2022 Formulary

List of covered prescription drugs

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

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 12/01/2022.

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Introduction

December 2022

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 request procedure 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 preferred on the Formulary. Using therapeutic interchange may offer advantages, such as value through improved convenience, affordability, improved outcomes or fewer side effects. Two or more drugs may be considered appropriate for therapeutic interchange 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 Formulary alternative that may be considered appropriate for therapeutic interchange, , 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, athletic performance, sexual dysfunction, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders.)

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 or Mental Health and Substance Use Disorders. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage, when prescribed for treatment of morbid obesity.

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: Neiu bạn nói Tieing 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 wikanang 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):

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿਵੱਚ 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: ถ้าคุณพดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี 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	PA, QL (48 tabs every 30 days); High Risk Medications require PA for members age 70 and older
butalbital-acetaminophen-caffeine cap 50-300-40 mg	1	PA, QL (48 caps every 30 days); High Risk Medications require PA for members age 70 and older
butalbital-acetaminophen-caffeine cap 50-325-40 mg	1	PA, QL (48 caps every 30 days); High Risk Medications require PA for members age 70 and older
butalbital-acetaminophen-caffeine tab 50-325-40 mg	1	PA, QL (48 tabs every 30 days); High Risk Medications require PA for members age 70 and older
butalbital-aspirin-caffeine cap 50-325-40 mg	1	PA, QL (48 caps every 30 days); High Risk Medications require PA for members age 70 and older
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 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
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 ANALGESICS - DRUGS TO TREAT PAIN		
acetaminophen w/ codeine soln 120-12 mg/5ml	1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-15 mg	1	ST, QL (400 tabs every 30 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 every 30 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 300-60 mg	1	ST, QL (180 tabs every 30 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	PA, QL (48 caps every 30 days); High Risk Medications require PA for members age 70 and older
butorphanol tartrate soln 1mg/ml, 2mg/ml	MB	
butorphanol tartrate soln 10mg/ml	1	QL (2 bottles every 30 days)
codeine sulfate tabs 30mg	1	ST, QL (42 tabs every 30 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 every 30 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 every 30 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 every 30 days)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 5-325 mg	1	ST, QL (240 tabs every 30 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 7.5-325 mg	1	ST, QL (180 tabs every 30 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 every 30 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 every 30 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 every 30 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 every 30 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 every 30 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 every 30 days)
hydromorphone hcl tb24 32mg	1	ST, PA; High Strength Requires PA
methadone hcl conc 10mg/ml	1	QL (30 mL every 30 days); (indicated for opioid addiction)
(Methadone Hcl Conc 10mg/ml) METHADONE HYDROCHLORIDE I	1	ST, QL (60 mL every 30 days); (generic of Methadone Intensol, indicated for pain)
methadone hcl soln 5mg/5ml	1	ST, QL (450 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methadone hcl soln 10mg/5ml	1	ST, QL (300 mL every 30 days)
methadone hcl tabs 5mg	1	ST, QL (90 tabs every 30 days)
methadone hcl tabs 10mg	1	ST, QL (60 tabs every 30 days)
methadone hcl tbso 40mg	1	QL (9 tabs every 30 days)
(Methadone Hcl Tbso 40mg) METHADOSE	1	QL (9 tabs every 30 days)
morphine sulfate cp24 10mg, 20mg, 30mg	1	ST, QL (60 caps every 30 days)
morphine sulfate cp24 50mg, 60mg, 80mg	1	ST, QL (30 caps every 30 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 every 30 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 every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate soln 20mg/ml	1	ST, QL (135 mL every 30 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 every 30 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 every 30 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 every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
morphine sulfate beads cp24 30mg, 45mg, 60mg, 75mg, 90mg	1	ST, QL (30 caps every 30 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 every 30 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 every 30 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 every 30 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 every 30 days)
NUCYNTA ER TB12 150mg, 200mg, 250mg ***(tapentadol hcl)***	3	ST, PA; High Strength Requires PA
oxycodone hcl caps 5mg	1	ST, QL (180 caps every 30 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 every 30 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 every 30 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 every 30 days)
oxycodone hcl t12a 40mg, 60mg, 80mg	1	ST, PA; High Strength Requires PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone hcl tabs 5mg, 10mg	1	ST, QL (180 tabs every 30 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 every 30 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 every 30 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 every 30 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	1	ST, QL (360 tabs every 30 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 every 30 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 every 30 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 every 30 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 every 30 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
oxymorphone hcl tabs 5mg	1	ST, QL (180 tabs every 30 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 every 30 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 every 30 days)
oxymorphone hcl tb12 20mg, 30mg, 40mg	1	ST, PA; High Strength Requires PA
tramadol hcl tabs 50mg	1	ST, QL (180 tabs every 30 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 every 30 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 every 30 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 every 30 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 every 30 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 every 30 days)
buprenorphine ptwk 15mcg/hr, 20mcg/hr	1	ST, PA; High Strength Requires Prior Auth
buprenorphine hcl soln .3mg/ml	MB	
SUBLOCADE SOSY 100mg/0.5ml, 300mg/1.5ml ***(buprenorphine)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SALICYLATES		
(Aspirin Chew 81mg) GOODSENSE ASPIRIN	PV	QL (100 tabs every 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 every 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		
ANTHELMINTICS		
EMVERM CHEW 100mg ***(mebendazole)***	3	QL (12 tabs every 365 days)
ivermectin tabs 3mg	1	
praziquantel tabs 600mg	1	QL (24 tabs every 365 days)
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	1	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
tinidazole tabs 250mg, 500mg	1	
tobramycin sulfate soln 40mg/ml, 80mg/2ml; solr 1.2gm	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
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 every 30 days)
abacavir sulfate tabs 300mg	1	SP, QL (60 tabs every 30 days)
APTIVUS CAPS 250mg ***(tipranavir)***	2	SP, QL (120 caps every 30 days)
APTIVUS SOLN 100mg/ml ***(tipranavir)***	2	SP, QL (285 mL every 28 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
atazanavir sulfate caps 150mg, 300mg	1	SP, QL (30 caps every 30 days)
atazanavir sulfate caps 200mg	1	SP, QL (60 caps every 30 days)
CRIXIVAN CAPS 200mg ***(indinavir sulfate)***	2	SP, QL (450 caps every 30 days)
CRIXIVAN CAPS 400mg ***(indinavir sulfate)***	2	SP, QL (180 caps every 30 days)
didanosine cpdr 200mg, 250mg, 400mg	1	SP, QL (30 caps every 30 days)
EDURANT TABS 25mg ***(rilpivirine hcl)***	2	SP, QL (60 tabs every 30 days)
efavirenz caps 50mg, 200mg	1	SP, QL (90 caps every 30 days)
efavirenz tabs 600mg	1	SP, QL (30 tabs every 30 days)
emtricitabine caps 200mg	1	SP, QL (30 caps every 30 days)
EMTRIVA SOLN 10mg/ml ***(emtricitabine)***	2	SP, QL (680 ml every 28 days)
etravirine tabs 100mg	1	SP, QL (120 tabs every 30 days)
etravirine tabs 200mg	1	SP, QL (60 tabs every 30 days)
fosamprenavir calcium tabs 700mg	1	SP, QL (120 tabs every 30 days)
FUZEON SOLR 90mg ***(enfuvirtide)***	MB	
INTELENCE TABS 25mg ***(etravirine)***	2	SP, QL (120 tabs every 30 days)
INVIRASE TABS 500mg ***(saquinavir mesylate)***	2	SP, QL (120 tabs every 30 days)
ISENTRESS CHEW 25mg, 100mg ***(raltegravir potassium)***	2	SP, QL (180 tabs every 30 days)
ISENTRESS PACK 100mg ***(raltegravir potassium)***	2	SP, QL (60 packets every 30 days)
ISENTRESS TABS 400mg ***(raltegravir potassium)***	2	SP, QL (120 tabs every 30 days)
ISENTRESS HD TABS 600mg ***(raltegravir potassium)***	2	SP, QL (60 tabs every 30 days)
lamivudine soln 10mg/ml	1	SP, QL (960 ml every 30 days)
lamivudine tabs 150mg	1	SP, QL (60 tabs every 30 days)
lamivudine tabs 300mg	1	SP, QL (30 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LEXIVA SUSP 50mg/ml ***(fosamprenavir calcium)***	2	SP, QL (1575 mL every 28 days)
maraviroc tabs 150mg	1	SP, QL (60 tabs every 30 days)
maraviroc tabs 300mg	1	SP, QL (120 tabs every 30 days)
nevirapine susp 50mg/5ml	1	SP, QL (1200 mL every 30 days)
nevirapine tabs 200mg	1	SP, QL (60 tabs every 30 days)
nevirapine tb24 100mg	1	SP, QL (90 tabs every 30 days)
nevirapine tb24 400mg	1	SP, QL (30 tabs every 30 days)
NORVIR PACK 100mg ***(ritonavir)***	2	SP, QL (360 packets every 30 days)
NORVIR SOLN 80mg/ml ***(ritonavir)***	2	SP, QL (480 mL every 30 days)
PREZISTA SUSP 100mg/ml ***(darunavir)***	2	SP, QL (400 ml every 30 days)
PREZISTA TABS 75mg ***(darunavir)***	2	SP, QL (300 tabs every 30 days)
PREZISTA TABS 150mg ***(darunavir)***	2	SP, QL (180 tabs every 30 days)
PREZISTA TABS 600mg ***(darunavir)***	2	SP, QL (60 tabs every 30 days)
PREZISTA TABS 800mg ***(darunavir)***	2	SP, QL (30 tabs every 30 days)
RETROVIR IV INFUSION SOLN 10mg/ml ***(zidovudine)***	MB	
REYATAZ PACK 50mg ***(atazanavir sulfate)***	2	SP, QL (180 packets every 30 days)
ritonavir tabs 100mg	1	SP, QL (360 tabs every 30 days)
SELZENTRY SOLN 20mg/ml ***(maraviroc)***	2	SP, QL (1840 mL every 30 days)
SELZENTRY TABS 25mg ***(maraviroc)***	2	SP, QL (240 tabs every 30 days)
SELZENTRY TABS 75mg ***(maraviroc)***	2	SP, QL (60 tabs every 30 days)
stavudine caps 15mg, 20mg, 30mg, 40mg	1	SP, QL (60 caps every 30 days)
tenofovir disoproxil fumarate tabs 300mg	1	SP, QL (30 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TIVICAY TABS 10mg ***(dolutegravir sodium)***	2	SP, QL (240 tabs every 30 days)
TIVICAY TABS 25mg, 50mg ***(dolutegravir sodium)***	2	SP, QL (60 tabs every 30 days)
TIVICAY PD TBSO 5mg ***(dolutegravir sodium)***	2	SP, QL (360 tabs every 30 days)
TROGARZO SOLN 200mg/1.33ml ***(ibalizumab-uiyk)***	MB	
TYBOST TABS 150mg ***(cobicistat)***	2	SP, QL (30 tabs every 30 days)
VIRACEPT TABS 250mg ***(nelfinavir mesylate)***	2	SP, QL (300 tabs every 30 days)
VIRACEPT TABS 625mg ***(nelfinavir mesylate)***	2	SP, QL (120 tabs every 30 days)
VIREAD POWD 40mg/gm ***(tenofovir disoproxil fumarate)***	2	SP, QL (240 gm every 30 days)
VIREAD TABS 150mg, 200mg, 250mg ***(tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs every 30 days)
zidovudine caps 100mg	1	SP, QL (180 caps every 30 days)
zidovudine syrp 50mg/5ml	1	SP, QL (1920 ml every 30 days)
zidovudine tabs 300mg	1	SP, QL (60 tabs every 30 days)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg	1	SP, QL (30 tabs every 30 days)
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg	1	SP, QL (60 tabs every 30 days)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs every 30 days)
CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs every 30 days)
DESCOVY TAB 120-15MG ***(emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs every 30 days)
DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs every 30 days); $0 copay for PrEP
DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)***	2	SP, QL (30 tabs every 30 days)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	1	SP, QL (30 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	1	SP, QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	1	SP, QL (30 tabs every 30 days); $0 copay for PrEP
EVOTAZ TAB 300-150 ***(atazanavir sulfate-cobicistat)***	2	SP, QL (30 tabs every 30 days)
GENVOYA TAB ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)***	2	SP, QL (30 tabs every 30 days)
lamivudine-zidovudine tab 150-300 mg	1	SP, QL (60 tabs every 30 days)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	1	SP, QL (480 ml every 30 days)
lopinavir-ritonavir tab 100-25 mg	1	SP, QL (240 tabs every 30 days)
lopinavir-ritonavir tab 200-50 mg	1	SP, QL (120 tabs every 30 days)
ODEFSEY TAB ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)***	2	SP, QL (30 tabs every 30 days)
PREZCOBIX TAB 800-150 ***(darunavir-cobicistat)***	2	SP, QL (30 tabs every 30 days)
TEMIXYS TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	2	SP, QL (30 tabs every 30 days)
TRIUMEQ PD TAB ***(abacavir-dolutegravir-lamivudine)***	2	SP, QL (180 tabs every 30 days)
TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)***	2	SP, QL (30 tabs every 30 days)
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
rifabutin caps 150mg	1	
rifampin caps 150mg, 300mg	1	
rifampin solr 600mg	MB	
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
BARACLUDE SOLN .05mg/ml ***(entecavir)***	3	SP, QL (630 mL every 30 days)
cidofovir soln 75mg/ml	MB	
entecavir tabs .5mg, 1mg	4	SP, QL (30 tabs every 30 days)
EPIVIR HBV SOLN 5mg/ml ***(lamivudine (hbv))***	2	SP
famciclovir tabs 125mg, 250mg, 500mg	1	
lamivudine (hbv) tabs 100mg	1	SP
oseltamivir phosphate caps 30mg	1	QL (40 caps every 90 days)
oseltamivir phosphate caps 45mg, 75mg	1	QL (20 caps every 90 days)
oseltamivir phosphate susr 6mg/ml	1	QL (360 mL every 90 days)
RELENZA DISKHALER AEPB 5mg/blister ***(zanamivir)***	2	QL (2 inhalers every 90 days)
rimantadine hydrochloride tabs 100mg	1	
valacyclovir hcl tabs 500mg, 1000mg	1	
valganciclovir hcl solr 50mg/ml	4	PA, QL (1000 mL every 30 days)
valganciclovir hcl tabs 450mg	4	PA, QL (120 tabs every 30 days)
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	
cefepime hcl solr 1gm, 2gm	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HEPATITIS C		
EPCLUSA PAK 150-37.5 ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 pellets every 28 days)
EPCLUSA PAK 200-50MG ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 pellets every 28 days)
EPCLUSA TAB 200-50MG ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 tabs every 28 days)
EPCLUSA TAB 400-100 ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (28 tabs every 28 days)
HARVONI PAK ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 pellets every 28 days)
HARVONI PAK 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 pellets every 28 days)
HARVONI TAB 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 tabs every 28 days)
HARVONI TAB 90-400MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (28 tabs every 28 days)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml ***(peginterferon alfa-2a)***	MB	
PEGINTRON KIT 50mcg/0.5ml ***(peginterferon alfa-2b)***	MB	
ribavirin (hepatitis c) caps 200mg; tabs 200mg	1	SP, PA
SOVALDI PACK 150mg, 200mg ***(sofosbuvir)***	4	SP, ST, PA, QL (28 pellets every 28 days)
SOVALDI TABS 200mg, 400mg ***(sofosbuvir)***	4	SP, ST, PA, QL (28 tabs every 28 days)
VOSEVI TAB ***(sofosbuvir-velpatasvir-voxilaprevir)***	4	SP, PA, QL (28 tabs every 28 days)
MISCELLANEOUS		
ALINIA SUSR 100mg/5ml ***(nitazoxanide)***	3	QL (540 mL every 30 days)
atovaquone susp 750mg/5ml	1	
aztreonam solr 1gm, 2gm	MB	
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
ertapenem sodium solr 1gm	MB	
linezolid soln 600mg/300ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 soln 500mg/100ml	MB	
nitazoxanide tabs 500mg	1	QL (20 tabs every 30 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	
PRIMSOL SOLN 50mg/5ml ***(trimethoprim hcl)***	2	
pyrimethamine tabs 25mg	3	PA
TRIMETHOPRIM TABS 100mg	3	
vancomycin hcl caps 125mg, 250mg	1	QL (80 caps every 10 days)
vancomycin hcl solr 1gm, 5gm, 10gm, 500mg, 750mg	MB	
XIFAXAN TABS 200mg ***(rifaximin)***	2	QL (9 tabs every 30 days)
XIFAXAN TABS 550mg ***(rifaximin)***	2	PA, MO
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 5000000unit, 20000000unit	MB	
(Penicillin G Potassium Solr 20000000unit) PFIZERPEN	MB	
penicillin g sodium solr 5000000unit	MB	
penicillin v potassium solr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	1	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
doxycycline hyclate caps 50mg, 100mg; tabs 100mg	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	QL (120 caps every 30 days)
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	
dacarbazine solr 100mg, 200mg	MB	
EMCYT CAPS 140mg ***(estramustine phosphate sodium)***	4	OAC
GLEOSTINE CAPS 10mg, 40mg, 100mg ***(lomustine)***	4	SP; OAC
GLIADEL WAF 7.7MG ***(carmustine in polifeprosan)***	MB	
ifosfamide soln 1gm/20ml, 3gm/60ml; solr 1gm	MB	
LEUKERAN TABS 2mg ***(chlorambucil)***	2	OAC
MATULANE CAPS 50mg ***(procarbazine hcl)***	2	OAC
melphalan tabs 2mg	1	OAC
melphalan hcl solr 50mg	MB	
TEMODAR SOLR 100mg ***(temozolomide)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg	4	SP, PA; OAC
ANTIBIOTICS		
bleomycin sulfate solr 15unit, 30unit	MB	
daunorubicin hcl soln 20mg/4ml	MB	
doxorubicin hcl soln 2mg/ml; solr 10mg	MB	
(Doxorubicin Hcl Solr 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	
mitomycin solr 5mg, 20mg, 40mg	MB	
mitoxantrone hcl conc 2mg/ml	MB	
ANTIMETABOLITES		
ALIMTA SOLR 100mg, 500mg ***(pemetrexed disodium)***	MB	
azacitidine susr 100mg	MB	
capecitabine tabs 150mg	4	SP, PA, QL (120 tabs every 30 days); OAC
capecitabine tabs 500mg	4	SP, PA, QL (300 tabs every 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	
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	
pemetrexed disodium solr 100mg, 500mg	MB	
TABLOID TABS 40mg ***(thioguanine)***	2	OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
paclitaxel protein-bound particles for iv susp 100 mg	MB	
ANTIMITOTIC, VINCA ALKALOIDS		
vinblastine sulfate soln 1mg/ml	MB	
vincristine sulfate soln 1mg/ml	MB	
vinorelbine tartrate soln 10mg/ml, 50mg/5ml	MB	
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA TABS 10mg, 50mg ***(venetoclax)***	4	PA, QL (120 every 30 days); OAC
VENCLEXTA TABS 100mg ***(venetoclax)***	4	PA, QL (180 every 30 days); OAC
VENCLEXTA TAB START PK ***(venetoclax)***	4	PA, QL (1 pack every 28 days); OAC
BIOLOGIC RESPONSE MODIFIERS		
ERBITUX SOLN 100mg/50ml, 200mg/100ml ***(cetuximab)***	MB	
ERIVEDGE CAPS 150mg ***(vismodegib)***	4	SP, PA, QL (30 caps every 30 days); OAC
GAZYVA SOLN 1000mg/40ml ***(obinutuzumab)***	MB	
KADCYLA SOLR 100mg, 160mg ***(ado-trastuzumab emtansine)***	MB	
KEYTRUDA SOLN 100mg/4ml ***(pembrolizumab)***	MB	
POMALYST CAPS 1mg, 2mg, 3mg, 4mg ***(pomalidomide)***	4	SP, PA, QL (21 caps every 28 days); OAC
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg ***(lenalidomide)***	4	SP, PA, QL (28 caps every 28 days); OAC
REVLIMID CAPS 20mg, 25mg ***(lenalidomide)***	4	SP, PA, QL (21 caps every 28 days); OAC
THALOMID CAPS 50mg, 100mg ***(thalidomide)***	4	SP, PA, QL (28 caps every 28 days); OAC
THALOMID CAPS 150mg, 200mg ***(thalidomide)***	4	SP, PA, QL (56 caps every 28 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TICE BCG SUSR 50mg ***(bcg live intravesical)***	MB	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate tabs 250mg	4	SP, PA, QL (120 tabs every 30 days); OAC
abiraterone acetate tabs 500mg	4	SP, PA, QL (60 tabs every 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
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 every 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
letrozole tabs 2.5mg	1	MO; OAC
leuprolide acetate kit 1mg/0.2ml	MB	
LYSODREN TABS 500mg ***(mitotane)***	2	OAC
megestrol acetate susp 40mg/ml; tabs 20mg, 40mg	1	OAC
nilutamide tabs 150mg	1	OAC
NUBEQA TABS 300mg ***(darolutamide)***	4	SP, PA, QL (120 tabs every 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 every 30 days); OAC
XTANDI TABS 40mg ***(enzalutamide)***	4	SP, PA, QL (120 tabs every 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XTANDI TABS 80mg ***(enzalutamide)***	4	SP, PA, QL (60 tabs every 30 days); OAC
YONSA TABS 125mg ***(abiraterone acetate)***	4	SP, PA, QL (120 tabs every 30 days); OAC
KINASE INHIBITORS		
ALECENSA CAPS 150mg ***(alectinib hcl)***	4	SP, PA, QL (240 caps every 30 days); OAC
BOSULIF TABS 100mg ***(bosutinib)***	4	SP, PA, QL (90 tabs every 30 days); OAC
BOSULIF TABS 400mg, 500mg ***(bosutinib)***	4	SP, PA, QL (30 tabs every 30 days); OAC
CABOMETYX TABS 20mg, 40mg, 60mg ***(cabozantinib s-malate)***	4	SP, PA, QL (30 tabs every 30 days); OAC
CALQUENCE CAPS 100mg ***(acalabrutinib)***	4	PA, QL (60 caps every 30 days); OAC
CALQUENCE TABS 100mg ***(acalabrutinib maleate)***	4	PA, QL (60 tabs every 30 days); OAC
CAPRELSA TABS 100mg ***(vandetanib)***	4	PA, QL (60 tabs every 30 days); OAC
CAPRELSA TABS 300mg ***(vandetanib)***	4	PA, QL (30 tabs every 30 days); OAC
COMETRIQ KIT 20mg ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 100MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 140MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 kit every 28 days); OAC
erlotinib hcl tabs 25mg	4	SP, PA, QL (60 tabs every 30 days); OAC
erlotinib hcl tabs 100mg, 150mg	4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus tabs 2.5mg, 5mg, 7.5mg, 10mg	4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus tbso 2mg, 5mg	4	SP, PA, QL (60 tabs every 30 days); OAC
everolimus tbso 3mg	4	SP, PA, QL (90 tabs every 30 days); OAC
IBRANCE CAPS 75mg, 100mg, 125mg ***(palbociclib)***	4	SP, PA, QL (21 caps every 28 days); OAC
IBRANCE TABS 75mg, 100mg, 125mg ***(palbociclib)***	4	SP, PA, QL (21 tabs every 28 days); OAC
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg ***(ponatinib hcl)***	4	PA, QL (30 tabs every 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
imatinib mesylate tabs 100mg	4	SP, PA, QL (120 tabs every 30 days); OAC
imatinib mesylate tabs 400mg	4	SP, PA, QL (60 tabs every 30 days); OAC
IMBRUVICA CAPS 70mg ***(ibrutinib)***	4	PA, QL (30 caps every 30 days); OAC
IMBRUVICA CAPS 140mg ***(ibrutinib)***	4	PA, QL (90 caps every 30 days); OAC
IMBRUVICA SUSP 70mg/ml ***(ibrutinib)***	4	PA, QL (216 ml every 36 days); OAC
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg ***(ibrutinib)***	4	PA, QL (30 tabs every 30 days); OAC
INLYTA TABS 1mg ***(axitinib)***	4	SP, PA, QL (240 tabs every 30 days); OAC
INLYTA TABS 5mg ***(axitinib)***	4	SP, PA, QL (120 tabs every 30 days); OAC
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg ***(ruxolitinib phosphate)***	4	SP, PA, QL (60 tabs every 30 days); OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (21 tabs every 28 days); 200 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (42 tabs every 28 days); 400 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	4	SP, PA, QL (63 tabs every 28 days); 600 mg dose; OAC
lapatinib ditosylate tabs 250mg	4	SP, PA, QL (180 tabs every 30 days); OAC
LENVIMA 4 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (30 caps every 30 days); OAC
LENVIMA 8 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA 10 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	4	SP, PA, QL (30 caps every 30 days); OAC
LENVIMA 12MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps every 30 days); OAC
LENVIMA 20 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA CAP 14 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA CAP 18 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps every 30 days); OAC
LENVIMA CAP 24 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (90 caps every 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LORBRENA TABS 25mg ***(lorlatinib)***	4	SP, PA, QL (90 tabs every 30 days); OAC
LORBRENA TABS 100mg ***(lorlatinib)***	4	SP, PA, QL (30 tabs every 30 days); OAC
MEKINIST TABS 2mg ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (30 tabs every 30 days); OAC
MEKINIST TABS .5mg ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (90 tabs every 30 days); OAC
NEXAVAR TABS 200mg ***(sorafenib tosylate)***	4	SP, PA, QL (120 tabs every 30 days); OAC
RYDAPT CAPS 25mg ***(midostaurin)***	4	SP, PA, QL (224 caps every 28 days); OAC
sorafenib tosylate tabs 200mg	4	SP, PA, QL (120 tabs every 30 days); OAC
SPRYCEL TABS 20mg ***(dasatinib)***	4	SP, PA, QL (90 tabs every 30 days); OAC
SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg ***(dasatinib)***	4	SP, PA, QL (30 tabs every 30 days); OAC
STIVARGA TABS 40mg ***(regorafenib)***	4	SP, PA, QL (84 tabs every 28 days); OAC
sunitinib malate caps 12.5mg, 25mg, 37.5mg, 50mg	4	SP, PA, QL (30 caps every 30 days); OAC
TAFINLAR CAPS 50mg, 75mg ***(dabrafenib mesylate)***	4	SP, PA, QL (120 caps every 30 days); OAC
TUKYSA TABS 50mg, 150mg ***(tucatinib)***	4	PA, QL (120 tabs every 30 days); OAC
VITRAKVI CAPS 25mg ***(larotrectinib sulfate)***	4	SP, PA, QL (180 caps every 30 days); OAC
VITRAKVI CAPS 100mg ***(larotrectinib sulfate)***	4	SP, PA, QL (60 caps every 30 days); OAC
VITRAKVI SOLN 20mg/ml ***(larotrectinib sulfate)***	4	SP, PA, QL (300 mL every 30 days); OAC
VOTRIENT TABS 200mg ***(pazopanib hcl)***	4	SP, PA, QL (120 tabs every 30 days); OAC
XALKORI CAPS 200mg, 250mg ***(crizotinib)***	4	SP, PA, QL (120 caps every 30 days); OAC
ZELBORAF TABS 240mg ***(vemurafenib)***	4	SP, PA, QL (240 tabs every 30 days); OAC
ZYDELIG TABS 100mg, 150mg ***(idelalisib)***	4	SP, PA, QL (60 tabs every 30 days); OAC
ZYKADIA TABS 150mg ***(ceritinib)***	4	SP, PA, QL (90 tabs every 30 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MISCELLANEOUS		
arsenic trioxide soln 10mg/10ml, 12mg/6ml	MB	
bexarotene caps 75mg	4	SP, PA; OAC
FARYDAK CAPS 10mg, 15mg, 20mg ***(panobinostat lactate)***	4	SP, PA, QL (6 caps every 21 days); OAC
hydroxyurea caps 500mg	1	OAC
IDHIFA TABS 50mg, 100mg ***(enasidenib mesylate)***	4	SP, PA, QL (30 tabs every 30 days); OAC
LYNPARZA TABS 100mg, 150mg ***(olaparib)***	4	SP, PA, QL (120 tabs every 30 days); OAC
NIPENT SOLR 10mg ***(pentostatin)***	MB	
ODOMZO CAPS 200mg ***(sonidegib phosphate)***	4	SP, PA, QL (30 caps every 30 days); OAC
ONCASPAR SOLN 750unit/ml ***(pegaspargase)***	MB	
PHOTOFRIN SOLR 75mg ***(porfimer sodium)***	MB	
QUADRAMET SOLN 1850mbq/ml ***(samarium sm 153 lexidronam)***	MB	
tretinoin (chemotherapy) caps 10mg	1	OAC
VISTOGARD PACK 10gm ***(uridine triacetate (emergency treatment))***	4	QL (20 packets every 5 days); OAC
ZEJULA CAPS 100mg ***(niraparib tosylate)***	4	SP, PA, QL (90 caps every 30 days); OAC
ZOLINZA CAPS 100mg ***(vorinostat)***	4	SP, PA, QL (120 caps every 30 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	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 300-100 ***(nirmatrelvir-ritonavir)***	PV	QL (30 tabs every 30 days)
MISC. ANTIVIRALS		
LAGEVRIO CAPS 200mg ***(molnupiravir)***	PV	QL (40 caps every 30 days)
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
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
trandolapril-verapamil hcl tab er 1-240 mg	1	MO
trandolapril-verapamil hcl tab er 2-180 mg	1	MO
trandolapril-verapamil hcl tab er 2-240 mg	1	MO
trandolapril-verapamil hcl tab er 4-240 mg	1	MO
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl tabs 5mg, 10mg, 20mg, 40mg	1	MO
captopril tabs 12.5mg, 25mg, 50mg, 100mg	1	MO
enalapril maleate tabs 2.5mg, 5mg, 10mg, 20mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
telmisartan-amlodipine tab 40-5 mg	1	MO
telmisartan-amlodipine tab 40-10 mg	1	MO
telmisartan-amlodipine tab 80-5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
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
flecainide acetate tabs 50mg, 100mg, 150mg	1	MO
lidocaine hcl (cardiac) sosy 50mg/5ml, 100mg/5ml	MB	
mexiletine hcl caps 150mg, 200mg, 250mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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		
icosapent ethyl caps 1gm	1	MO; Only indicated as an adjunct to diet to reduce TG levels in adult patients with severe (greater than or equal to 500 mg/dL) hypertriglyceridemia
icosapent ethyl caps .5gm	1	MO
omega-3-acid ethyl esters cap 1 gm	1	MO
VASCEPA CAPS .5gm ***(icosapent ethyl)***	2	MO
ANTILIPEMICS, PCSK9 INHIBITORS		
PRALUENT SOAJ 75mg/ml, 150mg/ml ***(alirocumab)***	MB	
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
atenolol & chlorthalidone tab 100-25 mg	1	MO
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
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 62.5mcg, 125mcg, 250mcg	1	MO
(Digoxin Tabs 125mcg, 250mcg) DIGOX	1	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
chlorthalidone tabs 25mg, 50mg	1	MO
DIURIL SUSP 250mg/5ml ***(chlorothiazide)***	3	MO
ethacrynic acid tabs 25mg	3	MO
furosemide soln 10mg/ml	MB	
furosemide soln 10mg/ml, 40mg/5ml; tabs 20mg, 40mg, 80mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
HEART FAILURE		
ENTRESTO TAB 24-26MG ***(sacubitril-valsartan)***	2	MO
ENTRESTO TAB 49-51MG ***(sacubitril-valsartan)***	2	MO
ENTRESTO TAB 97-103MG ***(sacubitril-valsartan)***	2	MO
MISCELLANEOUS		
clonidine ptwk .1mg/24hr, .2mg/24hr, .3mg/24hr	1	MO
clonidine hcl tabs .1mg, .2mg, .3mg	1	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 every 30 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 every 30 days)
ambrisentan tabs 5mg, 10mg	4	SP, PA, QL (30 tabs every 30 days)
bosentan tabs 62.5mg, 125mg	4	SP, PA, QL (60 tabs every 30 days)
OPSUMIT TABS 10mg ***(macitentan)***	4	SP, PA, QL (30 tabs every 30 days)
ORENITRAM TBCR .125mg, .25mg, 1mg, 2.5mg, 5mg ***(treprostinil diolamine)***	4	SP, PA
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 every 30 days)
tadalafil (pulmonary hypertension) tabs 20mg	4	SP, PA, QL (60 tabs every 30 days)
TYVASO SOLN .6mg/ml ***(treprostinil)***	4	SP, PA, QL (28 ampules every 28 days)
TYVASO REFILL SOLN .6mg/ml ***(treprostinil)***	4	SP, PA, QL (28 ampules every 28 days)
TYVASO STARTER SOLN .6mg/ml ***(treprostinil)***	4	SP, PA, QL (28 ampules every 28 days)
UPTRAVI SOLR 1800mcg ***(selexipag)***	MB	
UPTRAVI TABS 200mcg ***(selexipag)***	4	SP, PA, QL (140 tabs every 28 days)
UPTRAVI TABS 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg ***(selexipag)***	4	SP, PA, QL (60 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
UPTRAVI PACK TAB 200/800 ***(selexipag)***	4	SP, PA, QL (1 pack every 28 days)
VENTAVIS SOLN 10mcg/ml, 20mcg/ml ***(iloprost)***	4	SP, PA, QL (270 ampules every 30 days)
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
acamprosate calcium tbec 333mg	1	PA, MO
disulfiram tabs 250mg, 500mg	1	MO
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam tabs .25mg, .5mg, 1mg, 2mg; tbdp .25mg, .5mg, 1mg, 2mg	1	QL (150 tabs every 30 days)
ALPRAZOLAM INTENSOL CONC 1mg/ml ***(alprazolam)***	2	QL (300 mL every 30 days)
buspirone hcl tabs 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
clomipramine hcl caps 25mg, 50mg	1	QL (150 caps every 30 days), MO; QL applies to members age 65 and older
clomipramine hcl caps 75mg	1	QL (90 caps every 30 days), MO; QL applies to members age 65 and older
fluvoxamine maleate cp24 100mg, 150mg; tabs 25mg, 50mg, 100mg	1	MO
lorazepam conc 2mg/ml	1	QL (150 mL every 30 days)
lorazepam tabs .5mg, 1mg, 2mg	1	QL (150 tabs every 30 days)
meprobamate tabs 200mg, 400mg	1	
oxazepam caps 10mg, 15mg, 30mg	1	QL (120 caps every 30 days)
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
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	MO
clonazepam tabs .5mg, 1mg, 2mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clorazepate dipotassium tabs 3.75mg, 7.5mg, 15mg	1	QL (180 tabs every 30 days)
(Diazepam Conc 5mg/ml) DIAZEPAM INTENSOL	1	QL (240 mL every 30 days)
diazepam soln 5mg/5ml	1	QL (1200 mL every 30 days)
diazepam soln 5mg/ml	MB	
diazepam tabs 2mg, 5mg, 10mg	1	QL (120 tabs every 30 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	
gabapentin caps 100mg, 300mg, 400mg	1	QL (6 caps every day), MO
gabapentin soln 250mg/5ml	1	QL (72 mL every day), MO
gabapentin tabs 600mg	1	QL (6 tabs every day), MO
gabapentin tabs 800mg	1	QL (4 tabs every day), MO
lacosamide soln 10mg/ml; tabs 50mg, 100mg, 150mg, 200mg	1	MO
lacosamide soln 200mg/20ml	MB	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
NAYZILAM SOLN 5mg/0.1ml ***(midazolam (anticonvulsant))***	2	QL (10 units every 30 days)
oxcarbazepine susp 60mg/ml; tabs 150mg, 300mg, 600mg	1	MO
phenobarbital elix 20mg/5ml; tabs 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	1	MO
(Phenytoin Chew 50mg) PHENYTOIN INFATABS	1	MO
phenytoin 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
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 every 30 days)
vigabatrin tabs 500mg	4	SP, PA, QL (180 tabs every 30 days)
XCOPRI TABS 50mg, 100mg, 150mg, 200mg ***(cenobamate)***	2	MO
XCOPRI PAK 12.5-25 ***(cenobamate)***	2	
XCOPRI PAK 50-100MG ***(cenobamate)***	2	
XCOPRI PAK 50-200MG ***(cenobamate)***	2	MO
XCOPRI PAK 100-150 ***(cenobamate)***	2	MO
XCOPRI PAK 150-200 ***(cenobamate)***	2	
XCOPRI PAK 150-200 ***(cenobamate)***	2	MO
zonisamide caps 25mg, 50mg, 100mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 25mg	1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 50mg	1	QL (30 tabs every 30 days), MO; QL applies to members age 65 and older
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 every 30 days), MO; QL applies to members age 65 and older
amoxapine tabs 150mg	1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 75mg	1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 100mg, 150mg	1	QL (30 tabs every 30 days), MO; QL applies to members age 65 and older
desvenlafaxine succinate tb24 25mg, 50mg, 100mg	1	ST, QL (30 tabs every 30 days), MO; (generic of Pristiq) PA**
doxepin hcl caps 10mg, 25mg, 50mg	1	QL (90 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl caps 75mg	1	QL (60 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl caps 100mg, 150mg	1	QL (30 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl conc 10mg/ml	1	QL (450 mL every 30 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 every 30 days), MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FETZIMA CAP TITRATIO ***(levomilnacipran hcl)***	3	ST, QL (30 caps every 30 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 every 30 days), MO; QL applies to members age 65 and older
imipramine hcl tabs 50mg	1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
imipramine pamoate caps 75mg, 100mg	1	QL (30 caps every 30 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 every 30 days), MO; QL applies to members age 65 and older
nortriptyline hcl caps 25mg	1	QL (60 caps every 30 days), MO; QL applies to members age 65 and older
nortriptyline hcl caps 50mg	1	QL (30 caps every 30 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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
nortriptyline hcl soln 10mg/5ml	1	QL (750 mL every 30 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 every 30 days), MO; QL applies to members age 65 and older
protriptyline hcl tabs 10mg	1	QL (60 tabs every 30 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 every 30 days), MO; QL applies to members age 65 and older
trimipramine maleate caps 100mg	1	QL (30 caps every 30 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
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
INBRIJA CAPS 42mg ***(levodopa)***	4	PA, QL (300 caps every 30 days)
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr ***(rotigotine)***	2	MO
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
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**
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 10 mg	1	QL (90 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 15 mg	1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 20 mg	1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine tab 5 mg	1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 10 mg	1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 15 mg	1	QL (60 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 20 mg	1	QL (60 tabs every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine tab 30 mg	1	QL (30 tabs every 30 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 every 30 days), MO
dexmethylphenidate hcl cp24 25mg, 30mg, 35mg, 40mg	1	QL (30 caps every 30 days), MO
dexmethylphenidate hcl tabs 2.5mg, 5mg	1	QL (120 tabs every 30 days), MO
dexmethylphenidate hcl tabs 10mg	1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate cp24 5mg, 10mg	1	QL (120 caps every 30 days), MO
dextroamphetamine sulfate cp24 15mg	1	QL (60 caps every 30 days), MO
dextroamphetamine sulfate soln 5mg/5ml	1	QL (1,200 mL every 30 days), MO
(Dextroamphetamine Sulfate Tabs 2.5mg, 7.5mg) ZENZEDI	1	QL (120 tabs every 30 days), MO
dextroamphetamine sulfate tabs 5mg, 10mg	1	QL (120 tabs every 30 days), MO
dextroamphetamine sulfate tabs 15mg, 20mg	1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate tabs 30mg	1	QL (30 tabs every 30 days), MO
guanfacine hcl (adhd) tb24 1mg, 2mg, 3mg, 4mg	1	MO
methamphetamine hcl tabs 5mg	1	QL (150 tabs every 30 days), MO
methylphenidate hcl chew 2.5mg, 5mg, 10mg	1	QL (180 chew tabs every 30 days), MO
methylphenidate hcl cp24 20mg, 30mg; cpcr 10mg, 20mg, 30mg	1	QL (60 caps every 30 days), MO
methylphenidate hcl cp24 40mg, 60mg; cpcr 40mg, 50mg, 60mg	1	QL (30 caps every 30 days), MO
methylphenidate hcl soln 5mg/5ml	1	QL (1800 mL every 30 days), MO
methylphenidate hcl soln 10mg/5ml	1	QL (900 mL every 30 days), MO
methylphenidate hcl tabs 5mg, 10mg	1	QL (180 tabs every 30 days), MO
methylphenidate hcl tabs 20mg; tbcr 10mg, 20mg	1	QL (90 tabs every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl tbcr 18mg, 27mg, 36mg	1	QL (60 tabs every 30 days), MO
methylphenidate hcl tbcr 54mg	1	QL (30 tabs every 30 days), MO
VYVANSE CAPS 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)***	2	QL (60 caps every 30 days), MO
VYVANSE CAPS 40mg, 50mg, 60mg, 70mg ***(lisdexamfetamine dimesylate)***	2	QL (30 caps every 30 days), MO
VYVANSE CHEW 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)***	2	QL (60 chew tabs every 30 days), MO
VYVANSE CHEW 40mg, 50mg, 60mg ***(lisdexamfetamine dimesylate)***	2	QL (30 chew tabs every 30 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 every 30 days)
HETLIOZ CAPS 20mg ***(tasimelteon)***	4	PA, QL (30 caps every 30 days)
ramelteon tabs 8mg	1	QL (15 tabs every 30 days)
temazepam caps 7.5mg, 15mg, 22.5mg, 30mg	1	QL (15 caps every 30 days)
zaleplon caps 5mg, 10mg	1	QL (15 caps every 30 days)
zolpidem tartrate tabs 5mg, 10mg; tbcr 6.25mg, 12.5mg	1	QL (15 tabs every 30 days)
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SOAJ 70mg/ml, 140mg/ml ***(erenumab-aooe)***	MB	
AJOVY SOAJ 225mg/1.5ml; SOSY 225mg/1.5ml ***(fremanezumab-vfrm)***	MB	
almotriptan malate tabs 6.25mg, 12.5mg	1	QL (12 tabs every 30 days)
dihydroergotamine mesylate soln 1mg/ml	MB	
eletriptan hydrobromide tabs 20mg, 40mg	1	QL (12 tabs every 30 days)
EMGALITY SOAJ 120mg/ml; SOSY 100mg/ml, 120mg/ml ***(galcanezumab-gnlm)***	MB	
ergotamine w/ caffeine tab 1-100 mg	3	
frovatriptan succinate tabs 2.5mg	1	QL (18 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
naratriptan hcl tabs 1mg, 2.5mg	1	QL (12 tabs every 30 days)
rizatriptan benzoate tabs 5mg, 10mg; tbdp 5mg, 10mg	1	QL (18 tabs every 30 days)
sumatriptan soln 5mg/act	1	QL (24 sprays every 30 days)
sumatriptan soln 20mg/act	1	QL (12 sprays every 30 days)
sumatriptan succinate soaj 4mg/0.5ml; soct 4mg/0.5ml	1	QL (18 syringes every 30 days)
sumatriptan succinate soaj 6mg/0.5ml; soct 6mg/0.5ml; sosy 6mg/0.5ml	1	QL (12 units every 30 days)
sumatriptan succinate soln 6mg/0.5ml	1	QL (12 vials every 30 days)
sumatriptan succinate tabs 25mg, 50mg, 100mg	1	QL (12 tabs every 30 days)
zolmitriptan soln 2.5mg, 5mg	1	QL (12 sprays every 30 days)
zolmitriptan tabs 2.5mg, 5mg; tbdp 2.5mg, 5mg	1	QL (12 tabs every 30 days)
MISCELLANEOUS		
EVRYSDI SOLR .75mg/ml ***(risdiplam)***	4	PA, QL (2 bottles every 24 days)
GUANIDINE HCL TABS 125mg	3	
LITHIUM SOLN 8meq/5ml	3	MO
lithium carbonate caps 150mg, 300mg, 600mg; tabs 300mg; tbcr 300mg, 450mg	1	MO
pyridostigmine bromide soln 60mg/5ml; tabs 60mg; tbcr 180mg	1	
riluzole tabs 50mg	1	MO
MOVEMENT DISORDERS		
tetrabenazine tabs 12.5mg	4	SP, PA, QL (120 tabs every 30 days)
tetrabenazine tabs 25mg	4	SP, PA, QL (60 tabs every 30 days)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO TABS 7mg, 14mg ***(teriflunomide)***	4	SP, PA, QL (30 tabs every 30 days)
AVONEX PSKT 30mcg/0.5ml ***(interferon beta-1a)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
AVONEX PEN AJKT 30mcg/0.5ml ***(interferon beta-1a)***	MB	
BETASERON KIT .3mg ***(interferon beta-1b)***	MB	
COPAXONE SOSY 20mg/ml, 40mg/ml ***(glatiramer acetate)***	MB	
dalfampridine tb12 10mg	4	SP, PA, QL (60 tabs every 30 days)
dimethyl fumarate cpdr 120mg	4	SP, PA, QL (14 caps every 28 days)
dimethyl fumarate cpdr 240mg	4	SP, PA, QL (60 caps every 30 days)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	4	SP, PA, QL (1 kit every 30 days)
GILENYA CAPS .5mg ***(fingolimod hcl)***	4	SP, PA, QL (30 caps every 30 days)
(Glatiramer Acetate Sosy 20mg/ml) GLATOPA	MB	
glatiramer acetate sosy 40mg/ml	MB	
PLEGRIDY SOPN 125mcg/0.5ml; SOSY 125mcg/0.5ml ***(peginterferon beta-1a)***	MB	
PLEGRIDY INJ STARTER ***(peginterferon beta-1a)***	MB	
PLEGRIDY PEN INJ STARTER ***(peginterferon beta-1a)***	MB	
REBIF SOSY 22mcg/0.5ml, 44mcg/0.5ml ***(interferon beta-1a)***	MB	
REBIF REBIDO INJ TITRATN ***(interferon beta-1a)***	MB	
REBIF REBIDOSE SOAJ 22mcg/0.5ml, 44mcg/0.5ml ***(interferon beta-1a)***	MB	
REBIF TITRTN INJ PACK ***(interferon beta-1a)***	MB	
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 days), MO
armodafinil tabs 150mg, 200mg, 250mg	1	PA, QL (30 tabs every 30 days), MO
modafinil tabs 100mg, 200mg	1	PA, QL (60 tabs every 30 days), MO
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	QL (2 units every day)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	QL (3 tabs every day)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	QL (3 tabs every day)
ZUBSOLV SUB 0.7-0.18 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units every day)
ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units every day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units every day)
ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (3 units every day)
ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (2 units every day)
ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	QL (1 unit every day)
OPIOID ANTAGONIST		
naloxone hcl liqd 4mg/0.1ml	1	
naloxone hcl soct .4mg/ml; soln .4mg/ml, 4mg/10ml; sosy 2mg/2ml	MB	
naltrexone hcl tabs 50mg	1	
VIVITROL SUSR 380mg ***(naltrexone)***	MB	
OPIOID PARTIAL AGONISTS		
buprenorphine hcl subl 2mg, 8mg	1	QL (90 tabs every 30 days); Must obtain approval after the first 30 day supply
PSYCHOTHERAPEUTIC-MISC		
NUEDEXTA CAP 20-10MG ***(dextromethorphan hbr-quinidine sulfate)***	2	PA, MO
pimozide tabs 1mg, 2mg	1	MO
SMOKING DETERRENTS		
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 TAB 0.5& 1MG ***(varenicline tartrate)***	PV	$0 limited to 2 treatment cycles/year
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NICOTROL INHALER INHA 10mg ***(nicotine)***	PV	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
NICOTROL NS SOLN 10mg/ml ***(nicotine)***	PV	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
varenicline tartrate tabs .5mg, 1mg	PV	$0 limited to 2 treatment cycles/year
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	PV	$0 limited to 2 treatment cycles/year
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ACROMEGALY		
octreotide acetate soln 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; sosy 50mcg/ml, 100mcg/ml, 500mcg/ml	MB	
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml ***(lanreotide acetate)***	MB	
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg ***(pegvisomant)***	MB	
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	
testosterone enanthate soln 200mg/ml	MB	
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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**
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, QL (3 mL every 28 days), MO; PA**
OZEMPIC INJ 8MG/3ML ***(semaglutide)***	2	ST, QL (3 mL every 28 days), MO; PA**
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml ***(dulaglutide)***	2	ST, QL (4 pens every 28 days), MO; PA**
VICTOZA SOPN 18mg/3ml ***(liraglutide)***	2	ST, QL (3 pens every 30 days), MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
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-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
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**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/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**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 30 days)
cinacalcet hcl tabs 90mg	4	SP, PA, QL (120 tabs every 30 days)
CHELATING AGENTS		
ADDYI TABS 100mg ***(flibanserin)***	3	PA, MO
CHEMET CAPS 100mg ***(succimer)***	3	
deferiprone tabs 500mg, 1000mg	4	SP, PA
FERRIPROX SOLN 100mg/ml ***(deferiprone)***	4	PA
FERRIPROX TWICE-A-DAY TABS 1000mg ***(deferiprone)***	4	PA
penicillamine tabs 250mg	4	SP, PA
sildenafil citrate tabs 25mg, 50mg, 100mg	1	PA, QL (8 tabs every 21 days)
(Sodium Polystyrene Sulfonate Susp 15gm/60ml) SPS	1	
tadalafil tabs 10mg, 20mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl tabs 2.5mg, 5mg, 10mg, 20mg; tbdp 10mg	1	PA, QL (8 tabs every 21 days)
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)***	PV	QL (1 every 300 days), MO
BALCOLTRA TAB 0.1-20 ***(levonorgestrel-ethinyl estradiol-ferrous bisglycinate)***	PV	MO
CAYA DPR ***(diaphragm arc-spring)***	MB	
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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	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
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 1/35	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 every 300 days), MO
FC2 FEMALE MIS CONDOM ***(condoms - female)***	PV	QL (12 condoms every 30 days)
FEMCAP MIS 22MM ***(cervical caps)***	MB	
FEMCAP MIS 26MM ***(cervical caps)***	MB	
FEMCAP MIS 30MM ***(cervical caps)***	MB	
KYLEENA IUD 19.5mg ***(levonorgestrel (iud))***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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	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) SRONYX	PV	MO
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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 20.1mcg/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/day ***(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
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NORTREL 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NYLIA 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
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) LOW-OGESTREL	PV	MO
OMNIFLEX DPR ***(diaphragms)***	MB	
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TYBLUME CHW 0.1-0.02 ***(levonorgestrel & eth estradiol)***	PV	MO
WIDE-SEAL SILICONE DIAPHR DPRH 2% ***(diaphragm wide seal)***	MB	
DIABETIC SUPPLIES		
ACCU-CHECK KIT GUIDE ME ***(blood glucose monitoring supplies)***	MB	
ACCU-CHEK BLOOD GLUCOSE TEST KITS ***(blood glucose monitoring supplies)***	MB	
ACCU-CHEK BLOOD GLUCOSE TEST STRIPS ***(glucose blood)***	MB	
AUTOLET PLAT MIS 1.8MM ***(lancets misc.)***	MB	
BLOOD GLUCOSE CALIBRATION SOLUTION ***(blood glucose calibration)***	MB	
DEXCOM G5 MIS RECEIVER ***(continuous blood glucose system receiver)***	MB	
DEXCOM G5 MIS TRANSMIT ***(continuous blood glucose system transmitter)***	MB	
DEXCOM G6 MIS RECEIVER ***(continuous blood glucose system receiver)***	MB	
DEXCOM G6 MIS SENSOR ***(continuous blood glucose system sensor)***	MB	
DEXCOM G6 MIS TRANSMIT ***(continuous blood glucose system transmitter)***	MB	
G4 PLAT PED MIS RVC/SHAR ***(continuous blood glucose system receiver)***	MB	
G4 PLATINUM MIS PEDIATRC ***(continuous blood glucose system receiver)***	MB	
G4 PLATINUM MIS RCV/SHAR ***(continuous blood glucose system receiver)***	MB	
G4 PLATINUM MIS RECEIVER ***(continuous blood glucose system receiver)***	MB	
G4 PLATINUM MIS TRANSMIT ***(continuous blood glucose system transmitter)***	MB	
G4 SENSOR MIS ***(continuous blood glucose system sensor)***	MB	
G5/G4 MIS SENSOR ***(continuous blood glucose system sensor)***	MB	
INSULIN PEN NEEDLES ***(insulin pen needle)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INSULIN PEN NEEDLES/SYRINGES ***(insulin syringe/needle u-100)***	2	
LANCETS ***(lancets)***	MB	
LANCING DEVICE	MB	
NOVOFINE PEN NEEDLES ***(insulin pen needle)***	2	
OMNIPOD 5 G6 KIT INTRO ***(insulin infusion disposable pump)***	MB	
OMNIPOD 5 G6 MIS PODS ***(insulin infusion disposable pump)***	MB	
OMNIPOD DASH KIT INTRO ***(insulin infusion disposable pump)***	MB	
OMNIPOD DASH MIS PODS ***(insulin infusion disposable pump)***	MB	
OMNIPOD MIS CLASSIC ***(insulin infusion disposable pump)***	MB	
OMNIPOD PDM KIT CLASSIC ***(insulin infusion disposable pump)***	MB	
URINE GLUCOSE MONITORING SUPPLIES ***(urine glucose monitoring supplies)***	MB	
V-GO 20 KIT ***(insulin infusion disposable pump)***	MB	
V-GO 30 KIT ***(insulin infusion disposable pump)***	MB	
V-GO 40 KIT ***(insulin infusion disposable pump)***	MB	
ENDOMETRIOSIS		
danazol caps 50mg, 100mg, 200mg	1	
LUPANETA KIT 3.75-5 ***(leuprolide acetate & norethindrone acetate)***	MB	
LUPANETA KIT 11.25-5 ***(leuprolide acetate & norethindrone acetate)***	MB	
ORILISSA TABS 150mg, 200mg ***(elagolix sodium)***	2	
ENZYME REPLACEMENTS - DRUGS TO TREAT ENZYME DEFICIENCIES		
betaine anhy pow	4	PA
carglumic acid tbso 200mg	4	PA
CERDELGA CAPS 84mg ***(eliglustat tartrate)***	4	SP, PA, QL (56 caps every 28 days)
CYSTAGON CAPS 50mg, 150mg ***(cysteamine bitartrate)***	4	SP, PA
sapropterin dihydrochloride pack 100mg, 500mg; tabs 100mg	4	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sodium phenylbutyrate powd 3gm/tsp	4	SP, PA, QL (750g every 30 days)
sodium phenylbutyrate tabs 500mg	4	SP, PA, QL (1200 tabs every 30 days)
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
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMVEXXY MAINTENANCE PACK INST 4mcg, 10mcg ***(estradiol vaginal)***	2	MO
IMVEXXY STARTER PACK INST 4mcg, 10mcg ***(estradiol vaginal)***	2	MO
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
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
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 6.7mg/5ml, 15mg/5ml, 25mg/5ml; tbdp 10mg, 15mg, 30mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
HEREDITARY TYROSINEMIA TYPE 1 AGENTS		
nitisinone caps 2mg, 5mg, 10mg	4	SP, PA
ORFADIN CAPS 20mg; SUSP 4mg/ml ***(nitisinone)***	4	PA
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
NORDIPEN 5 MIS DEVICE ***(injection device)***	MB	
NORDIPEN DEL MIS SYSTEM ***(injection device)***	MB	
NORDITROPIN FLEXPRO SOPN 5mg/1.5ml, 10mg/1.5ml, 15mg/1.5ml, 30mg/3ml ***(somatropin)***	MB	
LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS		
SYNAREL SOLN 2mg/ml ***(nafarelin acetate)***	4	PA
TRIPTODUR SRER 22.5mg ***(triptorelin pamoate (cpp))***	MB	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TABS 10mg, 20mg ***(finerenone)***	3	PA, MO
MISCELLANEOUS		
cabergoline tabs .5mg	1	
calcitonin (salmon) soln 200unit/act	1	MO
INCRELEX SOLN 40mg/4ml ***(mecasermin)***	MB	
OSPHENA TABS 60mg ***(ospemifene)***	3	PA, MO
PROLIA SOSY 60mg/ml ***(denosumab)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
SUPPRELIN LA KIT 50mg ***(histrelin acetate (cpp))***	MB	
tolvaptan tabs 15mg, 30mg	4	SP, PA
TYMLOS SOPN 3120mcg/1.56ml ***(abaloparatide)***	MB	
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
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
CRINONE GEL 4% ***(progesterone (vaginal))***	2	
CRINONE GEL 8% ***(progesterone (vaginal))***	2	PA
medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg	1	MO
megestrol acetate (appetite) susp 625mg/5ml	1	MO; OAC
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
ENDOCRINE AND METABOLIC AGENTS - MISC.		
METABOLIC MODIFIERS		
MYALEPT SOLR 11.3mg ***(metreleptin)***	MB	
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	
dicyclomine hcl caps 10mg; soln 10mg/5ml; tabs 20mg	1	
dicyclomine hcl soln 10mg/ml	MB	
glycopyrrolate soln 1mg/5ml	1	MO
glycopyrrolate soln 1mg/5ml, 4mg/20ml	MB	
glycopyrrolate tabs 1mg, 2mg	1	
methscopolamine bromide tabs 2.5mg, 5mg	1	PA; High Risk Medications require PA for members age 70 and older

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIARRHEALS		
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	
MOTOFEN TAB 1-0.025 ***(difenoxin w/ atropine)***	3	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
AKYNZEO CAP 300-0.5 ***(netupitant-palonosetron)***	3	QL (2 caps every 28 days)
aprepitant caps 40mg	1	QL (3 caps every 180 days)
aprepitant caps 80mg	1	QL (4 caps every 28 days)
aprepitant caps 125mg	1	QL (2 caps every 28 days)
aprepitant capsule therapy pack 80 & 125 mg	1	QL (2 packs every 28 days)
dronabinol caps 2.5mg, 5mg, 10mg	1	QL (60 caps every 30 days)
granisetron hcl soln 1mg/ml	MB	
granisetron hcl tabs 1mg	1	QL (12 tabs every 28 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 every 28 days)
ondansetron hcl soln 4mg/2ml, 40mg/20ml; sosy 4mg/2ml	MB	
ondansetron hcl soln 4mg/5ml	1	QL (200 mL every 28 days)
ondansetron hcl tabs 4mg, 8mg	1	QL (18 tabs every 28 days)
ondansetron hcl tabs 24mg	1	QL (2 tabs every 28 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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 every 28 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
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium caps 750mg	1	
budesonide cpep 3mg; tb24 9mg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 45 through 75, Tier 2 for all others
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 45 through 75, otherwise not covered
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 45 through 75, otherwise not covered
PLENVU SOL ***(peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid)***	PV	$0 copay for members age 45 through 75, otherwise not covered
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	PV	$0 copay for members age 45 through 75, otherwise not covered
SUPREP BOWEL SOL PREP KIT ***(sodium sulfate-potassium sulfate-magnesium sulfate)***	PV	$0 copay for members age 45 through 75, otherwise not covered
SUTAB TAB ***(sodium sulfate-magnesium sulfate-potassium chloride)***	PV	$0 copay for members age 45 through 75, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MISCELLANEOUS		
cromolyn sodium (mastocytosis) conc 100mg/5ml	1	MO
misoprostol tabs 100mcg, 200mcg	1	MO
MOVANTIK TABS 12.5mg, 25mg ***(naloxegol oxalate)***	2	
SUCRAID SOLN 8500unit/ml ***(sacrosidase)***	3	PA, QL (354 mL every 30 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
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 25000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
ZENPEP CAP 40000UNT ***(pancrelipase (lipase-protease-amylase))***	2	PA, MO
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
dexlansoprazole cpdr 30mg, 60mg	1	QL (90 caps every 365 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
esomeprazole magnesium cpdr 20mg, 40mg	1	QL (90 caps every 365 days), MO
esomeprazole magnesium pack 10mg	1	QL (90 packets every 365 days), MO; Covered for age less than 1 year only
lansoprazole cpdr 15mg, 30mg	1	QL (90 caps every 365 days), MO
NEXIUM PACK 2.5mg, 5mg ***(esomeprazole magnesium)***	3	QL (90 packets every 365 days), MO; Covered for age less than 1 year only
omeprazole cpdr 10mg, 20mg, 40mg	1	QL (90 caps every 365 days), MO
pantoprazole sodium tbec 20mg, 40mg	1	QL (90 tabs every 365 days), MO
rabeprazole sodium tbec 20mg	1	QL (90 tabs every 365 days), MO
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 every 30 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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PHEXXI GEL ***(lactic acid-citric acid-potassium bitartrate)***	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		
ELMIRON CAPS 100mg ***(pentosan polysulfate sodium)***	3	
potassium citrate (alkalinizer) tbcr 15meq, 540mg, 1080mg	1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
bethanechol chloride tabs 5mg, 10mg, 25mg, 50mg	1	
darifenacin hydrobromide tb24 7.5mg, 15mg	1	MO
fesoterodine fumarate tb24 4mg, 8mg	1	MO
flavoxate hcl tabs 100mg	1	MO
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	
(Miconazole Nitrate Vaginal Supp 200mg) MICONAZOLE 3	1	
terconazole vaginal crea .4%, .8%; supp 80mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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 300mg/3ml; sosy 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	MB	
fondaparinux sodium soln 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	MB	
FRAGMIN SOLN 95000unit/3.8ml; SOSY 2500unit/0.2ml, 5000unit/0.2ml, 7500unit/0.3ml, 10000unit/ml, 12500unit/0.5ml, 15000unit/0.6ml, 18000unt/0.72ml ***(dalteparin sodium)***	MB	
heparin sodium (porcine) soln 1000unit/ml, 5000unit/0.5ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	MB	
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 SUSR 1mg/ml; 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; 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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
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 every 30 days)
PROMACTA TABS 50mg, 75mg ***(eltrombopag olamine)***	4	SP, PA, QL (60 tabs every 30 days)
RETACRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml ***(epoetin alfa-epbx)***	MB	
ZIEXTENZO SOSY 6mg/0.6ml ***(pegfilgrastim-bmez)***	MB	
HEMOPHILIA A AGENTS		
HEMLIBRA SOLN 30mg/ml, 60mg/0.4ml, 105mg/0.7ml, 150mg/ml ***(emicizumab-kxwh)***	MB	
HEREDITARY ANGIOEDEMA		
icatibant acetate soln 30mg/3ml	MB	
MISCELLANEOUS		
anagrelide hcl caps .5mg, 1mg	1	MO
cilostazol tabs 50mg, 100mg	1	MO
DROXIA CAPS 200mg, 300mg, 400mg ***(hydroxyurea (sickle cell disease))***	2	MO; OAC
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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		
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
ACTEMRA SOLN 80mg/4ml, 200mg/10ml, 400mg/20ml ***(tocilizumab)***	MB	
SIMPONI ARIA SOLN 50mg/4ml ***(golimumab)***	MB	
SKYRIZI SOLN 600mg/10ml ***(risankizumab-rzaa (crohn's))***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ACTEMRA SOSY 162mg/0.9ml ***(tocilizumab)***	MB	
COSENTYX SOSY 75mg/0.5ml, 150mg/ml ***(secukinumab)***	MB	
COSENTYX SENSOREADY PEN SOAJ 150mg/ml ***(secukinumab)***	MB	
ENBREL SOLN 25mg/0.5ml; SOLR 25mg; SOSY 25mg/0.5ml, 50mg/ml ***(etanercept)***	MB	
ENBREL MINI SOCT 50mg/ml ***(etanercept)***	MB	
ENBREL SURECLICK SOAJ 50mg/ml ***(etanercept)***	MB	
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml, 40mg/0.4ml, 40mg/0.8ml ***(adalimumab)***	MB	
HUMIRA PEDIA INJ CROHNS ***(adalimumab)***	MB	
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml ***(adalimumab)***	MB	
HUMIRA PEN PNKT 40mg/0.4ml ***(adalimumab)***	MB	
HUMIRA PEN KIT PS/UV ***(adalimumab)***	MB	
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml ***(adalimumab)***	MB	
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml ***(adalimumab)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml; SOSY 150mg/1.14ml, 200mg/1.14ml ***(sarilumab)***	MB	
OTEZLA TABS 30mg ***(apremilast)***	4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA TAB 10/20/30 ***(apremilast)***	4	SP, PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
RINVOQ TB24 15mg ***(upadacitinib)***	4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Ankylosing Spondylitis, Atopic Dermatitis, Psoriatic Arthritis, and Rheumatoid Arthritis. Preferred agent for Ulcerative Colitis (after failure of Humira)
RINVOQ TB24 30mg ***(upadacitinib)***	4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Atopic Dermatitis. Preferred agent for Ulcerative Colitis (after failure of Humira).
RINVOQ TB24 45mg ***(upadacitinib)***	4	SP, PA, QL (56 tabs every 56 days); Preferred agent for Ulcerative Colitis (after failure of Humira). Dose is one time induction dose for UC diagnosis only.
SIMPONI SOAJ 50mg/0.5ml, 100mg/ml; SOSY 50mg/0.5ml, 100mg/ml ***(golimumab)***	MB	
SKYRIZI PSKT 75mg/0.83ml; SOSY 150mg/ml ***(risankizumab-rzaa)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SKYRIZI SOCT 360mg/2.4ml ***(risankizumab-rzaa (crohn's))***	MB	
SKYRIZI PEN SOAJ 150mg/ml ***(risankizumab-rzaa)***	MB	
STELARA SOLN 45mg/0.5ml; SOSY 45mg/0.5ml, 90mg/ml ***(ustekinumab)***	MB	
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml ***(ixekizumab)***	MB	
TREMFYA SOPN 100mg/ml; SOSY 100mg/ml ***(guselkumab)***	MB	
XELJANZ SOLN 1mg/ml ***(tofacitinib citrate)***	4	SP, PA, QL (240 mL every 24 days)
XELJANZ TABS 5mg ***(tofacitinib citrate)***	4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Rheumatoid Arthritis. Preferred agent for Ulcerative Colitis
XELJANZ TABS 10mg ***(tofacitinib citrate)***	4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Ulcerative Colitis
XELJANZ XR TB24 11mg ***(tofacitinib citrate)***	4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Rheumatoid Arthritis. Preferred agent for Ulcerative Colitis
XELJANZ XR TB24 22mg ***(tofacitinib citrate)***	4	SP, PA, QL (30 tabs every 30 days); 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
HEREDITARY ANGIOEDEMA		
HAEGARDA SOLR 2000unit, 3000unit ***(c1 esterase inhibitor (human))***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
ARCALYST SOLR 220mg ***(rilonacept)***	MB	
INTRON A SOLN 6000000unit/ml, 10000000unit/ml; SOLR 10000000unit, 18000000unit, 50000000unit ***(interferon alfa-2b)***	MB	
IMMUNOSUPPRESSANTS		
azathioprine tabs 50mg, 75mg, 100mg	1	MO
cyclosporine caps 25mg, 100mg	1	SP
cyclosporine soln 50mg/ml	MB	
cyclosporine modified (for microemulsion) caps 25mg, 50mg, 100mg; soln 100mg/ml	1	SP
(Cyclosporine Modified (For Microemulsion) Caps 25mg, 100mg; Soln 100mg/ml) GENGRAF	1	SP
everolimus (immunosuppressant) tabs .25mg, .5mg, .75mg, 1mg	1	SP
mycophenolate mofetil caps 250mg; susr 200mg/ml; tabs 500mg	1	SP
mycophenolate mofetil hcl solr 500mg	MB	
mycophenolate sodium tbec 180mg, 360mg	1	SP
PROGRAF SOLN 5mg/ml ***(tacrolimus)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SANDIMMUNE SOLN 100mg/ml ***(cyclosporine)***	3	SP
sirolimus soln 1mg/ml; tabs .5mg, 1mg, 2mg	1	SP
tacrolimus caps .5mg, 1mg, 5mg	1	SP
VACCINES		
ACTHIB INJ ***(haemophilus b polysac conj vac)***	MB	
ADACEL INJ ***(tetanus toxoid-diphtheria-acellular pertussis adsorb (tdap))***	MB	
BEXSERO INJ ***(meningococcal vac group b (recombant omv adjuvanted))***	MB	
BOOSTRIX INJ ***(tetanus toxoid-diphtheria-acellular pertussis adsorb (tdap))***	MB	
DAPTACEL INJ ***(diphtheria, acellular pertussis & tetanus toxoids)***	MB	
DENGVAXIA SUS ***(dengue virus vaccine live tetravalent)***	MB	
DIP/TET PED INJ 25-5LFU	MB	
ENGERIX-B SUSP 20mcg/ml ***(hepatitis b vaccine (recomb))***	MB	
FLUMIST QUAD SUS 2022-23 ***(influenza virus vaccine live quadrivalent)***	MB	
FLUZONE QUAD INJ 2022-23 ***(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	
M-M-R II INJ ***(measles, mumps & rubella virus vaccines)***	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
QUADRACEL INJ 0.5ML ***(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	
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	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VAXELIS INJ ***(diph-tet tox-acell pert ad-polio ipv-hib-hepatitis b recomb)***	MB	
VAXNEUVANCE INJ ***(pneumococcal 15-valent conjugate vaccine)***	MB	
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
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
sodium chloride soln 2.5meq/ml	MB	
(Sodium Chloride Flush Soln .9%) MONOJECT SODIUM CHLORIDE	MB	
sodium fluoride chew 1mg; tabs 1mg	1	MO
(Sodium Fluoride Chew 2.2mg) NAFRINSE	1	MO
sodium fluoride chew .25mg, .5mg; soln .5mg/ml; tabs .5mg	PV	MO; $0 applies for ages 5 and under, otherwise not covered
(Sodium Fluoride Soln .125mg/drop) FLUORITAB	PV	MO; $0 applies for ages 5 and under, otherwise not covered
(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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PRENATAL VITAMINS		
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	
(*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	
VITAMINS		
calcitriol caps .25mcg, .5mcg; soln 1mcg/ml	1	MO
cyanocobalamin soln 1000mcg/ml	MB	
doxercalciferol caps .5mcg, 1mcg, 2.5mcg	1	MO
ergocalciferol caps 50000unit	1	MO
folic acid caps 800mcg	PV	QL (100 caps every 30 days), MO; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
folic acid tabs 1mg	1	MO
folic acid tabs 400mcg	PV	QL (100 tabs every 30 days); $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 800mcg	PV	QL (100 tabs every 30 days), MO; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
paricalcitol caps 1mcg, 2mcg, 4mcg	1	MO
phytonadione tabs 5mg	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	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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	QL (20 mL every 30 days)
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	
flurbiprofen sodium soln .03%	1	
FML OINT .1% ***(fluorometholone (ophth))***	2	
ILEVRO SUSP .3% ***(nepafenac)***	2	
ketorolac tromethamine (ophth) soln .4%, .5%	1	
loteprednol etabonate susp .5%	1	
NEVANAC SUSP .1% ***(nepafenac)***	2	
prednisolone acetate (ophth) susp 1%	1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
cromolyn sodium (ophth) soln 4%	1	
epinastine hcl (ophth) soln .05%	1	
olopatadine hcl soln .1%, .2%	1	
ZERVIATE SOLN .24% ***(cetirizine hcl (ophth))***	3	
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
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	1	MO
brinzolamide susp 1%	1	MO
carteolol hcl (ophth) soln 1%	1	MO
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**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DRY EYE DISEASE		
RESTASIS EMUL .05% ***(cyclosporine (ophth))***	1	MO
RESTASIS MULTIDOSE EMUL .05% ***(cyclosporine (ophth))***	2	MO; Multi-dose vial remains on preferred brand tier
MISCELLANEOUS		
atropine sulfate (ophthalmic) soln 1%	1	MO
CYSTARAN SOLN .44% ***(cysteamine hcl)***	4	PA, QL (4 bottles every 28 days)
LACRISERT INST 5mg ***(artificial tear insert)***	3	
phenylephrine hcl (mydriatic) soln 2.5%, 10%	1	
tropicamide soln .5%, 1%	1	MO
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS		
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg ***(alpha1-proteinase inhibitor (human))***	MB	
ANAPHYLAXIS TREATMENT AGENTS		
epinephrine (anaphylaxis) soaj .15mg/0.3ml, .3mg/0.3ml	1	QL (4 auto-injectors every 30 days)
epinephrine (anaphylaxis) soaj .15mg/0.15ml	1	QL (4 auto-injectors every 30 days); (generic of Adrenaclick)
EPIPEN 2-PAK SOAJ .3mg/0.3ml ***(epinephrine (anaphylaxis))***	2	QL (4 auto-injectors every 30 days)
EPIPEN-JR 2-PAK SOAJ .15mg/0.3ml ***(epinephrine (anaphylaxis))***	2	QL (4 auto-injectors every 30 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPT AER 62.5-25 ***(umeclidinium-vilanterol)***	2	QL (1 package every 30 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	QL (6 boxes every 30 days), MO
STIOLTO AER 2.5-2.5 ***(tiotropium bromide-olodaterol hcl)***	2	QL (1 package every 30 days), MO
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS		
TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (1 package every 30 days), MO
TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (1 package every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
ipratropium bromide soln .02%	1	QL (5 boxes every 30 days), MO
ipratropium bromide (nasal) soln .03%, .06%	1	MO
SPIRIVA HANDIHALER CAPS 18mcg ***(tiotropium bromide monohydrate)***	2	QL (1 package every 30 days), MO
SPIRIVA RESPIMAT AERS 1.25mcg/act, 2.5mcg/act ***(tiotropium bromide monohydrate)***	2	QL (1 package every 30 days), MO
ANTIHISTAMINE COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	1	QL (1 package every 30 days)
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
azelastine hcl soln .1%	1	QL (2 bottles every 30 days)
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
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 every 30 days)
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate aers 108mcg/act	1	QL (2 inhalers every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
albuterol sulfate nebu .5%	1	QL (60 mL every 30 days), MO
albuterol sulfate nebu .083%, .63mg/3ml, 1.25mg/3ml	1	QL (5 boxes every 30 days), MO
albuterol sulfate syrp 2mg/5ml; tabs 2mg, 4mg; tb12 4mg, 8mg	1	MO
formoterol fumarate nebu 20mcg/2ml	1	QL (60 vials every 30 days), MO
levalbuterol hcl nebu 1.25mg/0.5ml	1	QL (45 mL every 30 days), MO
levalbuterol hcl nebu .31mg/3ml, .63mg/3ml, 1.25mg/3ml	1	QL (300 mL every 30 days), MO
levalbuterol tartrate aero 45mcg/act	1	QL (2 inhalers every 30 days), MO
STRIVERDI RESPIMAT AERS 2.5mcg/act ***(olodaterol hcl)***	2	QL (1 package every 30 days), MO
terbutaline sulfate tabs 2.5mg, 5mg	1	MO
COLD/COUGH		
benzonatate caps 100mg, 200mg	1	
guaifenesin-codeine soln 100-10 mg/5ml	1	QL (60 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	1	QL (30 mL every day); Subject to initial 7-day limit
(Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 mg/5ml) HYDROMET	1	QL (30 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	1	QL (6 tabs every day); Subject to initial 7-day limit
promethazine & phenylephrine syrup 6.25-5 mg/5ml	1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	1	QL (30 mL every day); Subject to initial 7-day limit
promethazine-dm syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml	1	QL (30 mL every day); Subject to initial 7-day limit
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TUZISTRA XR SUS ***(codeine polistirex-chlorpheniramine polistirex)***	3	QL (20 mL every day); Subject to initial 7-day limit
CYSTIC FIBROSIS		
CAYSTON SOLR 75mg ***(aztreonam lysine)***	4	SP, PA, QL (84 vials every 28 days)
KALYDECO PACK 25mg, 50mg, 75mg ***(ivacaftor)***	4	PA, QL (56 packets every 28 days)
KALYDECO TABS 150mg ***(ivacaftor)***	4	PA, QL (56 tabs every 28 days); carton consists of 56 tablets
KALYDECO TABS 150mg ***(ivacaftor)***	4	PA, QL (60 tabs every 30 days); packet consists of 60 tablets
ORKAMBI GRA 75-94MG ***(lumacaftor-ivacaftor)***	4	PA, QL (56 packets every 28 days)
ORKAMBI GRA 100-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (56 packets every 28 days)
ORKAMBI GRA 150-188 ***(lumacaftor-ivacaftor)***	4	PA, QL (56 packets every 28 days)
ORKAMBI TAB 100-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (112 tabs every 28 days)
ORKAMBI TAB 200-125 ***(lumacaftor-ivacaftor)***	4	PA, QL (112 tabs every 28 days)
SYMDEKO TAB 50-75MG ***(tezacaftor-ivacaftor)***	4	PA, QL (56 tabs every 28 days)
SYMDEKO TAB 100-150 ***(tezacaftor-ivacaftor)***	4	PA, QL (56 tabs every 28 days)
tobramycin nebu 300mg/4ml	4	SP, PA, QL (224 mL every 28 days)
tobramycin nebu 300mg/5ml	4	SP, PA, QL (280 mL every 28 days)
TRIKAFTA TAB ***(elexacaftor-tezacaftor-ivacaftor)***	4	PA, QL (84 tabs every 28 days)
LEUKOTRIENE MODIFIERS		
zileuton tb12 600mg	2	PA, 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 every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MISCELLANEOUS		
acetylcysteine soln 10%, 20%	1	
DALIRESP TABS 250mcg, 500mcg ***(roflumilast)***	3	PA, MO
sodium chloride (inhalant) nebu .9%, 3%, 7%, 10%	1	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) soln .025%	1	QL (3 containers every 30 days)
fluticasone propionate (nasal) susp 50mcg/act	1	QL (1 container every 30 days)
PULMONARY FIBROSIS AGENTS		
ESBRIET CAPS 267mg ***(pirfenidone)***	4	SP, PA, QL (270 caps every 30 days)
pirfenidone tabs 267mg	4	SP, PA, QL (270 tabs every 30 days)
pirfenidone tabs 801mg	4	SP, PA, QL (90 tabs every 30 days)
RESPIRATORY THERAPY SUPPLIES		
ADULT RESPIRATORY MASK ***(spacer/aerosol-holding chambers)***	2	
HOLD CHAMBER MIS MEDIUM ***(spacer/aerosol-holding chambers)***	2	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	2	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	2	
SEVERE ASTHMA AGENTS		
NUCALA SOAJ 100mg/ml; SOLR 100mg; SOSY 40mg/0.4ml, 100mg/ml ***(mepolizumab)***	MB	
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml ***(omalizumab)***	MB	
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act ***(fluticasone furoate (inhalation))***	2	QL (1 package every 30 days), MO
budesonide (inhalation) susp 1mg/2ml	1	QL (1 box every 30 days), MO
budesonide (inhalation) susp .5mg/2ml	1	QL (2 boxes every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
budesonide (inhalation) susp .25mg/2ml	1	QL (3 boxes every 30 days), MO
QVAR REDIHALER AERB 40mcg/act, 80mcg/act ***(beclomethasone dipropionate hfa)***	2	QL (2 packages every 30 days), MO
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
ADVAIR DISKU AER 100/50 ***(fluticasone-salmeterol)***	1	QL (1 package every 30 days), MO
ADVAIR DISKU AER 250/50 ***(fluticasone-salmeterol)***	1	QL (1 package every 30 days), MO
ADVAIR DISKU AER 500/50 ***(fluticasone-salmeterol)***	1	QL (1 package every 30 days), MO
ADVAIR HFA AER 45/21 ***(fluticasone-salmeterol)***	2	QL (1 package every 30 days), MO
ADVAIR HFA AER 115/21 ***(fluticasone-salmeterol)***	2	QL (1 package every 30 days), MO
ADVAIR HFA AER 230/21 ***(fluticasone-salmeterol)***	2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)***	2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)***	2	QL (1 package every 30 days), MO
SYMBICORT AER 80-4.5 ***(budesonide-formoterol fumarate dihydrate)***	2	QL (3 packages every 30 days), MO
SYMBICORT AER 160-4.5 ***(budesonide-formoterol fumarate dihydrate)***	2	QL (3 packages every 30 days), MO
XANTHINES - DRUGS TO TREAT COPD		
aminophylline soln 25mg/ml	MB	
theophylline elix 80mg/15ml; 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, QL (45g every 28 days); PA applies for members age 35 and older
adapalene-benzoyl peroxide gel 0.1-2.5%	1	
adapalene-benzoyl peroxide gel 0.3-2.5%	1	
benzoyl peroxide-erythromycin gel 5-3%	1	QL (47g every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1	QL (45g every 30 days)
clindamycin phosphate (topical) foam 1%; swab 1%	1	
clindamycin phosphate (topical) gel 1%	1	QL (75g every 30 days)
clindamycin phosphate (topical) lotn 1%; soln 1%	1	QL (60 mL every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1-5%	1	QL (50g every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	1	QL (50g every 30 days)
erythromycin (acne aid) gel 2%	1	QL (60g every 30 days)
(Erythromycin (Acne Aid) Pads 2%) ERY	1	
erythromycin (acne aid) soln 2%	1	QL (60 mL every 30 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	QL (120g every 30 days)
mupirocin oint 2%	1	QL (30g every 30 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 every 30 days)
ciclopirox sham 1%	1	QL (120 mL every 30 days)
ciclopirox soln 8%	1	
ciclopirox olamine crea .77%	1	QL (120g every 30 days)
ciclopirox olamine susp .77%	1	QL (120 mL every 30 days)
clotrimazole (topical) crea 1%	1	QL (120g every 30 days)
clotrimazole (topical) soln 1%	1	QL (120 mL every 30 days)
clotrimazole w/ betamethasone cream 1-0.05%	1	QL (60g every 30 days)
clotrimazole w/ betamethasone lotion 1-0.05%	1	QL (60 mL every 30 days)
econazole nitrate crea 1%	1	QL (60g every 30 days)
ERTACZO CREA 2% ***(sertaconazole nitrate)***	3	QL (60g every 30 days)
JUBLIA SOLN 10% ***(efinaconazole)***	3	PA, QL (4 mL every 28 days)
ketoconazole (topical) crea 2%	1	QL (120g every 30 days)
MENTAX CREA 1% ***(butenafine hcl)***	3	QL (60g every 30 days)
naftifine hcl crea 1%, 2%	1	QL (60g every 30 days)
nystatin (topical) crea 100000unit/gm; oint 100000unit/gm; powd 100000unit/gm	1	QL (120g every 30 days)
(Nystatin (Topical) Powd 100000unit/gm) NYAMYC	1	QL (120g every 30 days)
(Nystatin (Topical) Powd 100000unit/gm) NYSTOP	1	QL (120g every 30 days)
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1	QL (60g every 30 days)
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1	QL (60g every 30 days)
oxiconazole nitrate crea 1%	1	QL (60g every 30 days)
sulconazole nitrate crea 1%	1	QL (60g every 30 days)
sulconazole nitrate soln 1%	1	QL (60 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl (antipruritic) crea 5%	3	ST, QL (45g every 30 days); PA**
DERMATOLOGY, ANTIPSORIATICS		
acitretin caps 10mg, 17.5mg, 25mg	1	
calcipotriene soln .005%	1	ST, QL (60 mL every 30 days); PA**
calcitriol (topical) oint 3mcg/gm	3	ST, QL (100g every 30 days); PA**
methoxsalen rapid caps 10mg	1	
tazarotene crea .1%; gel .05%, .1%	1	PA
TAZORAC CREA .05%; GEL .05%, .1% ***(tazarotene)***	2	PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) sham 2%	1	QL (120 mL every 30 days)
selenium sulfide lotn 2.5%	1	
DERMATOLOGY, CORTICOSTEROIDS		
alclometasone dipropionate crea .05%; oint .05%	1	QL (120g every 30 days)
amcinonide crea .1%	1	QL (120g every 30 days)
amcinonide lotn .1%	1	QL (120 mL every 30 days)
AMCINONIDE OINT .1%	2	QL (120g every 30 days)
betamethasone dipropionate (topical) crea .05%; oint .05%	1	QL (120g every 30 days)
betamethasone dipropionate (topical) lotn .05%	1	QL (120 mL every 30 days)
betamethasone dipropionate augmented crea .05%; gel .05%; oint .05%	1	QL (120g every 30 days)
betamethasone dipropionate augmented lotn .05%	1	QL (120 mL every 30 days)
betamethasone valerate crea .1%; foam .12%; oint .1%	1	QL (120g every 30 days)
betamethasone valerate lotn .1%	1	QL (120 mL every 30 days)
calcipotriene-betamethasone dipropionate oint 0.005-0.064%	2	ST, QL (60g every 30 days); PA**
clobetasol propionate crea .05%; foam .05%; gel .05%; oint .05%	1	QL (120g every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clobetasol propionate liqd .05%; lotn .05%; sham .05%; soln .05%	1	QL (120 mL every 30 days)
clobetasol propionate emollient base crea .05%	1	QL (120g every 30 days)
clocortolone pivalate crea .1%	3	QL (120g every 30 days)
desonide crea .05%; oint .05%	1	QL (120g every 30 days)
desonide lotn .05%	1	QL (120 mL every 30 days)
desoximetasone crea .05%, .25%; gel .05%; oint .25%	1	QL (120g every 30 days)
diflorasone diacetate crea .05%; oint .05%	3	QL (120g every 30 days)
fluocinolone acetonide crea .01%, .025%; oint .025%	1	QL (120g every 30 days)
fluocinolone acetonide oil .01%; soln .01%	1	QL (120 mL every 30 days)
fluocinonide crea .05%; gel .05%; oint .05%	1	QL (120g every 30 days)
fluocinonide soln .05%	1	QL (120 mL every 30 days)
fluticasone propionate crea .05%; oint .005%	1	QL (120g every 30 days)
fluticasone propionate lotn .05%	1	QL (120 mL every 30 days)
halobetasol propionate crea .05%; oint .05%	1	QL (120g every 30 days)
(Hydrocortisone (Topical) Crea 1%) ALA-CORT	1	QL (120g every 30 days)
hydrocortisone (topical) crea 1%, 2.5%; oint 2.5%	1	QL (120g every 30 days)
hydrocortisone (topical) lotn 2.5%	1	QL (120 mL every 30 days)
hydrocortisone butyrate crea .1%; oint .1%	1	QL (120g every 30 days)
hydrocortisone butyrate soln .1%	1	QL (120 mL every 30 days)
hydrocortisone valerate crea .2%; oint .2%	1	QL (120g every 30 days)
mometasone furoate crea .1%; oint .1%	1	QL (120g every 30 days)
mometasone furoate soln .1%	1	QL (120 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
prednicarbate crea .1%; oint .1%	1	QL (120g every 30 days)
(Triamcinolone Acetonide (Topical) Crea .1%) TRIDERM	1	QL (120g every 30 days)
triamcinolone acetonide (topical) crea .025%, .1%, .5%; oint .025%, .1%, .5%	1	QL (120g every 30 days)
triamcinolone acetonide (topical) lotn .025%, .1%	1	QL (120 mL every 30 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine oint 5%	1	QL (50g every 30 days)
lidocaine ptch 5%	1	PA, QL (90 patches every 30 days)
lidocaine hcl gel 2%; prsy 2%	MB	
lidocaine hcl soln 4%	1	QL (50 mL every 30 days)
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30g every 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
bexarotene (topical) gel 1%	4	SP, PA
CONDYLOX GEL .5% ***(podofilox)***	3	
DENAVIR CREA 1% ***(penciclovir)***	3	
diclofenac sodium (topical) gel 1%	1	QL (300g every 30 days)
EUCRISA OINT 2% ***(crisaborole)***	2	ST, QL (60g every 30 days); PA**
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	QL (60g every 30 days)
metronidazole (topical) crea .75%; gel .75%, 1%	1	QL (60g every 30 days)
metronidazole (topical) lotn .75%	1	QL (60 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MIRVASO GEL .33% ***(brimonidine tartrate (topical))***	3	PA
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
(Crotamiton Lotn 10%) CROTAN	1	
ivermectin (pediculicide) lotn .5%	1	ST; PA**
lindane sham 1%	1	
malathion lotn .5%	1	ST; PA**
permethrin crea 5%	1	
spinosad susp .9%	1	ST; PA**
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01% ***(becaplermin)***	3	PA, QL (30g every 30 days)
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl caps 30mg	1	MO
clotrimazole troc 10mg	1	QL (90 lozenges every 30 days)
lidocaine hcl (mouth-throat) soln 2%	1	
nystatin (mouth-throat) susp 100000unit/ml	1	
ORAVIG TABS 50mg ***(miconazole (mouth-throat))***	3	QL (14 tabs every 30 days)
pilocarpine hcl (oral) tabs 5mg, 7.5mg	1	MO
triamcinolone acetonide (mouth) pste .1%	1	
(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, ALOGLIPTIN/METFORMIN HYDR, 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	NATROBA 4830-D
Drug Names	SPINOSAD
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 1 day supply of permethrin 1% or permethrin 5% within the past 60 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, 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	OVIDE 4831-D
Drug Names	MALATHION
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 1 day supply of permethrin 1% within the past 60 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 1 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 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	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)

Step Therapy Group	VITAMIN D ANALOGS TOPICAL 1381-E
Drug Names	CALCIPOTRIENE, CALCIPOTRIENE/BETAMETHASO, CALCITRIOL
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30-day supply of a topical steroid within the past 180 days.

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