25mg, 100mg; Soln 100mg/ml) GENGRAF	1	SP, MO
everolimus (immunosuppressant) tabs .25mg, .5mg, .75mg	1	SP, MO
mycophenolate mofetil caps 250mg; susr 200mg/ml; tabs 500mg	1	SP, MO
mycophenolate mofetil hcl solr 500mg	MB	
mycophenolate sodium tbec 180mg, 360mg	1	SP, MO
PROGRAF SOLN 5mg/ml ***(tacrolimus)***	MB	
SANDIMMUNE SOLN 100mg/ml ***(cyclosporine)***	3	SP, MO
sirolimus soln 1mg/ml; tabs .5mg, 1mg, 2mg	1	SP, MO
tacrolimus caps .5mg, 1mg, 5mg	1	SP, MO
ZORTRESS TABS 1mg ***(everolimus (immunosuppressant))***	2	SP, MO
VACCINES		
ACTHIB INJ ***(haemophilus b polysac conj vac)***	MB	
ADACEL INJ ***(tetanus toxoid-diphtheria-acellular pertussis adsorb (tdap))***	MB	
AFLURIA QUAD INJ 2021-22 ***(influenza virus vaccine split quadrivalent)***	MB	
BEXSERO INJ ***(meningococcal vac group b (recombant omv adjuvanted))***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BOOSTRIX INJ ***(tetanus toxoid-diphtheria-acellular pertussis adsorb (tdap))***	MB	
DAPTACEL INJ ***(diphtheria, acellular pertussis & tetanus toxoids)***	MB	
DIP/TET PED INJ 25-5LFU	MB	
ENGERIX-B INJ 10mcg/0.5ml, 20mcg/ml; SUSP 10mcg/0.5ml, 20mcg/ml ***(hepatitis b vaccine (recomb))***	MB	
FLUAD QUADRIVALENT 2021-2 PRSY .5ml ***(influenza virus vacc types a & b surf antigen adjuvant quad)***	MB	
FLUARIX QUAD INJ 2021-22 ***(influenza virus vaccine split quadrivalent)***	MB	
FLUBLOK QUAD INJ 2021-22 ***(influenza virus vac recomb hemagglutinin (ha) quadrivalent)***	MB	
FLUCLVX QUAD INJ 2021-22 ***(influenza virus vaccine tissue-cultured subunit quadrivalent)***	MB	
FLULAVAL QUA INJ 2021-22 ***(influenza virus vaccine split quadrivalent)***	MB	
FLUMIST QUAD SUS 2021-22 ***(influenza virus vaccine live quadrivalent)***	MB	
FLUZONE HD INJ 2021-22 ***(influenza virus vac split high-dose quad preservative free)***	MB	
FLUZONE QUAD INJ 2021-22 ***(influenza virus vaccine split quadrivalent)***	MB	
GARDASIL 9 INJ ***(human papillomavirus (hpv) 9-valent recombinant vaccine)***	MB	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml ***(hepatitis a vaccine)***	MB	
HEPLISAV-B SOSY 20mcg/0.5ml ***(hepatitis b vaccine recombinant adjuvanted)***	MB	
HIBERIX SOLR 10mcg ***(haemophilus b polysac conj vac)***	MB	
INFANRIX INJ ***(diphtheria, acellular pertussis & tetanus toxoids)***	MB	
IPOL INJ INACTIVE ***(poliovirus vaccine, ipv)***	MB	
KINRIX INJ ***(diph-tetanus tox ad-acell pertussis & polio virus, ipv vac)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
M-M-R II INJ ***(measles, mumps & rubella virus vaccines)***	MB	
MENACTRA INJ ***(meningococcal (a,c,y&w-135) polysacch diphth conj vaccine)***	MB	
MENQUADFI INJ ***(meningococcal (a,c,y&w-135) polysacch tetanus conj vaccine)***	MB	
MENVEO INJ ***(meningococcal (a,c,y&w-135) oligosaccharide conjugate vac)***	MB	
PEDIARIX INJ 0.5ML ***(diph-tetanus tox-acell pert-hepatitis b recomb-polio ipv vac)***	MB	
PEDVAX HIB SUSP 7.5mcg/0.5ml ***(haemophilus b polysac conj vac)***	MB	
PENTACEL INJ ***(diph-ac pert-tet tox ad-polio ipv-haemophil b poly vac)***	MB	
PNEUMOVAX 23/1 DOSE INJ 25mcg/0.5ml ***(pneumococcal vac polyvalent)***	MB	
PREVNAR 13 INJ ***(pneumococcal 13-valent conjugate vaccine)***	MB	
PREVNAR 20 INJ ***(pneumococcal 20-valent conjugate vaccine)***	MB	
PROQUAD INJ ***(measles-mumps-rubella-varicella virus vaccines)***	MB	
QUADRACEL INJ ***(diph-tetanus tox ad-acell pertussis & polio virus, ipv vac)***	MB	
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml ***(hepatitis b vaccine (recomb))***	MB	
ROTARIX SUS ***(rotavirus vaccine, live oral)***	PV	$0 copay for members age 18 and younger, otherwise not covered
ROTATEQ SOL ***(rotavirus vaccine, live oral pentavalent)***	PV	$0 copay for members age 18 and younger, otherwise not covered
SHINGRIX SUSR 50mcg/0.5ml ***(zoster vaccine recombinant adjuvanted)***	MB	
TDVAX INJ 2-2 LF ***(tetanus-diphtheria toxoids (td))***	MB	
TENIVAC INJ 5-2LF ***(tetanus-diphtheria toxoids (td))***	MB	
TRUMENBA INJ ***(meningococcal group b vaccine (recombinant))***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TWINRIX INJ ***(hepatitis a (inactivated)-hepatitis b (recombinant) vaccines)***	MB	
VAQTA SUSP 25unit/0.5ml, 50unit/ml ***(hepatitis a vaccine)***	MB	
VARIVAX INJ 1350pfu/0.5ml ***(varicella virus vaccine live)***	MB	
VAXELIS INJ ***(diph-tet tox-acell pert ad-polio ipv-hib-hepatitis b recomb)***	MB	
VAXNEUVANCE INJ ***(pneumococcal 15-valent conjugate vaccine)***	MB	
ZOSTAVAX SUSR 19400unt/0.65ml ***(zoster vaccine live)***	MB	
MEDICAL DEVICES		
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
FC2 FEMALE MIS CONDOM ***(condoms - female)***	PV	
FEMCAP MIS 22MM ***(cervical caps)***	MB	
FEMCAP MIS 26MM ***(cervical caps)***	MB	
FEMCAP MIS 30MM ***(cervical caps)***	MB	
DIABETIC SUPPLIES		
CAREFINE MIS 32GX6MM ***(insulin pen needle)***	2	
INSULIN PEN NEEDLES/SYRINGES ***(insulin syringe/needle u-100)***	2	
NOVOFINE PEN NEEDLES ***(insulin pen needle)***	2	
MISCELLANEOUS		
ADULT RESPIRATORY MASK ***(spacer/aerosol-holding chambers)***	2	
ADULT RESPIRATORY MASK ***(spacer/aerosol-holding chambers)***	2	
HUMATROPEN MIS FOR 6MG ***(injection device)***	MB	
HUMATROPEN MIS FOR 12MG ***(injection device)***	MB	
HUMATROPEN MIS FOR 24MG ***(injection device)***	MB	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	2	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
FLUORABON SOLN .55mg/0.6ml ***(sodium fluoride)***	PV	MO; $0 applies for ages 5 and under, otherwise not covered
magnesium sulfate soln 2gm/50ml, 50%	MB	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	MB	
(Potassium Bicarbonate Tbef 25meq) EFFER-K	1	MO
potassium chloride cpcr 8meq, 10meq; soln 10%, 20%; tbcr 8meq, 10meq, 20meq	1	MO
(Potassium Chloride Tbcr 8meq) KLOR-CON 8	1	MO
(Potassium Chloride Tbcr 10meq) KLOR-CON 10	1	MO
potassium chloride microencapsulated crystals er tbcr 10meq, 20meq	1	MO
(Potassium Chloride Microencapsulated Crystals Er Tbcr 15meq) KLOR-CON M15	1	MO
(Potassium Chloride Microencapsulated Crystals Er Tbcr 20meq) KLOR-CON M20	1	MO
sodium chloride soln 2.5meq/ml	MB	
(Sodium Chloride Flush Soln .9%) MONOJECT SODIUM CHLORIDE	MB	
(Sodium Fluoride Chew 1mg) FLUORITAB	1	MO
(Sodium Fluoride Chew 1mg) LUDENT	1	MO
sodium fluoride chew 1mg; tabs 1mg	1	MO
(Sodium Fluoride Chew 2.2mg) NAFRINSE	1	MO
(Sodium Fluoride Chew .25mg, .5mg) LUDENT	PV	MO; $0 applies for ages 5 and under, otherwise not covered
sodium fluoride chew .25mg, .5mg; soln .5mg/ml; tabs .5mg	PV	MO; $0 applies for ages 5 and under, otherwise not covered
(Sodium Fluoride Chew .25mg, .5mg; Soln .125mg/drop) FLUORITAB	PV	MO; $0 applies for ages 5 and under, otherwise not covered
(Sodium Fluoride Soln .25mg/drop) FLURA-DROPS	PV	MO; $0 applies for ages 5 and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Sodium Fluoride Soln .125mg/drop) NAFRINSE DROPS	PV	MO; $0 applies for ages 5 and under, otherwise not covered
IV REPLACEMENT SOLUTIONS		
potassium chloride soln 2meq/ml	MB	
sodium chloride soln .45%, .9%, 3%, 5%	MB	
VITAMINS		
calcitriol caps .25mcg, .5mcg; soln 1mcg/ml	1	MO
CITRANATAL CAP HARMONY ***(prenatal w/o vit a w/ fe fumarate-fe carbonyl-dss-fa-dha)***	2	
CITRANATAL CAP MEDLEY ***(prenatal w/o vit a w/ fe fumarate-fe carbonyl-fa-dha)***	2	
CITRANATAL MIS ***(prenatal w/o vit a w/ fe carbonyl-fe gluconate-dss-fa-dha)***	2	
CITRANATAL MIS 90 DHA ***(prenatal w/o vit a w/ fe carbonyl-fe gluconate-dss-fa-dha)***	2	
CITRANATAL MIS B-CALM ***(prenatal w/o vit a w/ fe carbonyl-fe gluconate-fa & vit b6)***	2	
CITRANATAL PAK ASSURE ***(prenatal w/o vit a w/ fe carbonyl-fe gluconate-dss-fa-dha)***	2	
CITRANATAL PAK DHA ***(prenatal w/o vit a w/ fe carbonyl-fe gluconate-dss-fa-dha)***	2	
CITRANATAL TAB BLOOM ***(prenatal vit w/ docusate-fe carbonyl-fe gluconate-folic acid)***	2	
CITRANATAL TAB RX ***(prenatal without vit a w/ fe carbonyl-fe gluc-docusate-fa)***	2	
cyanocobalamin soln 1000mcg/ml	MB	
doxercalciferol caps .5mcg, 1mcg, 2.5mcg	1	MO
ergocalciferol caps 50000unit	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
folic acid caps 800mcg	PV	QL (100 caps / 30 days), MO; $0 copay available for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 1mg	1	MO
folic acid tabs 400mcg	PV	QL (100 tabs / 30 days); $0 copay available for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 800mcg	PV	QL (100 tabs / 30 days), MO; $0 copay available for members 55 and younger capable of pregnancy, otherwise not covered
paricalcitol caps 1mcg, 2mcg, 4mcg	1	MO
phytonadione tabs 5mg	1	
(*prenatal Vit W/ Iron Carbonyl-Fa Tab 29-1 mg***) PRENATABS RX	1	
(*prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg***) ELITE-OB	1	
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1	
BLEPHAMIDE OIN S.O.P. ***(sulfacetamide sod-prednisolone)***	2	
BLEPHAMIDE SUS OP ***(sulfacetamide sod-prednisolone)***	2	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	1	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	1	
neomycin-polymyxin-hc ophth susp	1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1% ***(tobramycin-dexamethasone)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TOBRADEX ST SUS 0.3-0.05 ***(tobramycin-dexamethasone)***	2	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
AZASITE SOLN 1% ***(azithromycin (ophth))***	2	
bacitracin (ophthalmic) oint 500unit/gm	1	
bacitracin-polymyxin b ophth oint	1	
(Bacitracin-Polymyxin B Ophth Oint) POLYCIN	1	
BESIVANCE SUSP .6% ***(besifloxacin hcl)***	3	
ciprofloxacin hcl (ophth) soln .3%	1	
erythromycin (ophth) oint 5mg/gm	1	
gatifloxacin (ophth) soln .5%	1	
(Gentamicin Sulfate (Ophth) Oint .3%) GENTAK	1	
gentamicin sulfate (ophth) soln .3%	1	
levofloxacin (ophth) soln .5%	1	
moxifloxacin hcl (ophth) soln .5%	1	
NATACYN SUSP 5% ***(natamycin)***	2	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	1	
ofloxacin (ophth) soln .3%	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
sulfacetamide sodium (ophth) oint 10%; soln 10%	1	
tobramycin (ophth) soln .3%	1	
trifluridine soln 1%	1	
ZIRGAN GEL .15% ***(ganciclovir ophthalmic)***	3	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL SOLN .45% ***(ketorolac tromethamine (ophth))***	2	
bromfenac sodium (ophth) soln .09%	1	
dexamethasone sodium phosphate (ophth) soln .1%	1	
diclofenac sodium (ophth) soln .1%	1	
difluprednate emul .05%	1	
DUREZOL EMUL .05% ***(difluprednate)***	2	
flurbiprofen sodium soln .03%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FML OINT .1% ***(fluorometholone (ophth))***	2	
FML FORTE SUSP .25% ***(fluorometholone (ophth))***	2	
ILEVRO SUSP .3% ***(nepafenac)***	2	
ketorolac tromethamine (ophth) soln .4%, .5%	1	
loteprednol etabonate susp .5%	1	
MAXIDEX SUSP .1% ***(dexamethasone (ophth))***	2	
NEVANAC SUSP .1% ***(nepafenac)***	2	
PRED MILD SUSP .12% ***(prednisolone acetate (ophth))***	2	
prednisolone acetate (ophth) susp 1%	1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	2	
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
ALOCRIL SOLN 2% ***(nedocromil sodium (ophth))***	3	
ALOMIDE SOLN .1% ***(lodoxamide tromethamine)***	3	
azelastine hcl (ophth) soln .05%	1	
bepotastine besilate soln 1.5%	1	
BEPREVE SOLN 1.5% ***(bepotastine besilate)***	3	
cromolyn sodium (ophth) soln 4%	1	
epinastine hcl (ophth) soln .05%	1	
LASTACAFT SOLN .25% ***(alcaftadine)***	2	
olopatadine hcl soln .1%, .2%	1	
PAZEO SOLN .7% ***(olopatadine hcl)***	2	
ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA		
ALPHAGAN P SOLN .1% ***(brimonidine tartrate)***	3	MO
apraclonidine hcl soln .5%	1	
betaxolol hcl (ophth) soln .5%	1	MO
BETIMOL SOLN .25%, .5% ***(timolol)***	3	MO
BETOPTIC-S SUSP .25% ***(betaxolol hcl (ophth))***	2	MO
brimonidine tartrate soln .15%, .2%	1	MO
brinzolamide susp 1%	1	MO
carteolol hcl (ophth) soln 1%	1	MO
COMBIGAN SOL 0.2/0.5% ***(brimonidine tartrate-timolol maleate)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dorzolamide hcl soln 2%	1	MO
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml	1	MO
IOPIDINE SOLN 1% ***(apraclonidine hcl)***	3	
latanoprost soln .005%	1	MO
levobunolol hcl soln .5%	1	MO
LUMIGAN SOLN .01% ***(bimatoprost)***	2	ST, MO; PA**
PHOSPHOLINE IODIDE SOLR .125% ***(echothiophate iodide)***	3	MO
pilocarpine hcl soln 1%	1	MO
SIMBRINZA SUS 1-0.2% ***(brinzolamide-brimonidine tartrate)***	2	MO
timolol maleate (ophth) solg .25%, .5%; soln .25%, .5%	1	MO
travoprost soln .004%	1	MO
ZIOPTAN SOLN .015mg/ml ***(tafluprost)***	3	ST, MO; PA**
MISCELLANEOUS		
atropine sulfate soln 1%	3	MO
CYSTARAN SOLN .44% ***(cysteamine hcl)***	4	PA, QL (4 bottles / 28 days), MO
LACRISERT INST 5mg ***(artificial tear insert)***	3	
phenylephrine hcl (mydriatic) soln 2.5%, 10%	1	
RESTASIS EMUL .05% ***(cyclosporine (ophth))***	2	MO
tropicamide soln .5%, 1%	1	MO
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ANAPHYLAXIS TREATMENT AGENTS		
epinephrine (anaphylaxis) soaj .15mg/0.3ml, .3mg/0.3ml	1	QL (4 auto-injectors / 25 days)
epinephrine (anaphylaxis) soaj .15mg/0.15ml	1	QL (4 auto-injectors / 25 days); (generic of Adrenaclick)
EPIPEN 2-PAK SOAJ .3mg/0.3ml ***(epinephrine (anaphylaxis))***	2	QL (4 auto-injectors / 25 days)
EPIPEN-JR 2-PAK SOAJ .15mg/0.3ml ***(epinephrine (anaphylaxis))***	2	QL (4 auto-injectors / 25 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPT AER 62.5-25 ***(umeclidinium-vilanterol)***	2	QL (1 package / 25 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BEVESPI AER 9-4.8MCG ***(glycopyrrolate-formoterol fumarate)***	2	QL (1 package / 25 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	QL (6 boxes / 25 days), MO
TRELEGY AER ELLIPTA ***(fluticasone-umeclidinium-vilanterol)***	2	QL (1 package / 25 days), MO
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
INCRUSE ELLIPTA AEPB 62.5mcg/inh ***(umeclidinium bromide)***	2	QL (1 package / 25 days), MO
ipratropium bromide soln .02%	1	QL (5 boxes / 25 days), MO
ipratropium bromide (nasal) soln .03%, .06%	1	MO
SPIRIVA HANDIHALER CAPS 18mcg ***(tiotropium bromide monohydrate)***	2	QL (1 package / 25 days), MO
SPIRIVA RESPIMAT AERS 1.25mcg/act, 2.5mcg/act ***(tiotropium bromide monohydrate)***	2	QL (1 package / 25 days), MO
ANTIHISTAMINE COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	1	QL (1 package / 25 days)
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
azelastine hcl soln .1%, .15%	1	QL (2 bottles / 25 days)
brompheniramine tannate chew 12mg	1	
carbinoxamine maleate soln 4mg/5ml; tabs 4mg	1	
clemastine fumarate tabs 2.68mg	1	PA; High Risk Medications require PA for members age 70 and older
cyproheptadine hcl syrp 2mg/5ml; tabs 4mg	1	
desloratadine tabs 5mg; tbdp 2.5mg, 5mg	1	
diphenhydramine hcl soln 50mg/ml	MB	
hydroxyzine hcl soln 25mg/ml, 50mg/ml	MB	
hydroxyzine hcl syrp 10mg/5ml; tabs 10mg, 25mg, 50mg	1	PA; High Risk Medications require PA for members age 70 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydroxyzine pamoate caps 25mg, 50mg, 100mg	1	PA; High Risk Medications require PA for members age 70 and older
levocetirizine dihydrochloride soln 2.5mg/5ml; tabs 5mg	1	
olopatadine hcl (nasal) soln .6%	1	QL (1 container / 25 days)
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate aers 108mcg/act	1	QL (2 inhalers / 25 days), MO
albuterol sulfate nebu .5%	1	QL (60 mL / 25 days), MO
albuterol sulfate nebu .083%, .63mg/3ml, 1.25mg/3ml	1	QL (5 boxes / 25 days), MO
albuterol sulfate syrp 2mg/5ml; tabs 2mg, 4mg; tb12 4mg, 8mg	1	MO
formoterol fumarate nebu 20mcg/2ml	1	QL (60 vials / 25 days), MO
levalbuterol hcl nebu 1.25mg/0.5ml	1	QL (45 mL / 25 days), MO
levalbuterol hcl nebu .31mg/3ml, .63mg/3ml, 1.25mg/3ml	1	QL (300 mL / 25 days), MO
levalbuterol tartrate aero 45mcg/act	1	QL (2 inhalers / 25 days), MO
metaproterenol sulfate syrp 10mg/5ml	1	MO
PERFOROMIST NEBU 20mcg/2ml ***(formoterol fumarate)***	2	QL (60 vials / 25 days), MO
STRIVERDI RESPIMAT AERS 2.5mcg/act ***(olodaterol hcl)***	2	QL (1 package / 25 days), MO
terbutaline sulfate tabs 2.5mg, 5mg	1	MO
BIOLOGIC RESPONSE MODIFIERS		
NUCALA SOAJ 100mg/ml; SOLR 100mg; SOSY 100mg/ml ***(mepolizumab)***	MB	MO
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml ***(omalizumab)***	MB	
COLD/COUGH		
benzonatate caps 100mg, 200mg	1	
(Guaifenesin-Codeine Soln 100-10 mg/5ml) GUAIFENESIN AC	1	
hydrocodone w/ homatropine syrup 5-1.5 mg/5ml	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Hydrocodone W/ Homatropine Syrup 5-1.5 mg/5ml) HYDROMET	1	
hydrocodone w/ homatropine tab 5-1.5 mg	1	
promethazine & phenylephrine syrup 6.25-5 mg/5ml	1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	1	
promethazine-dm syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml	1	
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1	
TUZISTRA XR SUS ***(codeine polistirex-chlorpheniramine polistirex)***	3	
LEUKOTRIENE MODIFIERS		
zileuton tb12 600mg	2	MO
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES		
montelukast sodium chew 4mg, 5mg; pack 4mg; tabs 10mg	1	MO
zafirlukast tabs 10mg, 20mg	1	MO
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
cromolyn sodium nebu 20mg/2ml	1	QL (2 boxes / 25 days), MO
MISCELLANEOUS		
acetylcysteine soln 10%, 20%	1	
DALIRESP TABS 250mcg, 500mcg ***(roflumilast)***	3	PA, MO
ESBRIET CAPS 267mg ***(pirfenidone)***	4	SP, PA, QL (270 caps / 30 days), MO
ESBRIET TABS 267mg ***(pirfenidone)***	4	SP, PA, QL (270 tabs / 30 days), MO
ESBRIET TABS 801mg ***(pirfenidone)***	4	SP, PA, QL (90 tabs / 30 days), MO
KALYDECO PACK 25mg, 50mg, 75mg ***(ivacaftor)***	4	PA, QL (56 packets / 28 days), MO
KALYDECO TABS 150mg ***(ivacaftor)***	4	PA, QL (56 tabs / 28 days), MO; carton consists of 56 tablets

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KALYDECO TABS 150mg ***(ivacaftor)***	4	PA, QL (60 tabs / 30 days), MO; packet consists of 60 tablets
ORKAMBI GRA 100-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (56 packets / 28 days), MO
ORKAMBI GRA 150-188 ***(lumacaftor-ivacaftor)***	4	PA, QL (56 packets / 28 days), MO
ORKAMBI TAB 100-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (112 tabs / 28 days), MO
ORKAMBI TAB 200-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (112 tabs / 28 days), MO
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg ***(alpha1-proteinase inhibitor (human))***	MB	
sodium chloride (inhalant) nebu .9%, 3%, 7%, 10%	1	
SYMDEKO TAB 50-75MG ***(tezacaftor-ivacaftor)***	4	PA, QL (56 tabs / 28 days), MO
SYMDEKO TAB 100-150 ***(tezacaftor-ivacaftor)***	4	PA, QL (56 tabs / 28 days), MO
TRIKAFTA TAB ***(elexacaftor-tezacaftor-ivacaftor)***	4	PA, QL (84 tabs / 28 days), MO
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) soln .025%	1	QL (3 containers / 25 days)
fluticasone propionate (nasal) susp 50mcg/act	1	QL (1 container / 25 days)
OMNARIS SUSP 50mcg/act ***(ciclesonide (nasal))***	3	ST, QL (1 package / 25 days); PA**
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act ***(fluticasone furoate (inhalation))***	2	QL (1 package / 25 days), MO
budesonide (inhalation) susp 1mg/2ml	1	QL (1 box / 25 days), MO
budesonide (inhalation) susp .5mg/2ml	1	QL (2 boxes / 25 days), MO
budesonide (inhalation) susp .25mg/2ml	1	QL (3 boxes / 25 days), MO
QVAR REDIHALER AERB 40mcg/act, 80mcg/act ***(beclomethasone dipropionate hfa)***	2	QL (2 packages / 25 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
ADVAIR DISKU AER 100/50 ***(fluticasone-salmeterol)***	1	QL (1 package / 25 days), MO
ADVAIR DISKU AER 250/50 ***(fluticasone-salmeterol)***	1	QL (1 package / 25 days), MO
ADVAIR DISKU AER 500/50 ***(fluticasone-salmeterol)***	1	QL (1 package / 25 days), MO
ADVAIR HFA AER 45/21 ***(fluticasone-salmeterol)***	2	QL (1 package / 25 days), MO
ADVAIR HFA AER 115/21 ***(fluticasone-salmeterol)***	2	QL (1 package / 25 days), MO
ADVAIR HFA AER 230/21 ***(fluticasone-salmeterol)***	2	QL (1 package / 25 days), MO
BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)***	2	QL (1 package / 25 days), MO
BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)***	2	QL (1 package / 25 days), MO
SYMBICORT AER 80-4.5 ***(budesonide-formoterol fumarate dihydrate)***	2	QL (3 packages / 25 days), MO
SYMBICORT AER 160-4.5 ***(budesonide-formoterol fumarate dihydrate)***	2	QL (3 packages / 25 days), MO
XANTHINES - DRUGS TO TREAT COPD		
aminophylline soln 25mg/ml	MB	
ELIXOPHYLLIN ELIX 80mg/15ml ***(theophylline)***	3	MO
theophylline soln 80mg/15ml; tb12 300mg, 450mg; tb24 400mg, 600mg	1	MO
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
adapalene crea .1%; gel .1%, .3%	1	PA; PA applies for members age 35 and older
adapalene-benzoyl peroxide gel 0.1-2.5%	1	
BENZIQ GEL 5.25% ***(benzoyl peroxide)***	2	
BENZIQ LS GEL 2.75% ***(benzoyl peroxide)***	2	
(Benzoyl Peroxide Liqd 2.5%) BP WASH	1	
(Benzoyl Peroxide Liqd 5.25%) BENZIQ WASH	1	
benzoyl peroxide-erythromycin gel 5-3%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1	
clindamycin phosphate (topical) foam 1%; swab 1%	1	
clindamycin phosphate (topical) gel 1%	1	QL (75g / 25 days)
clindamycin phosphate (topical) lotn 1%; soln 1%	1	QL (60mL / 25 days)
clindamycin phosphate-benzoyl peroxide gel 1-5%	1	
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	1	
EPIDUO FORTE GEL 0.3-2.5% ***(adapalene-benzoyl peroxide)***	3	
erythromycin (acne aid) gel 2%	1	QL (60g / 25 days)
(Erythromycin (Acne Aid) Pads 2%) ERY	1	
erythromycin (acne aid) soln 2%	1	QL (60mL / 25 days)
isotretinoin caps 10mg, 20mg, 30mg, 40mg	1	PA
sulfacetamide sodium (acne) lotn 10%	1	
tretinoin crea .025%, .05%, .1%; gel .01%, .025%, .05%	1	PA; PA applies for members age 35 and older
(Tretinoin Crea .025%; Gel .025%) AVITA	1	PA; PA applies for members age 35 and older
tretinoin microsphere gel .04%, .1%	1	PA; PA applies for members age 35 and older
DERMATOLOGY, ACTINIC KERATOSIS		
fluorouracil (topical) crea 5%; soln 2%, 5%	1	
imiquimod crea 5%	1	
PICATO GEL .015%, .05% ***(ingenol mebutate)***	3	
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) crea .1%; oint .1%	1	
mupirocin oint 2%	1	QL (30g / 25 days)
silver sulfadiazine crea 1%	1	
(Silver Sulfadiazine Crea 1%) SSD	1	
SULFAMYLON CREA 85mg/gm ***(mafenide acetate)***	3	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DERMATOLOGY, ANTIFUNGALS		
ciclopirox gel .77%	1	QL (120g / 25 days)
ciclopirox sham 1%	1	QL (120mL / 25 days)
ciclopirox soln 8%	1	
ciclopirox olamine crea .77%	1	QL (120g / 25 days)
ciclopirox olamine susp .77%	1	QL (120mL / 25 days)
clotrimazole (topical) crea 1%	1	QL (120g / 25 days)
clotrimazole (topical) soln 1%	1	QL (120mL / 25 days)
clotrimazole w/ betamethasone cream 1-0.05%	1	QL (60g / 25 days)
clotrimazole w/ betamethasone lotion 1-0.05%	1	QL (60mL / 25 days)
econazole nitrate crea 1%	1	QL (60g / 25 days)
ERTACZO CREA 2% ***(sertaconazole nitrate)***	3	QL (60g / 25 days)
JUBLIA SOLN 10% ***(efinaconazole)***	3	PA, QL (4mL / 21 days)
ketoconazole (topical) crea 2%	1	QL (120g / 25 days)
MENTAX CREA 1% ***(butenafine hcl)***	3	QL (60g / 25 days)
naftifine hcl crea 1%, 2%	1	QL (60g / 25 days)
nystatin (topical) crea 100000unit/gm; oint 100000unit/gm; powd 100000unit/gm	1	QL (120g / 25 days)
(Nystatin (Topical) Powd 100000unit/gm) NYAMYC	1	QL (120g / 25 days)
(Nystatin (Topical) Powd 100000unit/gm) NYSTOP	1	QL (120g / 25 days)
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1	QL (60g / 25 days)
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1	QL (60g / 25 days)
oxiconazole nitrate crea 1%	1	QL (60g / 25 days)
sulconazole nitrate crea 1%	1	QL (60g / 25 days)
sulconazole nitrate soln 1%	1	QL (60mL / 25 days)
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl (antipruritic) crea 5%	3	ST, QL (45 grams / 25 days); PA**
DERMATOLOGY, ANTIPSORIATICS		
acitretin caps 10mg, 17.5mg, 25mg	1	
calcipotriene soln .005%	1	
calcitriol (topical) oint 3mcg/gm	3	
COSENTYX SOSY 75mg/0.5ml, 150mg/ml ***(secukinumab)***	MB	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COSENTYX SENSOREADY PEN SOAJ 150mg/ml ***(secukinumab)***	MB	MO
methoxsalen rapid caps 10mg	1	
tazarotene crea .1%	1	PA
TAZORAC CREA .05%; GEL .05%, .1% ***(tazarotene)***	2	PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) sham 2%	1	
selenium sulfide lotn 2.5%	1	
DERMATOLOGY, CORTICOSTEROIDS		
alclometasone dipropionate crea .05%; oint .05%	1	QL (120g / 25 days)
amcinonide crea .1%	1	QL (120g / 25 days)
amcinonide lotn .1%	1	QL (120mL / 25 days)
AMCINONIDE OINT .1%	2	QL (120g / 25 days)
betamethasone dipropionate (topical) crea .05%; oint .05%	1	QL (120g / 25 days)
betamethasone dipropionate (topical) lotn .05%	1	QL (120mL / 25 days)
betamethasone dipropionate augmented crea .05%; gel .05%; oint .05%	1	QL (120g / 25 days)
betamethasone dipropionate augmented lotn .05%	1	QL (120mL / 25 days)
betamethasone valerate crea .1%; foam .12%; oint .1%	1	QL (120g / 25 days)
betamethasone valerate lotn .1%	1	QL (120mL / 25 days)
calcipotriene-betamethasone dipropionate oint 0.005-0.064%	2	
clobetasol propionate crea .05%; foam .05%; gel .05%; oint .05%	1	QL (120g / 25 days)
clobetasol propionate liqd .05%; lotn .05%; sham .05%; soln .05%	1	QL (120mL / 25 days)
clobetasol propionate emollient base crea .05%	1	QL (120g / 25 days)
clocortolone pivalate crea .1%	3	QL (120g / 25 days)
desonide crea .05%; oint .05%	1	QL (120g / 25 days)
desonide lotn .05%	1	QL (120mL / 25 days)
desoximetasone crea .05%, .25%; gel .05%; oint .25%	1	QL (120g / 25 days)
diflorasone diacetate crea .05%; oint .05%	3	QL (120g / 25 days)
fluocinolone acetonide crea .01%, .025%; oint .025%	1	QL (120g / 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluocinolone acetonide oil .01%; soln .01%	1	QL (120mL / 25 days)
fluocinonide crea .05%; gel .05%; oint .05%	1	QL (120g / 25 days)
fluocinonide soln .05%	1	QL (120mL / 25 days)
fluticasone propionate crea .05%; oint .005%	1	QL (120g / 25 days)
fluticasone propionate lotn .05%	1	QL (120mL / 25 days)
halobetasol propionate crea .05%; oint .05%	1	QL (120g / 25 days)
(Hydrocortisone (Topical) Crea 1%) ALA-CORT	1	QL (120g / 25 days)
hydrocortisone (topical) crea 1%, 2.5%; oint 2.5%	1	QL (120g / 25 days)
hydrocortisone (topical) lotn 2.5%	1	QL (120mL / 25 days)
hydrocortisone butyrate crea .1%; oint .1%	1	QL (120g / 25 days)
hydrocortisone butyrate soln .1%	1	QL (120mL / 25 days)
hydrocortisone valerate crea .2%; oint .2%	1	QL (120g / 25 days)
mometasone furoate crea .1%; oint .1%	1	QL (120g / 25 days)
mometasone furoate soln .1%	1	QL (120mL / 25 days)
prednicarbate crea .1%; oint .1%	1	QL (120g / 25 days)
(Triamcinolone Acetonide (Topical) Crea .1%) TRIDERM	1	QL (120g / 25 days)
triamcinolone acetonide (topical) crea .025%, .1%, .5%; oint .025%, .1%, .5%	1	QL (120g / 25 days)
triamcinolone acetonide (topical) lotn .025%, .1%	1	QL (120mL / 25 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine oint 5%	1	QL (50gm / 25 days)
lidocaine ptch 5%	1	PA, QL (90 patches / 25 days)
lidocaine hcl gel 2%	1	QL (60mL / 25 days)
lidocaine hcl prsy 2%	MB	
lidocaine hcl soln 4%	1	QL (50mL / 25 days)
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30gm / 25 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
CONDYLOX GEL .5% ***(podofilox)***	3	
DENAVIR CREA 1% ***(penciclovir)***	3	
diclofenac sodium (topical) gel 1%	1	QL (300g / 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
EUCRISA OINT 2% ***(crisaborole)***	2	ST, QL (60 grams / 25 days); PA**
lactic acid lotn 10%	1	
lactic acid (ammonium lactate) crea 12%; lotn 12%	1	
podofilox soln .5%	1	
RECTIV OINT .4% ***(nitroglycerin (intra-anal))***	3	
tacrolimus (topical) oint .03%, .1%	1	
TARGRETIN GEL 1% ***(bexarotene (topical))***	4	SP, PA
DERMATOLOGY, ROSACEA		
azelaic acid gel 15%	1	
FINACEA FOAM 15% ***(azelaic acid)***	2	
(Metronidazole (Topical) Crea .75%) ROSADAN	1	
metronidazole (topical) crea .75%; gel .75%, 1%; lotn .75%	1	
MIRVASO GEL .33% ***(brimonidine tartrate (topical))***	3	PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
(Crotamiton Lotn 10%) CROTAN	1	
EURAX CREA 10% ***(crotamiton)***	3	
ivermectin (pediculicide) lotn .5%	1	ST; PA**
lindane sham 1%	1	
malathion lotn .5%	1	
permethrin crea 5%	1	
spinosad susp .9%	1	
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01% ***(becaplermin)***	3	PA, QL (30g / 25 days)
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl caps 30mg	1	MO
clotrimazole troc 10mg	1	
lidocaine hcl (mouth-throat) soln 2%	1	
nystatin (mouth-throat) susp 100000unit/ml	1	
ORAVIG TABS 50mg ***(miconazole (mouth-throat))***	3	QL (14 tabs / 25 days)
pilocarpine hcl (oral) tabs 5mg, 7.5mg	1	MO
triamcinolone acetonide (mouth) pste .1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Triamcinolone Acetonide (Mouth) Pste .1%) ORALONE DENTAL PASTE	1	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
acetic acid (otic) soln 2%	1	
ciprofloxacin hcl (otic) soln .2%	1	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
CORTISPORIN SUS -TC OTIC ***(neomycin-colistin-hc-thonzonium)***	3	
fluocinolone acetonide (otic) oil .01%	1	
hydrocortisone w/ acetic acid otic soln 1-2%	1	
neomycin-polymyxin-hc otic soln 1%	1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1	
ofloxacin (otic) soln .3%	1	

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Step Therapy Criteria

Step Therapy Group	AMYLIN ANALOG 676-D
Drug Names	SYMLINPEN 120, SYMLINPEN 60
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of rapid-acting insulin or short-acting insulin, or pre-mixed insulin within the past 120 days
Step Therapy Group	ANTIPSYCHOTICS 657-D
Drug Names	LATUDA, REXULTI
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of generic aripiprazole, asenapine, olanzapine, paliperidone, quetiapine (regular or extended release), risperidone, or ziprasidone within the past 180 days
Step Therapy Group	DESVENLAFAXINE/FETZIMA 1888-E
Drug Names	DESVENLAFAXINE ER, FETZIMA, FETZIMA TITRATION PACK
Step Therapy Criteria	Coverage will be provided if the patient has filled a prescription for a 30 day supply of a generic serotonin-norepinephrine reuptake inhibitor (SNRI) OR generic mirtazapine, generic bupropion, or a generic selective serotonin reuptake inhibitor (SSRI) within the past 120 days.
Step Therapy Group	DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS 1009-D
Drug Names	ALOGLIPTIN, ALOGLIPTIN/METFORMIN HCL, JANUMET, JANUMET XR, JANUVIA, JENTADUETO XR
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days
Step Therapy Group	DOXEPIN 1496-E
Drug Names	DOXEPIN HYDROCHLORIDE
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 7 day supply of a generic topical corticosteroid AND at least a 7 day supply of topical tacrolimus (Protopic) within the past 120 days.
Step Therapy Group	EUCRISA 3199-E
Drug Names	EUCRISA
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a one day supply of a medium or higher potency topical corticosteroid within the past 180 days.
Step Therapy Group	GLP- 1 AGONIST 676-D
Drug Names	OZEMPIC, TRULICITY, VICTOZA
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days

Step Therapy Group	GLP-1 AGONIST/LONG ACTING INSULIN COMBO 676-D
Drug Names	SOLIQUA 100/33, XULTOPHY 100/3.6
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days
Step Therapy Group	LYRICA 656-D
Drug Names	PREGABALIN
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for regular release generic gabapentin (at least a 30 day supply within the past 120 days)
Step Therapy Group	OPIOID ER 2219-M
Drug Names	BELBUCA, BUPRENORPHINE, FENTANYL, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER, NUCYNTA ER, OXYCODONE HCL ER, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL ER, XTAMPZA ER
Step Therapy Criteria	Coverage will be provided if the member has filled a cumulative 8-day or greater supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative 30 days or greater within the past 90 days.
Step Therapy Group	OPIOID IR 2221-M
Drug Names	CODEINE SULFATE, HYDROMORPHONE HCL, MORPHINE SULFATE, NUCYNTA, OXYCODONE HCL, OXYCODONE HYDROCHLORIDE, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 8-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.
Step Therapy Group	OPIOID IR COMBO PRODUCTS 1358-E
Drug Names	ACETAMINOPHEN/CODEINE, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/ACETAMINOPHEN, HYDROCODONE/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, OXYCODONE/ASPIRIN, OXYCODONE/IBUPROFEN, TRAMADOL HYDROCHLORIDE/AC
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 8-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.
Step Therapy Group	PDPD HEP C
Drug Names	SOVALDI
Step Therapy Criteria	Must try Epclusa or Harvoni

Step Therapy Group	RANEXA 658-D
Drug Names	RANOLAZINE ER
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a beta blocker in combination with either a calcium channel blocker or long-acting nitrate (at least a 30 day supply within the past 365 days)
Step Therapy Group	SIMVA 80MG 981-D
Drug Names	SIMVASTATIN
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for 80mg strength of simvastatin (Zocor) or 10-80mg strength of ezetimibe-simvastatin (Vytorin) (at least a 290 day supply within the past 365 days)
Step Therapy Group	SKLICE 3744-D
Drug Names	IVERMECTIN
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 14 day supply of permethrin 1% within the past 60 days
Step Therapy Group	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 COMBINATIONS 676-D
Drug Names	FARXIGA, GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY XR, XIGDUO XR
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days
Step Therapy Group	TGST BISPHOSPHONATES 377-D
Drug Names	FOSAMAX PLUS D
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic bisphosphonate product (at least a 28 day supply within the past 365 days)
Step Therapy Group	TGST BPH-ALPHA1 BLCK 606-D
Drug Names	CARDURA XL
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic Benign Prostatic Hyperplasia (BPH) agent (e.g., alfuzosin ext-rel, doxazosin, silodosin, tamsulosin, terazosin) (at least a 30 day supply within the past 365 days)
Step Therapy Group	TGST NASAL STEROIDS 4591-D
Drug Names	OMNARIS
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30 day supply of at least one brand or generic over-the-counter (OTC) nasal steroid or at least one generic prescription nasal steroid within the past 180 days.
Step Therapy Group	TGST PPI 383-D
Drug Names	DEXILANT
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic proton pump inhibitor (at least a 30 day supply within the past 180 days)

Step Therapy Group	TGST PROSTAGL ANALOG 613-D
Drug Names	LUMIGAN, ZIOPTAN
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic prostaglandin analogue (other than bimatoprost) (at least a 30 day supply within the past 365 days)

Step Therapy Group	TGST SLEEP AGENTS 382-D
Drug Names	BELSOMRA
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic nonbenzodiazepine hypnotic (at least a 30 day supply within the past 180 days)

Step Therapy Group	TGST SSRI 384-D
Drug Names	VIIBRYD, VIIBRYD STARTER PACK
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a generic SSRI product (at least a 30 day supply within the past 365 days)

Step Therapy Group	ULORIC 540-D
Drug Names	FEBUXOSTAT
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for allopurinol (at least a 30 day supply within the past 180 days)

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