SHARP Health Plan

2023 Formulary

List of covered prescription drugs

Individual, family & employer-sponsored coverage through Covered California and Individual and family coverage directly from Sharp Health Plan

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

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 12/01/2023.

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Introduction

December 2023

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 and self-injectable drugs covered under the medical benefit.

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 approved by the federal Food and Drug Administration (FDA), 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, based on input from 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 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 Medi-Span® 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 CAPITAL LETTERS 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 when recommended for preventive use as indicated under **Preventive Care Services** 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 or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills.

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 of the required 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 by following the Prior Authorization process as described above. If Sharp Health Plan fails to respond to a completed Step Therapy Exception request within 72 hours of receiving a non-urgent request or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills.

When a provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the provider should submit their justification and clinical documentation

supporting the provider's determination with a Step Therapy Exception Request, and the Plan will approve the Step Therapy Exception Request.

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, we will notify your provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

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 through 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, you, your Authorized Representative or your Prescribing Provider may request a Formulary Exception, by following the Prior Authorization Request process described above. Once all of the required supporting information has been received, the Formulary 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 a Formulary Exception Request, the Member, an Authorized Representative, or the Provider can file an Appeal with Sharp Health Plan. Nonformulary Drugs that are approved for coverage and meet the Tier 4 description will be subject to the Tier 4 Cost Share. 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.

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?

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 Brand-Name Drug tier. 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.

In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

You Have the Right to Appeal

If you do not agree with a coverage decision, you, your Authorized Representative or your provider 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 provider may request an external Exception Request review. Sharp Health Plan will ensure that a decision is made within 72 hours of receiving the required supporting information in routine circumstances or within 24 hours of receiving the required supporting information 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 provider 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. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical condition (such as antibiotics to treat an infection) are covered.

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.

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.

4. Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see your Formulary and your Member Handbook under Diabetes treatment.

5. Items that are approved by the FDA as a medical device. Please see your Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning Services for information about medical devices covered by Sharp Health Plan.

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 version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the Brand-Name Drug is obtained. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

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).

Table of Contents

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION		
COX-2 INHIBITORS		
celecoxib (generic of CELEBREX) CAPS 50mg, 100mg, 200mg	Tier 1	MO
GOUT - DRUGS TO TREAT GOUT		
allopurinol tabs 100mg, 300mg	Tier 1	MO
colchicine (generic of COLCRYS) TABS .6mg	Tier 1	
colchicine w/ probenecid tab 0.5-500 mg	Tier 1	MO
febuxostat (generic of ULORIC) TABS 40mg, 80mg	Tier 1	ST, MO; PA**
probenecid tabs 500mg	Tier 1	MO
NSAIDS - DRUGS TO TREAT PAIN AND INFLAMMATION		
diclofenac potassium tabs 50mg	Tier 1	MO
diclofenac sodium tb24 100mg; tbec 25mg, 50mg, 75mg	Tier 1	MO
etodolac caps 200mg, 300mg; tabs 500mg; tb24 400mg, 500mg, 600mg	Tier 1	MO
etodolac (generic of LODINE) TABS 400mg	Tier 1	MO
fenoprofen calcium tabs 600mg	Tier 3	MO
flurbiprofen tabs 50mg, 100mg	Tier 1	MO
ibuprofen susp 100mg/5ml	Tier 1	
ibuprofen tabs 400mg, 600mg, 800mg	Tier 1	MO
ketorolac tromethamine soln 15mg/ml, 30mg/ml	MB	
ketorolac tromethamine tabs 10mg	Tier 1	QL (20 tabs every 30 days)
meclofenamate sodium caps 50mg, 100mg	Tier 1	MO
mefenamic acid caps 250mg	Tier 1	MO
meloxicam tabs 7.5mg, 15mg	Tier 1	MO
nabumetone tabs 500mg, 750mg	Tier 1	MO
naproxen tabs 250mg, 375mg	Tier 1	MO
naproxen (generic of NAPROSYN) TABS 500mg	Tier 1	MO
oxaprozin (generic of DAYPRO) TABS 600mg	Tier 1	MO
piroxicam (generic of FELDENE) CAPS 10mg, 20mg	Tier 1	MO
sulindac tabs 150mg, 200mg	Tier 1	MO
tolmetin sodium caps 400mg; tabs 600mg	Tier 1	MO
NSAIDS, COMBINATIONS		
diclofenac w/ misoprostol tab delayed release 50-0.2 mg (generic of ARTHROTEC 50)	Tier 1	MO
diclofenac w/ misoprostol tab delayed release 75-0.2 mg (generic of ARTHROTEC 75)	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPIOID ANALGESICS - DRUGS TO TREAT PAIN		
acetaminophen w/ codeine soln 120-12 mg/5ml	Tier 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	Tier 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	Tier 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
acetaminophen w/ codeine tab 300-60 mg	Tier 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
butorphanol tartrate soln 1mg/ml, 2mg/ml	MB	
butorphanol tartrate soln 10mg/ml	Tier 1	QL (2 bottles every 30 days)
codeine sulfate tabs 30mg	Tier 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	Tier 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	Tier 1	ST, QL (10 patches every 30 days)
fentanyl pt72 50mcg/hr, 75mcg/hr, 100mcg/hr	Tier 1	ST, PA; High Strength Requires PA
fentanyl citrate lpop 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	Tier 1	PA, QL (120 lozenges every 30 days)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	Tier 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	Tier 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	Tier 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	Tier 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	Tier 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 (generic of DILAUDID) SOLN 2mg/ml	MB	
hydromorphone hcl (generic of DILAUDID) TABS 2mg	Tier 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 (generic of DILAUDID) TABS 4mg	Tier 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
hydromorphone hcl (generic of DILAUDID) TABS 8mg	Tier 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	Tier 1	ST, QL (30 tabs every 30 days)
hydromorphone hcl tb24 32mg	Tier 1	ST, PA; High Strength Requires PA
methadone hcl (generic of METHADOSE) CONC 10mg/ml	Tier 1	QL (30 mL every 30 days); (indicated for opioid addiction)
methadone hcl (generic of METHADOSE) CONC 10mg/ml	Tier 1	ST, QL (45 mL every 30 days); (generic of Methadone Intensol, indicated for pain)
methadone hcl soln 5mg/5ml	Tier 1	ST, QL (450 mL every 30 days)
methadone hcl soln 10mg/5ml	Tier 1	ST, QL (225 mL every 30 days)
methadone hcl tabs 5mg	Tier 1	ST, QL (90 tabs every 30 days)
methadone hcl tabs 10mg	Tier 1	ST, QL (30 tabs every 30 days)
methadone hcl tbso 40mg	Tier 1	QL (9 tabs every 30 days)
morphine sulfate cp24 10mg, 20mg, 30mg	Tier 1	ST, QL (60 caps every 30 days)
morphine sulfate cp24 50mg, 60mg, 80mg	Tier 1	ST, QL (30 caps every 30 days)
morphine sulfate cp24 100mg	Tier 1	ST, PA; High Strength Requires PA
morphine sulfate soln 4mg/ml, 10mg/ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
morphine sulfate soln 10mg/5ml	Tier 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	Tier 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 100mg/5ml	Tier 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	Tier 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	Tier 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 (generic of MS CONTIN) TBCR 15mg, 30mg	Tier 1	ST, QL (90 tabs every 30 days)
morphine sulfate (generic of MS CONTIN) TBCR 60mg, 100mg, 200mg	Tier 1	ST, PA; High Strength Requires PA
morphine sulfate beads cp24 30mg, 45mg, 60mg, 75mg, 90mg	Tier 1	ST, QL (30 caps every 30 days)
morphine sulfate beads cp24 120mg	Tier 1	ST, PA; High Strength Requires PA
nalbuphine hcl soln 10mg/ml, 20mg/ml	MB	
NUCYNTA TABS 50MG	Tier 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	Tier 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	Tier 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	Tier 3	ST, QL (60 tabs every 30 days)
NUCYNTA ER TB12 150MG, 200MG, 250MG	Tier 3	ST, PA; High Strength Requires PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone hcl caps 5mg	Tier 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	Tier 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	Tier 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, 20mg	Tier 1	ST, QL (60 tabs every 30 days)
oxycodone hcl t12a 40mg, 80mg	Tier 1	ST, PA; High Strength Requires PA
oxycodone hcl tabs 5mg, 10mg	Tier 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 (generic of ROXICODONE) TABS 15mg	Tier 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	Tier 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 (generic of ROXICODONE) TABS 30mg	Tier 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 (generic of PERCOCET)	Tier 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 (generic of PERCOCET)	Tier 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 (generic of PERCOCET)	Tier 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
oxycodone w/ acetaminophen tab 10-325 mg (generic of PERCOCET)	Tier 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 5mg	Tier 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	Tier 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	Tier 1	ST, QL (60 tabs every 30 days)
oxymorphone hcl tb12 20mg, 30mg, 40mg	Tier 1	ST, PA; High Strength Requires PA
tramadol hcl tabs 50mg	Tier 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	Tier 1	ST, QL (30 tabs every 30 days)
tramadol hcl tb24 200mg, 300mg	Tier 1	ST, PA; High Strength Requires PA
tramadol-acetaminophen tab 37.5-325 mg	Tier 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	Tier 2	ST, QL (60 caps every 30 days)
XTAMPZA ER C12A 36MG	Tier 2	ST, PA; High Strength Requires Prior Auth
OPIOID PARTIAL AGONISTS		
BELBUCA FILM 75MCG, 150MCG, 300MCG, 450MCG	Tier 2	ST, QL (60 films every 30 days)
BELBUCA FILM 600MCG, 750MCG, 900MCG	Tier 2	ST, PA; High Strength Requires Prior Auth
buprenorphine (generic of BUTRANS) PTWK 5mcg/hr, 7.5mcg/hr, 10mcg/hr	Tier 1	ST, QL (4 patches every 30 days)
buprenorphine (generic of BUTRANS) PTWK 15mcg/hr, 20mcg/hr	Tier 1	ST, PA; High Strength Requires Prior Auth
buprenorphine hcl (generic of BUPRENEX) SOLN .3mg/ml	MB	
SUBLOCADE SOSY 100MG/0.5ML, 300MG/1.5ML	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SALICYLATES		
aspirin chew 81mg; tbec 81mg	PV	QL (100 tabs every 30 days); $0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tabs 500mg	Tier 1	MO
ANESTHETICS - DRUGS FOR NUMBING		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) (generic of XYLOCAINE) SOLN .5%, 1%, 2%	MB	
lidocaine hcl (local anesth.) (generic of XYLOCAINE-MPF) SOLN .5%, 1%, 2%	MB	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTHELMINTICS		
EMVERM CHEW 100MG	Tier 3	QL (12 tabs every 365 days)
ivermectin (generic of STROMECTOL) TABS 3mg	Tier 1	PA
praziquantel (generic of BILTRICIDE) TABS 600mg	Tier 1	QL (24 tabs every 365 days)
ANTI-BACTERIALS - MISCELLANEOUS		
amikacin sulfate soln 1gm/4ml, 500mg/2ml	MB	
fosfomycin tromethamine (generic of MONUROL) PACK 3gm	Tier 1	
gentamicin sulfate soln 40mg/ml	MB	
neomycin sulfate tabs 500mg	Tier 1	
paromomycin sulfate caps 250mg	Tier 1	
sulfadiazine tabs 500mg	Tier 1	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	Tier 1	
sulfamethoxazole-trimethoprim tab 400-80 mg (generic of BACTRIM)	Tier 1	
sulfamethoxazole-trimethoprim tab 800-160 mg (generic of BACTRIM DS)	Tier 1	
tinidazole tabs 250mg, 500mg	Tier 1	
tobramycin sulfate soln 40mg/ml, 80mg/2ml; solr 1.2gm	MB	
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
amphotericin b solr 50mg	MB	
CRESEMBA CAPS 74.5MG, 186MG	Tier 3	
fluconazole (generic of DIFLUCAN) SUSR 10mg/ml, 40mg/ml; TABS 100mg, 150mg, 200mg	Tier 1	
fluconazole tabs 50mg	Tier 1	
griseofulvin microsize susp 125mg/5ml; tabs 500mg	Tier 1	
griseofulvin ultramicrosize tabs 125mg, 250mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
itraconazole (generic of SPORANOX) CAPS 100mg; SOLN 10mg/ml	Tier 1	PA
nystatin tabs 500000unit	Tier 1	
posaconazole (generic of NOXAFIL) SUSP 40mg/ml	Tier 1	PA, MO
posaconazole (generic of NOXAFIL) TBEC 100mg	Tier 3	PA, MO
terbinafine hcl tabs 250mg	Tier 1	
voriconazole (generic of VFEND) SUSR 40mg/ml; TABS 50mg, 200mg	Tier 2	PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl tab 62.5-25 mg (generic of MALARONE)	Tier 1	
atovaquone-proguanil hcl tab 250-100 mg (generic of MALARONE)	Tier 1	
chloroquine phosphate tabs 250mg, 500mg	Tier 1	MO
COARTEM TAB 20-120MG	Tier 3	
mefloquine hcl tabs 250mg	Tier 1	MO
primaquine phosphate (generic of PRIMAQUINE PHOSPHATE) TABS 26.3mg	Tier 1	
quinine sulfate (generic of QUALAQUIN) CAPS 324mg	Tier 1	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate (generic of ZIAGEN) SOLN 20mg/ml	Tier 1	SP, QL (900 mL every 30 days)
abacavir sulfate (generic of ZIAGEN) TABS 300mg	Tier 1	SP, QL (60 tabs every 30 days)
APTIVUS CAPS 250MG	Tier 2	SP, QL (120 caps every 30 days)
atazanavir sulfate caps 150mg	Tier 1	SP, QL (30 caps every 30 days)
atazanavir sulfate (generic of REYATAZ) CAPS 200mg	Tier 1	SP, QL (60 caps every 30 days)
atazanavir sulfate (generic of REYATAZ) CAPS 300mg	Tier 1	SP, QL (30 caps every 30 days)
darunavir (generic of PREZISTA) TABS 600mg	Tier 1	SP, QL (60 tabs every 30 days)
darunavir (generic of PREZISTA) TABS 800mg	Tier 1	SP, QL (30 tabs every 30 days)
EDURANT TABS 25MG	Tier 2	SP, QL (60 tabs every 30 days)
efavirenz caps 50mg, 200mg	Tier 1	SP, QL (90 caps every 30 days)
efavirenz (generic of SUSTIVA) TABS 600mg	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine (generic of EMTRIVA) CAPS 200mg	Tier 1	SP, QL (30 caps every 30 days)
EMTRIVA SOLN 10MG/ML	Tier 2	SP, QL (680 ml every 28 days)
etravirine (generic of INTELENCE) TABS 100mg	Tier 1	SP, QL (120 tabs every 30 days)
etravirine (generic of INTELENCE) TABS 200mg	Tier 1	SP, QL (60 tabs every 30 days)
fosamprenavir calcium (generic of LEXIVA) TABS 700mg	Tier 1	SP, QL (120 tabs every 30 days)
FUZEON SOLR 90MG	MB	
INTELENCE TABS 25MG	Tier 2	SP, QL (120 tabs every 30 days)
ISENTRESS CHEW 25MG, 100MG	Tier 2	SP, QL (180 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ISENTRESS PACK 100MG	Tier 2	SP, QL (60 packets every 30 days)
ISENTRESS TABS 400MG	Tier 2	SP, QL (120 tabs every 30 days)
ISENTRESS HD TABS 600MG	Tier 2	SP, QL (60 tabs every 30 days)
lamivudine (generic of EPIVIR) SOLN 10mg/ml	Tier 1	SP, QL (960 ml every 30 days)
lamivudine (generic of EPIVIR) TABS 150mg	Tier 1	SP, QL (60 tabs every 30 days)
lamivudine (generic of EPIVIR) TABS 300mg	Tier 1	SP, QL (30 tabs every 30 days)
LEXIVA SUSP 50MG/ML	Tier 2	SP, QL (1575 mL every 28 days)
maraviroc (generic of SELZENTRY) TABS 150mg	Tier 1	SP, QL (60 tabs every 30 days)
maraviroc (generic of SELZENTRY) TABS 300mg	Tier 1	SP, QL (120 tabs every 30 days)
nevirapine susp 50mg/5ml	Tier 1	SP, QL (1200 mL every 30 days)
nevirapine tabs 200mg	Tier 1	SP, QL (60 tabs every 30 days)
nevirapine tb24 100mg	Tier 1	SP, QL (90 tabs every 30 days)
nevirapine tb24 400mg	Tier 1	SP, QL (30 tabs every 30 days)
NORVIR PACK 100MG	Tier 2	SP, QL (360 packets every 30 days)
NORVIR SOLN 80MG/ML	Tier 2	SP, QL (480 mL every 30 days)
PREZISTA SUSP 100MG/ML	Tier 2	SP, QL (400 ml every 30 days)
PREZISTA TABS 75MG	Tier 2	SP, QL (300 tabs every 30 days)
PREZISTA TABS 150MG	Tier 2	SP, QL (180 tabs every 30 days)
PREZISTA TABS 600MG	Tier 2	SP, QL (60 tabs every 30 days)
PREZISTA TABS 800MG	Tier 2	SP, QL (30 tabs every 30 days)
RETROVIR IV INFUSION SOLN 10MG/ML	MB	
REYATAZ PACK 50MG	Tier 2	SP, QL (180 packets every 30 days)
ritonavir (generic of NORVIR) TABS 100mg	Tier 1	SP, QL (360 tabs every 30 days)
SELZENTRY SOLN 20MG/ML	Tier 2	SP, QL (1840 mL every 30 days)
SELZENTRY TABS 25MG	Tier 2	SP, QL (240 tabs every 30 days)
SELZENTRY TABS 75MG	Tier 2	SP, QL (60 tabs every 30 days)
stavudine caps 15mg, 20mg, 30mg, 40mg	Tier 1	SP, QL (60 caps every 30 days)
tenofovir disoproxil fumarate (generic of VIREAD) TABS 300mg	Tier 1	SP, QL (30 tabs every 30 days)
TIVICAY TABS 10MG	Tier 2	SP, QL (240 tabs every 30 days)
TIVICAY TABS 25MG, 50MG	Tier 2	SP, QL (60 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TIVICAY PD TBSO 5MG	Tier 2	SP, QL (360 tabs every 30 days)
TROGARZO SOLN 200MG/1.33ML	MB	
TYBOST TABS 150MG	Tier 2	SP, QL (30 tabs every 30 days)
VIRACEPT TABS 250MG	Tier 2	SP, QL (300 tabs every 30 days)
VIRACEPT TABS 625MG	Tier 2	SP, QL (120 tabs every 30 days)
VIREAD POWD 40MG/GM	Tier 2	SP, QL (240 gm every 30 days)
VIREAD TABS 150MG, 200MG, 250MG	Tier 2	SP, QL (30 tabs every 30 days)
zidovudine (generic of RETROVIR) CAPS 100mg	Tier 1	SP, QL (180 caps every 30 days)
zidovudine (generic of RETROVIR) SYRP 50mg/5ml	Tier 1	SP, QL (1920 ml every 30 days)
zidovudine tabs 300mg	Tier 1	SP, QL (60 tabs every 30 days)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	Tier 1	SP, QL (30 tabs every 30 days)
BIKTARVY TAB	Tier 2	SP, QL (30 tabs every 30 days)
CIMDUO TAB 300-300	Tier 2	SP, QL (30 tabs every 30 days)
DESCOVY TAB 120-15MG	Tier 2	SP, QL (30 tabs every 30 days)
DESCOVY TAB 200/25MG	Tier 2	SP, QL (30 tabs every 30 days); $0 copay for PrEP
DOVATO TAB 50-300MG	Tier 2	SP, QL (30 tabs every 30 days)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg (generic of ATRIPLA)	Tier 1	SP, QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (generic of SYMFI LO)	Tier 1	SP, QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (generic of SYMFI)	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg (generic of TRUVADA)	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg (generic of TRUVADA)	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg (generic of TRUVADA)	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg (generic of TRUVADA)	Tier 1	SP, QL (30 tabs every 30 days); $0 copay for PrEP
EVOTAZ TAB 300-150	Tier 2	SP, QL (30 tabs every 30 days)
GENVOYA TAB	Tier 2	SP, QL (30 tabs every 30 days)
lamivudine-zidovudine tab 150-300 mg (generic of COMBIVIR)	Tier 1	SP, QL (60 tabs every 30 days)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml) (generic of KALETRA)	Tier 1	SP, QL (480 ml every 30 days)
lopinavir-ritonavir tab 100-25 mg (generic of KALETRA)	Tier 1	SP, QL (240 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lopinavir-ritonavir tab 200-50 mg (generic of KALETRA)	Tier 1	SP, QL (120 tabs every 30 days)
ODEFSEY TAB	Tier 2	SP, QL (30 tabs every 30 days)
PREZCOBIX TAB 800-150	Tier 2	SP, QL (30 tabs every 30 days)
TRIUMEQ PD TAB	Tier 3	SP, QL (180 tabs every 30 days)
TRIUMEQ TAB	Tier 3	SP, QL (30 tabs every 30 days)
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine caps 250mg	Tier 1	
ethambutol hcl tabs 100mg	Tier 1	
ethambutol hcl (generic of MYAMBUTOL) TABS 400mg	Tier 1	
isoniazid soln 100mg/ml	MB	
isoniazid syrp 50mg/5ml; tabs 100mg, 300mg	Tier 1	MO
PASER PACK 4GM	Tier 3	
PRIFTIN TABS 150MG	Tier 2	
pyrazinamide tabs 500mg	Tier 1	
rifabutin (generic of MYCOBUTIN) CAPS 150mg	Tier 1	
rifampin caps 150mg, 300mg	Tier 1	
rifampin (generic of RIFADIN) SOLR 600mg	MB	
SIRTURO TABS 20MG, 100MG	Tier 4	PA
TRECATOR TABS 250MG	Tier 2	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir caps 200mg; susp 200mg/5ml; tabs 400mg, 800mg	Tier 1	
adefovir dipivoxil tabs 10mg	Tier 4	SP
BARACLUDE SOLN .05MG/ML	Tier 4	SP, PA, QL (630 mL every 30 days)
cidofovir soln 75mg/ml	MB	
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
EPIVIR HBV SOLN 5MG/ML	Tier 2	SP
famciclovir tabs 125mg, 250mg, 500mg	Tier 1	
lamivudine (hbv) tabs 100mg	Tier 1	SP
oseltamivir phosphate (generic of TAMIFLU) CAPS 30mg	Tier 1	QL (40 caps every 90 days)
oseltamivir phosphate (generic of TAMIFLU) CAPS 45mg, 75mg	Tier 1	QL (20 caps every 90 days)
oseltamivir phosphate (generic of TAMIFLU) SUSR 6mg/ml	Tier 1	QL (360 mL every 90 days)
RELENZA DISKHALER AEPB 5MG/BLISTER	Tier 2	QL (2 inhalers every 90 days)
rimantadine hydrochloride tabs 100mg	Tier 1	
valacyclovir hcl (generic of VALTREX) TABS 500mg, 1000mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml	Tier 4	PA, QL (1000 mL every 30 days)
valganciclovir hcl (generic of VALCYTE) TABS 450mg	Tier 4	PA, QL (120 tabs every 30 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor caps 250mg, 500mg; susr 125mg/5ml, 250mg/5ml, 375mg/5ml	Tier 1	
cefadroxil caps 500mg; susr 250mg/5ml, 500mg/5ml; tabs 1gm	Tier 1	
cefazolin sodium solr 1gm	MB	
cefdinir caps 300mg; susr 125mg/5ml, 250mg/5ml	Tier 1	
cefepime hcl solr 1gm, 2gm	MB	
cefixime caps 400mg; susr 100mg/5ml, 200mg/5ml	Tier 1	
cefpodoxime proxetil susr 50mg/5ml, 100mg/5ml; tabs 100mg, 200mg	Tier 1	
cefprozil susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
ceftazidime solr 1gm, 2gm	MB	
ceftriaxone sodium solr 1gm, 2gm, 10gm, 250mg, 500mg	MB	
cefuroxime axetil tabs 250mg, 500mg	Tier 1	
cephalexin caps 250mg, 500mg, 750mg; susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
SUPRAX CHEW 100MG, 200MG; SUSR 500MG/5ML	Tier 2	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin pack 1gm; tabs 600mg	Tier 1	
azithromycin (generic of ZITHROMAX) SUSR 100mg/5ml, 200mg/5ml; TABS 250mg, 500mg	Tier 1	
clarithromycin susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
clarithromycin (generic of BIAXIN XL) TB24 500mg	Tier 1	
DIFICID SUSR 40MG/ML; TABS 200MG	Tier 2	PA
erythromycin base cpep 250mg; tabs 250mg, 500mg; tbec 250mg, 333mg, 500mg	Tier 1	
erythromycin ethylsuccinate (generic of E.E.S. GRANULES) SUSR 200mg/5ml	Tier 1	
erythromycin ethylsuccinate (generic of ERYPED 400) SUSR 400mg/5ml	Tier 1	
erythromycin ethylsuccinate tabs 400mg	Tier 1	
erythromycin stearate tabs 250mg	Tier 1	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO SUSR 500MG/5ML	Tier 3	
ciprofloxacin hcl tabs 100mg, 750mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ciprofloxacin hcl (generic of CIPRO) TABS 250mg, 500mg	Tier 1	
levofloxacin soln 25mg/ml	MB	
levofloxacin soln 25mg/ml; tabs 500mg	Tier 1	
levofloxacin (generic of LEVAQUIN) TABS 250mg, 750mg	Tier 1	
moxifloxacin hcl tabs 400mg	Tier 1	
ofloxacin tabs 300mg, 400mg	Tier 1	
HEPATITIS C		
EPCLUSA PAK 150-37.5	Tier 4	SP, PA, QL (28 pellets every 28 days)
EPCLUSA PAK 200-50MG	Tier 4	SP, PA, QL (28 pellets every 28 days)
EPCLUSA TAB 200-50MG	Tier 4	SP, PA, QL (28 tabs every 28 days)
EPCLUSA TAB 400-100	Tier 4	SP, PA, QL (28 tabs every 28 days)
HARVONI PAK	Tier 4	SP, PA, QL (28 pellets every 28 days)
HARVONI PAK 45-200MG	Tier 4	SP, PA, QL (28 pellets every 28 days)
HARVONI TAB 45-200MG	Tier 4	SP, PA, QL (28 tabs every 28 days)
HARVONI TAB 90-400MG	Tier 4	SP, PA, QL (28 tabs every 28 days)
PEGASYS SOLN 180MCG/ML; SOSY 180MCG/0.5ML	MB	
ribavirin (hepatitis c) caps 200mg; tabs 200mg	Tier 1	SP, PA
SOVALDI PACK 150MG, 200MG	Tier 4	SP, ST, PA, QL (28 pellets every 28 days)
SOVALDI TABS 200MG, 400MG	Tier 4	SP, ST, PA, QL (28 tabs every 28 days)
VOSEVI TAB	Tier 4	SP, PA, QL (28 tabs every 28 days)
MISCELLANEOUS		
ALINIA SUSR 100MG/5ML	Tier 3	QL (540 mL every 30 days)
atovaquone (generic of MEPRON) SUSP 750mg/5ml	Tier 1	
aztreonam (generic of AZACTAM) SOLR 1gm, 2gm	MB	
clindamycin hcl (generic of CLEOCIN) CAPS 75mg, 150mg, 300mg	Tier 1	
clindamycin palmitate hydrochloride (generic of CLEOCIN PEDIATRIC GRANULE) SOLR 75mg/5ml	Tier 1	
clindamycin phosphate (generic of CLEOCIN PHOSPHATE) SOLN 9gm/60ml, 600mg/4ml, 9000mg/60ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clindamycin phosphate soln 300mg/2ml	MB	
dapsone tabs 25mg, 100mg	Tier 1	MO
ertapenem sodium solr 1gm	MB	
linezolid (generic of ZYVOX) SOLN 600mg/300ml	MB	
linezolid (generic of ZYVOX) SUSR 100mg/5ml; TABS 600mg	Tier 1	
LINEZOLID INJ 2MG/ML	MB	
meropenem solr 1gm, 500mg	MB	
methenamine hippurate (generic of HIPREX) TABS 1gm	Tier 1	
metronidazole (generic of FLAGYL) CAPS 375mg	Tier 1	
metronidazole (generic of METRONIDAZOLE) SOLN 500mg/100ml	MB	
metronidazole tabs 250mg, 500mg	Tier 1	
nitazoxanide (generic of ALINIA) TABS 500mg	Tier 1	QL (20 tabs every 30 days)
nitrofurantoin susp 25mg/5ml	Tier 1	PA; High Risk Medications require PA for members age 70 and older
nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 25mg, 50mg, 100mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
nitrofurantoin monohyd macro (generic of MACROBID) CAPS 100mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
pentamidine isethionate (generic of NEBUPENT) SOLR 300mg	Tier 1	
pentamidine isethionate (generic of PENTAM 300) SOLR 300mg	MB	
polymyxin b sulfate solr 500000unit	MB	
pyrimethamine (generic of DARAPRIM) TABS 25mg	Tier 3	PA
trimethoprim tabs 100mg	Tier 1	
vancomycin hcl (generic of VANCOCIN) CAPS 125mg, 250mg	Tier 1	QL (80 caps every 10 days)
vancomycin hcl solr 1gm, 5gm, 10gm, 500mg, 750mg	MB	
XIFAXAN TABS 200MG	Tier 2	QL (9 tabs every 30 days)
XIFAXAN TABS 550MG	Tier 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	Tier 1	
amoxicillin & k clavulanate chew tab 200-28.5 mg	Tier 1	
amoxicillin & k clavulanate chew tab 400-57 mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml (generic of AUGMENTIN ES-600)	Tier 1	
amoxicillin & k clavulanate tab 250-125 mg	Tier 1	
amoxicillin & k clavulanate tab 500-125 mg (generic of AUGMENTIN)	Tier 1	
amoxicillin & k clavulanate tab 875-125 mg	Tier 1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	Tier 1	
ampicillin caps 500mg	Tier 1	
ampicillin sodium solr 1gm, 2gm	MB	
dicloxacillin sodium caps 250mg, 500mg	Tier 1	
penicillin g potassium solr 5000000unit, 20000000unit	MB	
penicillin g sodium solr 5000000unit	MB	
penicillin v potassium solr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 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	Tier 1	
doxycycline (monohydrate) caps 50mg, 100mg; tabs 50mg, 75mg, 100mg, 150mg	Tier 1	
doxycycline (monohydrate) (generic of VIBRAMYCIN) SUSR 25mg/5ml	Tier 1	
doxycycline hyclate caps 50mg; tabs 100mg	Tier 1	
doxycycline hyclate (generic of VIBRAMYCIN) CAPS 100mg	Tier 1	
doxycycline hyclate solr 100mg	MB	
minocycline hcl caps 50mg, 75mg, 100mg; tabs 50mg, 75mg, 100mg	Tier 1	
tetracycline hcl caps 250mg, 500mg	Tier 1	QL (120 caps every 30 days)
VIBRAMYCIN SYRP 50MG/5ML	Tier 3	
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
FLOVENT HFA AERO 44MCG/ACT, 110MCG/ACT, 220MCG/ACT	Tier 3	QL (6 inhalers per 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluticasone propionate hfa aero 44mcg/act, 110mcg/act, 220mcg/act	Tier 3	QL (6 inhalers per 75 days), MO
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
ANTICONVULSANTS - MISC.		
BRIVIACT SOLN 10MG/ML; TABS 10MG, 25MG, 50MG, 75MG, 100MG	Tier 3	MO
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
neostigmine methylsulfate (generic of BLOXIVERZ) SOLN 10mg/10ml	MB	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
busulfan (generic of BUSULFEX) SOLN 6mg/ml	MB	
carmustine (generic of BICNU) SOLR 100mg	MB	
cyclophosphamide caps 25mg, 50mg	Tier 1	OAC
cyclophosphamide solr 1gm, 2gm, 500mg	MB	
dacarbazine solr 100mg, 200mg	MB	
EMCYT CAPS 140MG	Tier 4	OAC
GLEOSTINE CAPS 10MG, 40MG, 100MG	Tier 4	SP; OAC
GLIADEL WAF 7.7MG	MB	
ifosfamide soln 1gm/20ml, 3gm/60ml	MB	
ifosfamide (generic of IFEX) SOLR 1gm	MB	
LEUKERAN TABS 2MG	Tier 2	OAC
MATULANE CAPS 50MG	Tier 2	OAC
melphalan tabs 2mg	Tier 1	OAC
melphalan hcl solr 50mg	MB	
TEMODAR SOLR 100MG	MB	
temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg	Tier 4	SP, PA; OAC
ANTIBIOTICS		
bleomycin sulfate solr 15unit, 30unit	MB	
daunorubicin hcl (generic of DAUNORUBICIN HYDROCHLORID) SOLN 20mg/4ml	MB	
doxorubicin hcl soln 2mg/ml; solr 10mg, 50mg	MB	
doxorubicin hcl liposomal (generic of DOXIL) INJ 2mg/ml	MB	
idarubicin hcl (generic of IDAMYCIN PFS) SOLN 5mg/5ml, 10mg/10ml, 20mg/20ml	MB	
mitomycin solr 5mg, 20mg, 40mg	MB	
mitoxantrone hcl conc 2mg/ml	MB	
ANTIMETABOLITES		
azacitidine (generic of VIDAZA) SUSR 100mg	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
capecitabine (generic of XELODA) TABS 150mg, 500mg	Tier 4	SP, PA; OAC
cladribine soln 10mg/10ml	MB	
clofarabine (generic of CLOLAR) 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 (generic of GEMCITABINE HYDROCHLORIDE) SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml	MB	
gemcitabine hcl solr 1gm, 2gm, 200mg	MB	
mercaptopurine tabs 50mg	Tier 1	OAC
methotrexate sodium soln 1gm/40ml, 50mg/2ml, 250mg/10ml; solr 1gm	MB	
pemetrexed disodium (generic of ALIMTA) SOLR 100mg, 500mg	MB	
TABLOID TABS 40MG	Tier 2	OAC
ANTIMITOTIC, TAXOIDS		
docetaxel (generic of 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	Tier 4	PA, QL (120 every 30 days); OAC
VENCLEXTA TABS 100MG	Tier 4	PA, QL (180 every 30 days); OAC
VENCLEXTA TAB START PK	Tier 4	PA, QL (1 pack every 28 days); OAC
BIOLOGIC RESPONSE MODIFIERS		
ERBITUX SOLN 100MG/50ML, 200MG/100ML	MB	
ERIVEDGE CAPS 150MG	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
GAZYVA SOLN 1000MG/40ML	MB	
KADCYLA SOLR 100MG, 160MG	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KEYTRUDA SOLN 100MG/4ML	MB	
POLIVY SOLR 30MG, 140MG	MB	
POMALYST CAPS 1MG, 2MG, 3MG, 4MG	Tier 4	SP, PA, QL (21 caps every 28 days); OAC
REVLIMID CAPS 2.5MG, 5MG, 10MG, 15MG	Tier 4	SP, PA, QL (28 caps every 28 days); OAC
REVLIMID CAPS 20MG, 25MG	Tier 4	SP, PA, QL (21 caps every 28 days); OAC
THALOMID CAPS 50MG, 100MG	Tier 4	SP, PA, QL (28 caps every 28 days); OAC
THALOMID CAPS 150MG, 200MG	Tier 4	SP, PA, QL (56 caps every 28 days); OAC
TICE BCG SUSR 50MG	MB	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate (generic of ZYTIGA) TABS 250mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
abiraterone acetate (generic of ZYTIGA) TABS 500mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
anastrozole (generic of ARIMIDEX) TABS 1mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
bicalutamide (generic of CASODEX) TABS 50mg	Tier 1	OAC
ELIGARD KIT 7.5MG, 22.5MG, 30MG, 45MG	MB	
ERLEADA TABS 60MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
ERLEADA TABS 240MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
exemestane (generic of AROMASIN) TABS 25mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
flutamide caps 125mg	Tier 1	OAC
fulvestrant (generic of FASLODEX) SOSY 250mg/5ml	MB	
letrozole (generic of FEMARA) TABS 2.5mg	Tier 1	MO; OAC
leuprolide acetate kit 1mg/0.2ml	MB	
LYSODREN TABS 500MG	Tier 2	OAC
megestrol acetate susp 40mg/ml; tabs 20mg, 40mg	Tier 1	OAC
nilutamide (generic of NILANDRON) TABS 150mg	Tier 1	OAC
NUBEQA TABS 300MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
tamoxifen citrate tabs 10mg, 20mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
toremifene citrate (generic of FARESTON) TABS 60mg	Tier 1	MO; OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XTANDI CAPS 40MG	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
XTANDI TABS 40MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
XTANDI TABS 80MG	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
YONSA TABS 125MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
KINASE INHIBITORS		
ALECENSA CAPS 150MG	Tier 4	SP, PA, QL (240 caps every 30 days); OAC
CABOMETYX TABS 20MG, 40MG, 60MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
CALQUENCE CAPS 100MG	Tier 4	PA, QL (60 caps every 30 days); OAC
CALQUENCE TABS 100MG	Tier 4	PA, QL (60 tabs every 30 days); OAC
CAPRELSA TABS 100MG	Tier 4	PA, QL (60 tabs every 30 days); OAC
CAPRELSA TABS 300MG	Tier 4	PA, QL (30 tabs every 30 days); OAC
COMETRIQ KIT 20MG	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 100MG	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 140MG	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
erlotinib hcl (generic of TARCEVA) TABS 25mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
erlotinib hcl (generic of TARCEVA) TABS 100mg, 150mg	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus (generic of AFINITOR) TABS 2.5mg, 5mg, 7.5mg, 10mg	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus (generic of AFINITOR DISPERZ) TBSO 2mg, 5mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
everolimus (generic of AFINITOR DISPERZ) TBSO 3mg	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
IBRANCE CAPS 75MG, 100MG, 125MG	Tier 4	SP, PA, QL (21 caps every 28 days); OAC
IBRANCE TABS 75MG, 100MG, 125MG	Tier 4	SP, PA, QL (21 tabs every 28 days); OAC
ICLUSIG TABS 10MG, 15MG, 30MG, 45MG	Tier 4	PA, QL (30 tabs every 30 days); OAC
imatinib mesylate (generic of GLEEVEC) TABS 100mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MEKINIST SOLR .05MG/ML	Tier 4	SP, PA, QL (12 bottles every 28 days); OAC
MEKINIST TABS 2MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
MEKINIST TABS .5MG	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
RYDAPT CAPS 25MG	Tier 4	SP, PA, QL (224 caps every 28 days); OAC
sorafenib tosylate (generic of NEXAVAR) TABS 200mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
SPRYCEL TABS 20MG	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
SPRYCEL TABS 50MG, 70MG, 80MG, 100MG, 140MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
STIVARGA TABS 40MG	Tier 4	SP, PA, QL (84 tabs every 28 days); OAC
sunitinib malate (generic of SUTENT) CAPS 12.5mg, 25mg, 37.5mg, 50mg	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
TAFINLAR CAPS 50MG, 75MG	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
TAFINLAR TBSO 10MG	Tier 4	SP, PA, QL (4 bottles every 28 days); OAC
TUKYSA TABS 50MG, 150MG	Tier 4	PA, QL (120 tabs every 30 days); OAC
VITRAKVI CAPS 25MG	Tier 4	SP, PA, QL (180 caps every 30 days); OAC
VITRAKVI CAPS 100MG	Tier 4	SP, PA, QL (60 caps every 30 days); OAC
VITRAKVI SOLN 20MG/ML	Tier 4	SP, PA, QL (300 mL every 30 days); OAC
VOTRIENT TABS 200MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
XALKORI CAPS 200MG, 250MG	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
ZELBORAF TABS 240MG	Tier 4	SP, PA, QL (240 tabs every 30 days); OAC
ZYDELIG TABS 100MG, 150MG	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
ZYKADIA TABS 150MG	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
MISCELLANEOUS		
arsenic trioxide soln 10mg/10ml	MB	
arsenic trioxide (generic of TRISENOX) SOLN 12mg/6ml	MB	
bexarotene (generic of TARGRETIN) CAPS 75mg	Tier 4	SP, PA; OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydroxyurea (generic of HYDREA) CAPS 500mg	Tier 1	OAC
IDHIFA TABS 50MG, 100MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
LYNPARZA TABS 100MG, 150MG	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
NIPENT SOLR 10MG	MB	
ODOMZO CAPS 200MG	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
ONCASPAR SOLN 750UNIT/ML	MB	
PHOTOFRIN SOLR 75MG	MB	
tretinoin (chemotherapy) caps 10mg	Tier 1	OAC
VISTOGARD PACK 10GM	Tier 4	QL (20 packets every 5 days); OAC
ZEJULA CAPS 100MG	Tier 4	SP, PA, QL (90 caps every 30 days); OAC
ZEJULA TABS 100MG, 200MG, 300MG	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
ZOLINZA CAPS 100MG	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
PLATINUM-BASED AGENTS		
carboplatin soln 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml, 1000mg/100ml	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	Tier 1	OAC
mesna (generic of MESNEX) SOLN 100mg/ml	MB	
MESNEX TABS 400MG	Tier 4	OAC
TOPOISOMERASE INHIBITORS		
etoposide caps 50mg	Tier 1	OAC
etoposide soln 1gm/50ml, 100mg/5ml, 500mg/25ml	MB	
irinotecan hcl (generic of CAMPTOSAR) SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml	MB	
irinotecan hcl soln 500mg/25ml	MB	
topotecan hcl (generic of HYCAMTIN) SOLR 4mg	MB	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 300-100	PV	QL (30 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HEPATITIS AGENTS		
PEGINTRON KIT 50MCG/0.5ML	MB	
MISC. ANTIVIRALS		
LAGEVRIO CAPS 200MG	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	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-10 mg (generic of LOTREL)	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-20 mg (generic of LOTREL)	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-40 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 10-20 mg (generic of LOTREL)	Tier 1	MO
amlodipine besylate-benazepril hcl cap 10-40 mg (generic of LOTREL)	Tier 1	MO
benazepril & hydrochlorothiazide tab 5-6.25 mg	Tier 1	MO
benazepril & hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT)	Tier 1	MO
benazepril & hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT)	Tier 1	MO
benazepril & hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT)	Tier 1	MO
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	Tier 1	MO
enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)	Tier 1	MO
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	Tier 1	MO
lisinopril & hydrochlorothiazide tab 10-12.5 mg (generic of ZESTORETIC)	Tier 1	MO
lisinopril & hydrochlorothiazide tab 20-12.5 mg (generic of ZESTORETIC)	Tier 1	MO
lisinopril & hydrochlorothiazide tab 20-25 mg (generic of ZESTORETIC)	Tier 1	MO
quinapril-hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO
quinapril-hydrochlorothiazide tab 20-12.5 mg (generic of ACCURETIC)	Tier 1	MO
quinapril-hydrochlorothiazide tab 20-25 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 1-240 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 2-180 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 2-240 mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
trandolapril-verapamil hcl tab er 4-240 mg	Tier 1	MO
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl tabs 5mg	Tier 1	MO
benazepril hcl (generic of LOTENSIN) TABS 10mg, 20mg, 40mg	Tier 1	MO
captopril tabs 12.5mg, 25mg, 50mg, 100mg	Tier 1	MO
enalapril maleate (generic of VASOTEC) TABS 2.5mg, 5mg, 10mg, 20mg	Tier 1	MO
fosinopril sodium tabs 10mg, 20mg, 40mg	Tier 1	MO
lisinopril (generic of ZESTRIL) TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	Tier 1	MO
moexipril hcl tabs 7.5mg, 15mg	Tier 1	MO
perindopril erbumine tabs 2mg, 4mg, 8mg	Tier 1	MO
quinapril hcl (generic of ACCUPRIL) TABS 5mg, 10mg, 20mg, 40mg	Tier 1	MO
ramipril (generic of ALTACE) CAPS 1.25mg, 2.5mg, 5mg, 10mg	Tier 1	MO
trandolapril tabs 1mg, 2mg, 4mg	Tier 1	MO
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
eplerenone (generic of INSPRA) TABS 25mg, 50mg	Tier 1	MO
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
prazosin hcl (generic of MINIPRESS) CAPS 1mg, 2mg, 5mg	Tier 1	MO
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-olmesartan medoxomil tab 5-20 mg (generic of AZOR)	Tier 1	MO
amlodipine besylate-olmesartan medoxomil tab 5-40 mg (generic of AZOR)	Tier 1	MO
amlodipine besylate-olmesartan medoxomil tab 10-20 mg (generic of AZOR)	Tier 1	MO
amlodipine besylate-olmesartan medoxomil tab 10-40 mg (generic of AZOR)	Tier 1	MO
amlodipine besylate-valsartan tab 5-160 mg (generic of EXFORGE)	Tier 1	MO
amlodipine besylate-valsartan tab 5-320 mg (generic of EXFORGE)	Tier 1	MO
amlodipine besylate-valsartan tab 10-160 mg (generic of EXFORGE)	Tier 1	MO
amlodipine besylate-valsartan tab 10-320 mg (generic of EXFORGE)	Tier 1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg (generic of EXFORGE HCT)	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg (generic of EXFORGE HCT)	Tier 1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg (generic of EXFORGE HCT)	Tier 1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg (generic of EXFORGE HCT)	Tier 1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg (generic of EXFORGE HCT)	Tier 1	MO
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg (generic of ATACAND HCT)	Tier 1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg (generic of ATACAND HCT)	Tier 1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg (generic of ATACAND HCT)	Tier 1	MO
irbesartan-hydrochlorothiazide tab 150-12.5 mg (generic of AVALIDE)	Tier 1	MO
irbesartan-hydrochlorothiazide tab 300-12.5 mg (generic of AVALIDE)	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 50-12.5 mg (generic of HYZAAR)	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 100-12.5 mg (generic of HYZAAR)	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 100-25 mg (generic of HYZAAR)	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg (generic of BENICAR HCT)	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg (generic of BENICAR HCT)	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg (generic of BENICAR HCT)	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg (generic of TRIBENZOR)	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg (generic of TRIBENZOR)	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg (generic of TRIBENZOR)	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg (generic of TRIBENZOR)	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg (generic of TRIBENZOR)	Tier 1	MO
telmisartan-amlodipine tab 40-5 mg	Tier 1	MO
telmisartan-amlodipine tab 40-10 mg	Tier 1	MO
telmisartan-amlodipine tab 80-5 mg	Tier 1	MO
telmisartan-amlodipine tab 80-10 mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
telmisartan-hydrochlorothiazide tab 40-12.5 mg (generic of MICARDIS HCT)	Tier 1	MO
telmisartan-hydrochlorothiazide tab 80-12.5 mg (generic of MICARDIS HCT)	Tier 1	MO
telmisartan-hydrochlorothiazide tab 80-25 mg (generic of MICARDIS HCT)	Tier 1	MO
valsartan-hydrochlorothiazide tab 80-12.5 mg (generic of DIOVAN HCT)	Tier 1	MO
valsartan-hydrochlorothiazide tab 160-12.5 mg (generic of DIOVAN HCT)	Tier 1	MO
valsartan-hydrochlorothiazide tab 160-25 mg (generic of DIOVAN HCT)	Tier 1	MO
valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT)	Tier 1	MO
valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT)	Tier 1	MO
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil (generic of ATACAND) TABS 4mg, 8mg, 16mg, 32mg	Tier 1	MO
irbesartan (generic of AVAPRO) TABS 75mg, 150mg, 300mg	Tier 1	MO
losartan potassium (generic of COZAAR) TABS 25mg, 50mg, 100mg	Tier 1	MO
olmesartan medoxomil (generic of BENICAR) TABS 5mg, 20mg, 40mg	Tier 1	MO
telmisartan (generic of MICARDIS) TABS 20mg, 40mg, 80mg	Tier 1	MO
valsartan (generic of DIOVAN) TABS 40mg, 80mg, 160mg, 320mg	Tier 1	MO
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl tabs 100mg, 200mg, 400mg	Tier 1	MO
disopyramide phosphate (generic of NORPACE) CAPS 100mg, 150mg	Tier 1	MO
dofetilide (generic of TIKOSYN) CAPS 125mcg, 250mcg, 500mcg	Tier 1	SP, PA
flecainide acetate tabs 50mg, 100mg, 150mg	Tier 1	MO
lidocaine hcl (cardiac) sosy 50mg/5ml, 100mg/5ml	MB	
MULTAQ TABS 400MG	Tier 3	PA, MO
NORPACE CR CP12 100MG, 150MG	Tier 2	MO
procainamide hcl soln 100mg/ml	MB	
propafenone hcl (generic of RYTHMOL SR) CP12 225mg, 325mg, 425mg	Tier 1	MO
propafenone hcl tabs 150mg, 225mg, 300mg	Tier 1	MO
sotalol hcl (generic of BETAPACE) TABS 80mg, 120mg, 160mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sotalol hcl tabs 240mg	Tier 1	MO
sotalol hcl (afib/afl) (generic of BETAPACE AF) TABS 80mg, 120mg, 160mg	Tier 1	MO
ANTILIPEMICS, BILE ACID RESINS		
cholestyramine (generic of QUESTRAN) PACK 4gm; POWD 4gm/dose	Tier 1	MO
cholestyramine light pack 4gm	Tier 1	MO
cholestyramine light (generic of QUESTRAN LIGHT) POWD 4gm/dose	Tier 1	MO
colestipol hcl (generic of COLESTID) GRAN 5gm; PACK 5gm; TABS 1gm	Tier 1	MO
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR		
ezetimibe (generic of ZETIA) TABS 10mg	Tier 1	MO
ANTILIPEMICS, FIBRATES		
choline fenofibrate (generic of TRILIPIX) CPDR 45mg, 135mg	Tier 1	MO
fenofibrate caps 150mg; tabs 54mg, 160mg	Tier 1	MO
fenofibrate (generic of TRICOR) TABS 48mg, 145mg	Tier 1	MO
fenofibrate micronized caps 43mg, 67mg, 134mg, 200mg	Tier 1	MO
gemfibrozil (generic of LOPID) TABS 600mg	Tier 1	MO
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg (generic of VYTORIN)	Tier 1	MO
ezetimibe-simvastatin tab 10-20 mg (generic of VYTORIN)	Tier 1	MO
ezetimibe-simvastatin tab 10-40 mg (generic of VYTORIN)	Tier 1	MO
ezetimibe-simvastatin tab 10-80 mg (generic of VYTORIN)	Tier 1	MO
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
atorvastatin calcium (generic of LIPITOR) TABS 10mg, 20mg	Tier 1	MO; $0 copay for members age 40 through 75
atorvastatin calcium (generic of LIPITOR) TABS 40mg, 80mg	Tier 1	MO; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
fluvastatin sodium caps 20mg, 40mg	Tier 1	MO; $0 copay for members age 40 through 75
fluvastatin sodium (generic of LESCOL XL) TB24 80mg	Tier 1	MO; $0 copay for members age 40 through 75

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lovastatin tabs 10mg, 20mg, 40mg	Tier 1	MO; $0 copay for members age 40 through 75
pravastatin sodium tabs 10mg, 20mg, 40mg, 80mg	Tier 1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium (generic of CRESTOR) TABS 5mg, 10mg	Tier 1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium (generic of CRESTOR) TABS 20mg, 40mg	Tier 1	MO; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
simvastatin tabs 5mg	Tier 1	MO; $0 copay for members age 40 through 75
simvastatin (generic of ZOCOR) TABS 10mg, 20mg, 40mg	Tier 1	MO; $0 copay for members age 40 through 75
simvastatin tabs 80mg	Tier 1	ST, MO; PA**; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
niacin (antihyperlipidemic) tbcr 500mg, 750mg, 1000mg	Tier 1	MO
ANTILIPEMICS, OMEGA-3 FATTY ACIDS		
icosapent ethyl (generic of VASCEPA) CAPS 1gm	Tier 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 (generic of VASCEPA) CAPS .5gm	Tier 1	MO
omega-3-acid ethyl esters cap 1 gm (generic of LOVAZA)	Tier 1	MO
ANTILIPEMICS, PCSK9 INHIBITORS		
PRALUENT SOAJ 75MG/ML, 150MG/ML	MB	
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg (generic of TENORETIC 50)	Tier 1	MO
atenolol & chlorthalidone tab 100-25 mg (generic of TENORETIC 100)	Tier 1	MO
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	Tier 1	MO
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	Tier 1	MO
metoprolol & hydrochlorothiazide tab 50-25 mg	Tier 1	MO
metoprolol & hydrochlorothiazide tab 100-25 mg	Tier 1	MO
metoprolol & hydrochlorothiazide tab 100-50 mg	Tier 1	MO
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl caps 200mg, 400mg	Tier 1	MO
atenolol (generic of TENORMIN) TABS 25mg, 50mg, 100mg	Tier 1	MO
betaxolol hcl tabs 10mg, 20mg	Tier 1	MO
bisoprolol fumarate tabs 5mg, 10mg	Tier 1	MO
carvedilol (generic of COREG) TABS 3.125mg, 6.25mg, 12.5mg, 25mg	Tier 1	MO
carvedilol phosphate (generic of COREG CR) CP24 10mg, 20mg, 40mg, 80mg	Tier 1	MO
labetalol hcl tabs 100mg, 200mg, 300mg	Tier 1	MO
metoprolol succinate (generic of TOPROL XL) TB24 25mg, 50mg, 100mg, 200mg	Tier 1	MO
metoprolol tartrate tabs 25mg	Tier 1	MO
metoprolol tartrate (generic of LOPRESSOR) TABS 50mg, 100mg	Tier 1	MO
nadolol (generic of CORGARD) TABS 20mg, 40mg	Tier 1	MO
nadolol tabs 80mg	Tier 1	MO
nebivolol hcl (generic of BYSTOLIC) TABS 2.5mg, 5mg, 10mg, 20mg	Tier 1	MO
pindolol tabs 5mg, 10mg	Tier 1	MO
propranolol hcl (generic of INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg	Tier 1	MO
propranolol hcl soln 20mg/5ml, 40mg/5ml; tabs 10mg, 20mg, 40mg, 60mg, 80mg	Tier 1	MO
timolol maleate tabs 5mg, 10mg, 20mg	Tier 1	MO
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS		
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 5-10 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 5-20 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 5-40 mg (generic of CADUET)	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine besylate-atorvastatin calcium tab 5-80 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-10 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-20 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-40 mg (generic of CADUET)	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-80 mg (generic of CADUET)	Tier 1	MO
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
amlodipine besylate (generic of NORVASC) TABS 2.5mg, 5mg, 10mg	Tier 1	MO
diltiazem hcl cp12 60mg, 90mg, 120mg; cp24 120mg, 180mg, 240mg; tabs 90mg	Tier 1	MO
diltiazem hcl soln 25mg/5ml, 125mg/25ml	MB	
diltiazem hcl (generic of CARDIZEM) TABS 30mg, 60mg, 120mg	Tier 1	MO
diltiazem hcl (generic of CARDIZEM LA) TB24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	Tier 1	MO
diltiazem hcl coated beads (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg, 360mg	Tier 1	MO
diltiazem hcl extended release beads (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	Tier 1	MO
felodipine tb24 2.5mg, 5mg, 10mg	Tier 1	MO
isradipine caps 2.5mg, 5mg	Tier 1	MO
nicardipine hcl caps 20mg, 30mg	Tier 1	MO
nifedipine tb24 30mg, 60mg, 90mg	Tier 1	MO
nifedipine (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	Tier 1	MO
nimodipine caps 30mg	Tier 1	
nisoldipine (generic of SULAR) TB24 8.5mg, 17mg, 34mg	Tier 1	MO
nisoldipine tb24 20mg, 25.5mg, 30mg, 40mg	Tier 1	MO
verapamil hcl cp24 100mg, 200mg, 300mg, 360mg; tabs 40mg, 80mg, 120mg; tbcr 120mg, 180mg, 240mg	Tier 1	MO
verapamil hcl (generic of VERELAN) CP24 120mg, 180mg, 240mg	Tier 1	MO
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
digoxin soln .05mg/ml	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
digoxin (generic of LANOXIN) TABS 62.5mcg, 125mcg, 250mcg	Tier 1	MO
DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS		
aliskiren fumarate (generic of TEKTURNA) TABS 150mg, 300mg	Tier 1	MO
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide cp12 500mg; tabs 125mg, 250mg	Tier 1	MO
ALDACTAZIDE TAB 50/50	Tier 2	MO
amiloride & hydrochlorothiazide tab 5-50 mg	Tier 1	MO
amiloride hcl tabs 5mg	Tier 1	MO
bumetanide tabs 1mg, 2mg	Tier 1	MO
bumetanide (generic of BUMEX) TABS .5mg	Tier 1	MO
chlorthalidone tabs 25mg, 50mg	Tier 1	MO
DIURIL SUSP 250MG/5ML	Tier 3	MO
ethacrynic acid (generic of EDECRIN) TABS 25mg	Tier 3	MO
furosemide soln 10mg/ml	MB	
furosemide soln 10mg/ml, 40mg/5ml	Tier 1	MO
furosemide (generic of LASIX) TABS 20mg, 40mg, 80mg	Tier 1	MO
hydrochlorothiazide caps 12.5mg; tabs 12.5mg, 25mg, 50mg	Tier 1	MO
indapamide tabs 1.25mg, 2.5mg	Tier 1	MO
methazolamide tabs 25mg, 50mg	Tier 1	MO
metolazone tabs 2.5mg, 5mg, 10mg	Tier 1	MO
spironolactone (generic of ALDACTONE) TABS 25mg, 50mg, 100mg	Tier 1	MO
spironolactone & hydrochlorothiazide tab 25-25 mg	Tier 1	MO
torsemide tabs 5mg, 10mg, 20mg, 100mg	Tier 1	MO
triamterene (generic of DYRENIUM) CAPS 50mg, 100mg	Tier 1	MO
triamterene & hydrochlorothiazide cap 37.5-25 mg	Tier 1	MO
triamterene & hydrochlorothiazide tab 37.5-25 mg (generic of MAXZIDE-25)	Tier 1	MO
triamterene & hydrochlorothiazide tab 75-50 mg (generic of MAXZIDE)	Tier 1	MO
HEART FAILURE		
ENTRESTO TAB 24-26MG	Tier 2	MO
ENTRESTO TAB 49-51MG	Tier 2	MO
ENTRESTO TAB 97-103MG	Tier 2	MO
MISCELLANEOUS		
clonidine (generic of CATAPRES-TTS-1) PTWK .1mg/24hr	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clonidine (generic of CATAPRES-TTS-2) PTWK .2mg/24hr	Tier 1	MO
clonidine (generic of CATAPRES-TTS-3) PTWK .3mg/24hr	Tier 1	MO
clonidine hcl tabs .1mg, .2mg, .3mg	Tier 1	MO
guanfacine hcl tabs 1mg, 2mg	Tier 1	MO
hydralazine hcl tabs 10mg, 25mg, 50mg, 100mg	Tier 1	MO
methyldopa tabs 250mg, 500mg	Tier 1	MO
midodrine hcl tabs 2.5mg, 5mg, 10mg	Tier 1	
minoxidil tabs 2.5mg, 10mg	Tier 1	MO
phenoxybenzamine hcl (generic of DIBENZYLINE) CAPS 10mg	Tier 4	PA, QL (360 caps every 30 days)
ranolazine tb12 500mg, 1000mg	Tier 1	ST, MO; PA**
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg	Tier 1	MO
isosorbide dinitrate tabs 10mg, 20mg, 30mg	Tier 1	MO
isosorbide mononitrate tabs 10mg, 20mg; tb24 30mg, 60mg, 120mg	Tier 1	MO
NITRO-BID OINT 2%	Tier 3	MO
NITRO-DUR PT24 .3MG/HR, .8MG/HR	Tier 2	MO
nitroglycerin pt24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	Tier 1	MO
nitroglycerin (generic of NITROLINGUAL PUMPSPRAY) SOLN .4mg/spray	Tier 1	MO
nitroglycerin (generic of NITROSTAT) SUBL .3mg, .4mg, .6mg	Tier 1	MO
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS TABS .5MG, 1MG, 1.5MG, 2MG, 2.5MG	Tier 4	SP, PA, QL (90 tabs every 30 days)
ambrisentan (generic of LETAIRIS) TABS 5mg, 10mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
bosentan (generic of TRACLEER) TABS 62.5mg, 125mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
OPSUMIT TABS 10MG	Tier 4	SP, PA, QL (30 tabs every 30 days)
ORENITRAM TBCR .125MG, .25MG, 1MG, 2.5MG, 5MG	Tier 4	SP, PA
ORENITRAM TAB MONTH 1	Tier 4	SP, PA
ORENITRAM TAB MONTH 2	Tier 4	SP, PA
ORENITRAM TAB MONTH 3	Tier 4	SP, PA
REMODULIN SOLN 20MG/20ML, 50MG/20ML, 100MG/20ML, 200MG/20ML	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sildenafil citrate (pulmonary hypertension) (generic of REVATIO) SOLN 10mg/12.5ml	MB	
sildenafil citrate (pulmonary hypertension) (generic of REVATIO) TABS 20mg	Tier 4	SP, PA, QL (360 tabs every 30 days)
tadalafil (pulmonary hypertension) (generic of ADCIRCA) TABS 20mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
TYVASO SOLN .6MG/ML	Tier 4	SP, PA, QL (28 ampules every 28 days)
TYVASO REFILL SOLN .6MG/ML	Tier 4	SP, PA, QL (28 ampules every 28 days)
TYVASO STARTER SOLN .6MG/ML	Tier 4	SP, PA, QL (28 ampules every 28 days)
UPTRAVI SOLR 1800MCG	MB	
UPTRAVI TABS 200MCG	Tier 4	SP, PA, QL (140 tabs every 28 days)
UPTRAVI TABS 400MCG, 600MCG, 800MCG, 1000MCG, 1200MCG, 1400MCG, 1600MCG	Tier 4	SP, PA, QL (60 tabs every 30 days)
UPTRAVI PACK TAB 200/800	Tier 4	SP, PA, QL (1 pack every 28 days)
VENTAVIS SOLN 10MCG/ML, 20MCG/ML	Tier 4	SP, PA, QL (270 ampules every 30 days)
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
acamprosate calcium tbec 333mg	Tier 1	PA, MO
disulfiram tabs 250mg, 500mg	Tier 1	MO
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam (generic of XANAX) TABS .25mg, .5mg, 1mg, 2mg	Tier 1	QL (150 tabs every 30 days)
alprazolam tbdp .25mg, .5mg, 1mg, 2mg	Tier 1	QL (150 tabs every 30 days)
ALPRAZOLAM INTENSOL CONC 1MG/ML	Tier 2	QL (300 mL every 30 days)
buspirone hcl tabs 5mg, 7.5mg, 10mg, 15mg, 30mg	Tier 1	
clomipramine hcl (generic of ANAFRANIL) CAPS 25mg, 50mg	Tier 1	QL (150 caps every 30 days), MO; QL applies to members age 65 and older
clomipramine hcl (generic of ANAFRANIL) CAPS 75mg	Tier 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	Tier 1	MO
lorazepam conc 2mg/ml	Tier 1	QL (150 mL every 30 days)
lorazepam (generic of ATIVAN) TABS .5mg, 1mg, 2mg	Tier 1	QL (150 tabs every 30 days)
meprobamate tabs 200mg, 400mg	Tier 1	
oxazepam caps 10mg, 15mg, 30mg	Tier 1	QL (120 caps every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride tabs 5mg; tbdp 5mg, 10mg	Tier 1	MO
donepezil hydrochloride (generic of ARICEPT) TABS 10mg, 23mg	Tier 1	MO
galantamine hydrobromide cp24 8mg, 16mg, 24mg; soln 4mg/ml; tabs 4mg, 8mg, 12mg	Tier 1	MO
memantine hcl cp24 7mg; soln 2mg/ml	Tier 1	PA, MO; PA applies for members less than 30 years of age
memantine hcl (generic of NAMENDA XR) CP24 14mg, 21mg, 28mg	Tier 1	PA, MO; PA applies for members less than 30 years of age
memantine hcl (generic of NAMENDA) TABS 5mg, 10mg	Tier 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 (generic of NAMENDA TITRATION PAK)	Tier 1	PA; PA applies for members less than 30 years of age
rivastigmine (generic of EXELON) PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	Tier 1	PA, MO
rivastigmine tartrate caps 1.5mg, 3mg, 4.5mg, 6mg	Tier 1	PA, MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
amitriptyline hcl tabs 10mg	Tier 1	QL (150 tabs every 30 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 25mg	Tier 1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 50mg	Tier 1	QL (30 tabs every 30 days), MO; QL applies to members age 65 and older
amitriptyline hcl tabs 75mg, 100mg, 150mg	Tier 1	PA, MO; High strength requires PA for members age 70 and older
amoxapine tabs 25mg, 50mg, 100mg	Tier 1	QL (90 tabs every 30 days), MO; QL applies to members age 65 and older
amoxapine tabs 150mg	Tier 1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
bupropion hcl tabs 75mg, 100mg	Tier 1	MO
bupropion hcl (generic of WELLBUTRIN SR) TB12 100mg, 150mg, 200mg	Tier 1	MO
bupropion hcl (generic of WELLBUTRIN XL) TB24 150mg, 300mg	Tier 1	MO
citalopram hydrobromide soln 10mg/5ml	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
citalopram hydrobromide (generic of CELEXA) TABS 10mg, 20mg, 40mg	Tier 1	MO
desipramine hcl (generic of NORPRAMIN) TABS 10mg, 25mg	Tier 1	QL (90 tabs every 30 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 50mg	Tier 1	QL (90 tabs every 30 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 75mg	Tier 1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
desipramine hcl tabs 100mg, 150mg	Tier 1	QL (30 tabs every 30 days), MO; QL applies to members age 65 and older
desvenlafaxine succinate (generic of PRISTIQ) TB24 25mg, 50mg, 100mg	Tier 1	ST, QL (30 tabs every 30 days), MO; (generic of Pristiq) PA**
doxepin hcl caps 10mg, 25mg, 50mg	Tier 1	QL (90 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl caps 75mg	Tier 1	QL (60 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl caps 100mg, 150mg	Tier 1	QL (30 caps every 30 days), MO; QL applies to members age 65 and older
doxepin hcl conc 10mg/ml	Tier 1	QL (450 mL every 30 days), MO; QL applies to members age 65 and older
duloxetine hcl (generic of CYMBALTA) CPEP 20mg, 30mg, 60mg	Tier 1	MO
EMSAM PT24 6MG/24HR, 9MG/24HR, 12MG/24HR	Tier 3	PA, MO
escitalopram oxalate soln 5mg/5ml	Tier 1	MO
escitalopram oxalate (generic of LEXAPRO) TABS 5mg, 10mg, 20mg	Tier 1	MO
FETZIMA CP24 20MG, 40MG, 80MG, 120MG	Tier 3	ST, QL (30 caps every 30 days), MO; PA**
FETZIMA CAP TITRATIO	Tier 3	ST, QL (30 caps every 30 days); PA**
fluoxetine hcl (generic of PROZAC) CAPS 10mg, 20mg, 40mg	Tier 1	MO
fluoxetine hcl cpdr 90mg; soln 20mg/5ml	Tier 1	MO
fluoxetine hcl tabs 10mg, 20mg	Tier 1	MO; (generic Sarafem not covered)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
imipramine hcl tabs 10mg, 25mg	Tier 1	QL (120 tabs every 30 days), MO; QL applies to members age 65 and older
imipramine hcl tabs 50mg	Tier 1	QL (60 tabs every 30 days), MO; QL applies to members age 65 and older
imipramine pamoate caps 75mg, 100mg	Tier 1	QL (30 caps every 30 days), MO; QL applies to members age 65 and older
imipramine pamoate caps 125mg, 150mg	Tier 1	PA, MO; High strength requires PA for members age 70 and older
MARPLAN TABS 10MG	Tier 3	MO
mirtazapine tabs 7.5mg, 45mg	Tier 1	MO
mirtazapine (generic of REMERON) TABS 15mg, 30mg	Tier 1	MO
mirtazapine (generic of REMERON SOLTAB) TBDP 15mg, 30mg, 45mg	Tier 1	MO
nefazodone hcl tabs 50mg, 100mg, 150mg, 200mg, 250mg	Tier 1	MO
nortriptyline hcl (generic of PAMELOR) CAPS 10mg	Tier 1	QL (150 caps every 30 days), MO; QL applies to members age 65 and older
nortriptyline hcl (generic of PAMELOR) CAPS 25mg	Tier 1	QL (60 caps every 30 days), MO; QL applies to members age 65 and older
nortriptyline hcl (generic of PAMELOR) CAPS 50mg	Tier 1	QL (30 caps every 30 days), MO; QL applies to members age 65 and older
nortriptyline hcl (generic of PAMELOR) CAPS 75mg	Tier 1	PA, MO; High strength requires PA for members age 65 and older
nortriptyline hcl soln 10mg/5ml	Tier 1	QL (750 mL every 30 days), MO; QL applies to members age 65 and older
paroxetine hcl (generic of PAXIL) TABS 10mg, 20mg, 30mg, 40mg	Tier 1	MO
paroxetine hcl (generic of PAXIL CR) TB24 12.5mg, 25mg, 37.5mg	Tier 1	MO
phenelzine sulfate (generic of NARDIL) TABS 15mg	Tier 1	MO
protriptyline hcl tabs 5mg	Tier 1	QL (90 tabs every 30 days), MO; QL applies to members age 65 and older
protriptyline hcl tabs 10mg	Tier 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
sertraline hcl (generic of ZOLOFT) CONC 20mg/ml; TABS 25mg, 50mg, 100mg	Tier 1	MO
tranylcypromine sulfate (generic of PARNATE) TABS 10mg	Tier 1	MO
trazodone hcl tabs 50mg, 100mg, 150mg, 300mg	Tier 1	MO
trimipramine maleate caps 25mg, 50mg	Tier 1	QL (60 caps every 30 days), MO; QL applies to members age 65 and older
trimipramine maleate caps 100mg	Tier 1	QL (30 caps every 30 days), MO; QL applies to members age 65 and older
venlafaxine hcl (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg	Tier 1	MO
venlafaxine hcl tabs 25mg, 37.5mg, 50mg, 75mg, 100mg; tb24 37.5mg, 75mg, 150mg	Tier 1	MO
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl caps 100mg; soln 50mg/5ml; tabs 100mg	Tier 1	MO
APOKYN SOCT 30MG/3ML	MB	
benztropine mesylate soln 1mg/ml	MB	
benztropine mesylate tabs .5mg, 1mg, 2mg	Tier 1	MO
bromocriptine mesylate (generic of PARLODEL) CAPS 5mg; TABS 2.5mg	Tier 1	MO
carbidopa tabs 25mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 10-100 mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 25-100 mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 25-250 mg	Tier 1	MO
carbidopa & levodopa tab 10-100 mg (generic of SINEMET)	Tier 1	MO
carbidopa & levodopa tab 25-100 mg (generic of SINEMET)	Tier 1	MO
carbidopa & levodopa tab 25-250 mg	Tier 1	MO
carbidopa & levodopa tab er 25-100 mg	Tier 1	MO
carbidopa & levodopa tab er 50-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg (generic of STALEVO 50)	Tier 1	MO
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg (generic of STALEVO 75)	Tier 1	MO
carbidopa-levodopa-entacapone tabs 25-100-200 mg (generic of STALEVO 100)	Tier 1	MO
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg (generic of STALEVO 125)	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg (generic of STALEVO 150)	Tier 1	MO
carbidopa-levodopa-entacapone tabs 50-200-200 mg (generic of STALEVO 200)	Tier 1	MO
entacapone (generic of COMTAN) TABS 200mg	Tier 1	MO
INBRIJA CAPS 42MG	Tier 4	PA, QL (300 caps every 30 days)
NEUPRO PT24 1MG/24HR, 2MG/24HR, 3MG/24HR, 4MG/24HR, 6MG/24HR, 8MG/24HR	Tier 2	MO
pramipexole dihydrochloride tabs .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg; tb24 1.5mg	Tier 1	MO
pramipexole dihydrochloride (generic of MIRAPEX ER) TB24 .375mg, .75mg, 2.25mg, 3mg, 3.75mg, 4.5mg	Tier 1	MO
rasagiline mesylate (generic of AZILECT) TABS .5mg, 1mg	Tier 1	MO
ropinirole hydrochloride tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	Tier 1	MO
selegiline hcl caps 5mg; tabs 5mg	Tier 1	MO
trihexyphenidyl hcl soln .4mg/ml; tabs 2mg, 5mg	Tier 1	MO
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
aripiprazole soln 1mg/ml; tbdp 10mg, 15mg	Tier 1	MO
aripiprazole (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg	Tier 1	MO
ARISTADA PRSY 441MG/1.6ML, 662MG/2.4ML, 882MG/3.2ML, 1064MG/3.9ML	MB	
ARISTADA INITIO PRSY 675MG/2.4ML	MB	
asenapine maleate (generic of SAPHRIS) SUBL 2.5mg, 5mg, 10mg	Tier 1	MO
chlorpromazine hcl soln 25mg/ml, 50mg/2ml	MB	
chlorpromazine hcl tabs 10mg, 25mg, 50mg, 100mg, 200mg	Tier 1	MO
clozapine (generic of CLOZARIL) TABS 25mg, 50mg, 100mg, 200mg	Tier 1	
clozapine tbdp 12.5mg, 25mg, 100mg, 150mg, 200mg	Tier 1	
fluphenazine decanoate soln 25mg/ml	MB	
fluphenazine hcl conc 5mg/ml; elix 2.5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg	Tier 1	MO
fluphenazine hcl soln 2.5mg/ml	MB	
haloperidol tabs .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	Tier 1	MO
haloperidol decanoate (generic of HALDOL DECANOATE 50) SOLN 50mg/ml	MB	
haloperidol decanoate (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
haloperidol lactate conc 2mg/ml	Tier 1	MO
haloperidol lactate soln 5mg/ml	MB	
loxapine succinate caps 5mg, 10mg, 25mg, 50mg	Tier 1	MO
lurasidone hcl (generic of LATUDA) TABS 20mg, 40mg, 60mg, 80mg, 120mg	Tier 1	MO
olanzapine (generic of ZYPREXA) SOLR 10mg	MB	
olanzapine (generic of ZYPREXA) TABS 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg	Tier 1	MO
olanzapine (generic of ZYPREXA ZYDIS) TBDP 5mg, 10mg, 15mg, 20mg	Tier 1	MO
paliperidone tb24 1.5mg	Tier 1	MO
paliperidone (generic of INVEGA) TB24 3mg, 6mg, 9mg	Tier 1	MO
perphenazine tabs 2mg, 4mg, 8mg, 16mg	Tier 1	MO
quetiapine fumarate (generic of SEROQUEL) TABS 25mg, 50mg, 100mg, 200mg, 300mg, 400mg	Tier 1	MO
quetiapine fumarate (generic of SEROQUEL XR) TB24 50mg, 150mg, 200mg, 300mg, 400mg	Tier 1	MO
risperidone (generic of RISPERDAL) SOLN 1mg/ml; TABS .5mg, 1mg, 2mg, 3mg, 4mg	Tier 1	MO
risperidone tabs .25mg; tbdp .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	Tier 1	MO
thioridazine hcl tabs 10mg, 25mg, 50mg, 100mg	Tier 1	MO
thiothixene caps 1mg, 2mg, 5mg, 10mg	Tier 1	MO
trifluoperazine hcl tabs 1mg, 2mg, 5mg, 10mg	Tier 1	MO
VRAYLAR CAPS 1.5MG, 3MG, 4.5MG, 6MG	Tier 2	ST, MO; PA**
VRAYLAR CAP 1.5-3MG	Tier 2	ST; PA**
ziprasidone hcl (generic of GEODON) CAPS 20mg, 40mg, 60mg, 80mg	Tier 1	MO
ANTISEIZURE AGENTS		
carbamazepine chew 100mg	Tier 1	MO
carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg	Tier 1	MO
carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml; TABS 200mg	Tier 1	MO
carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg	Tier 1	MO
clobazam (generic of ONFI) SUSP 2.5mg/ml; TABS 10mg, 20mg	Tier 1	MO
clonazepam (generic of KLONOPIN) TABS .5mg, 1mg, 2mg	Tier 1	
clorazepate dipotassium tabs 3.75mg, 7.5mg, 15mg	Tier 1	QL (180 tabs every 30 days)
diazepam conc 5mg/ml	Tier 1	QL (240 mL every 30 days)
diazepam soln 5mg/5ml	Tier 1	QL (1200 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diazepam soln 5mg/ml	MB	
diazepam (generic of VALIUM) TABS 2mg, 5mg, 10mg	Tier 1	QL (120 tabs every 30 days)
DILANTIN CAPS 30MG	Tier 3	MO
divalproex sodium (generic of DEPAKOTE SPRINKLES) CSDR 125mg	Tier 1	MO
divalproex sodium (generic of DEPAKOTE ER) TB24 250mg, 500mg	Tier 1	MO
divalproex sodium (generic of DEPAKOTE) TBEC 125mg, 250mg, 500mg	Tier 1	MO
ethosuximide (generic of ZARONTIN) CAPS 250mg; SOLN 250mg/5ml	Tier 1	MO
felbamate susp 600mg/5ml	Tier 1	MO
felbamate (generic of FELBATOL) TABS 400mg, 600mg	Tier 1	MO
fosphenytoin sodium (generic of CEREBYX) SOLN 100mgpe/2ml, 500mgpe/10ml	MB	
gabapentin (generic of NEURONTIN) CAPS 100mg, 300mg, 400mg	Tier 1	QL (6 caps every day), MO
gabapentin (generic of NEURONTIN) SOLN 250mg/5ml	Tier 1	QL (72 mL every day), MO
gabapentin (generic of NEURONTIN) TABS 600mg	Tier 1	QL (6 tabs every day), MO
gabapentin (generic of NEURONTIN) TABS 800mg	Tier 1	QL (4 tabs every day), MO
lacosamide (generic of VIMPAT) SOLN 10mg/ml; TABS 50mg, 100mg, 150mg, 200mg	Tier 1	MO
lacosamide (generic of VIMPAT) SOLN 200mg/20ml	MB	
lamotrigine (generic of LAMICTAL CHEWABLE DISPERS) CHEW 5mg, 25mg	Tier 1	MO
lamotrigine (generic of LAMICTAL STARTER/TAKING V) KIT 25mg	Tier 1	
lamotrigine (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	Tier 1	MO
lamotrigine (generic of LAMICTAL XR) TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	Tier 1	MO
lamotrigine (generic of LAMICTAL ODT) TBDP 25mg, 50mg, 100mg, 200mg	Tier 1	MO
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit (generic of LAMICTAL STARTER/NOT TAKI)	Tier 1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit (generic of LAMICTAL STARTER/TAKING C)	Tier 1	
levetiracetam (generic of KEPPRA) SOLN 100mg/ml; TABS 250mg, 500mg, 750mg, 1000mg	Tier 1	MO
levetiracetam (generic of KEPPRA) SOLN 500mg/5ml	MB	
levetiracetam (generic of KEPPRA XR) TB24 500mg, 750mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levetiracetam in sodium chloride iv soln 500 mg/100ml (generic of LEVETIRACETAM)	MB	
levetiracetam in sodium chloride iv soln 1000 mg/100ml (generic of LEVETIRACETAM)	MB	
levetiracetam in sodium chloride iv soln 1500 mg/100ml (generic of LEVETIRACETAM)	MB	
methsuximide (generic of CELONTIN) CAPS 300mg	Tier 1	MO
NAYZILAM SOLN 5MG/0.1ML	Tier 2	QL (10 units every 30 days)
oxcarbazepine (generic of TRILEPTAL) SUSP 60mg/ml; TABS 150mg, 300mg, 600mg	Tier 1	MO
phenobarbital elix 20mg/5ml; tabs 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	Tier 1	MO
phenytoin (generic of DILANTIN INFATABS) CHEW 50mg	Tier 1	MO
phenytoin (generic of DILANTIN-125) SUSP 125mg/5ml	Tier 1	MO
phenytoin sodium soln 50mg/ml	MB	
phenytoin sodium extended (generic of DILANTIN) CAPS 100mg	Tier 1	MO
phenytoin sodium extended caps 200mg, 300mg	Tier 1	MO
pregabalin (generic of LYRICA) CAPS 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg; SOLN 20mg/ml	Tier 1	ST, MO; PA**
primidone (generic of MYSOLINE) TABS 50mg, 250mg	Tier 1	MO
tiagabine hcl tabs 2mg, 4mg, 12mg, 16mg	Tier 1	MO
topiramate (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	Tier 1	MO
topiramate (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg	Tier 1	MO
valproate sodium soln 100mg/ml	MB	
valproate sodium soln 250mg/5ml	Tier 1	MO
valproic acid caps 250mg	Tier 1	MO
vigabatrin (generic of SABRIL) PACK 500mg	Tier 4	SP, PA, QL (180 packets every 30 days)
vigabatrin (generic of SABRIL) TABS 500mg	Tier 4	SP, PA, QL (180 tabs every 30 days)
XCOPRI TABS 50MG, 100MG, 150MG, 200MG	Tier 2	MO
XCOPRI PAK 12.5-25	Tier 2	
XCOPRI PAK 50-100MG	Tier 2	
XCOPRI PAK 100-150	Tier 2	MO
XCOPRI PAK 150-200	Tier 2	
XCOPRI PAK 150-200	Tier 2	MO
zonisamide (generic of ZONEGRAN) CAPS 25mg, 100mg	Tier 1	MO
zonisamide caps 50mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
amphetamine-dextroamphetamine cap er 24hr 5 mg (generic of ADDERALL XR)	Tier 1	QL (90 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 10 mg (generic of ADDERALL XR)	Tier 1	QL (90 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 15 mg (generic of ADDERALL XR)	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 20 mg (generic of ADDERALL XR)	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 25 mg (generic of ADDERALL XR)	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 30 mg (generic of ADDERALL XR)	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine tab 5 mg (generic of ADDERALL)	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 7.5 mg (generic of ADDERALL)	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 10 mg (generic of ADDERALL)	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 12.5 mg (generic of ADDERALL)	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 15 mg (generic of ADDERALL)	Tier 1	QL (60 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 20 mg (generic of ADDERALL)	Tier 1	QL (60 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 30 mg (generic of ADDERALL)	Tier 1	QL (30 tabs every 30 days), MO
atomoxetine hcl (generic of STRATTERA) CAPS 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg	Tier 1	MO
dexmethylphenidate hcl (generic of FOCALIN XR) CP24 5mg, 10mg, 15mg, 20mg	Tier 1	QL (60 caps every 30 days), MO
dexmethylphenidate hcl (generic of FOCALIN XR) CP24 25mg, 30mg, 35mg, 40mg	Tier 1	QL (30 caps every 30 days), MO
dexmethylphenidate hcl (generic of FOCALIN) TABS 2.5mg, 5mg	Tier 1	QL (120 tabs every 30 days), MO
dexmethylphenidate hcl (generic of FOCALIN) TABS 10mg	Tier 1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate cp24 5mg	Tier 1	QL (120 caps every 30 days), MO
dextroamphetamine sulfate (generic of DEXEDRINE) CP24 10mg	Tier 1	QL (120 caps every 30 days), MO
dextroamphetamine sulfate cp24 15mg	Tier 1	QL (60 caps every 30 days), MO
dextroamphetamine sulfate soln 5mg/5ml	Tier 1	QL (1,200 mL every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dextroamphetamine sulfate tabs 2.5mg, 5mg, 7.5mg, 10mg	Tier 1	QL (120 tabs every 30 days), MO
dextroamphetamine sulfate tabs 15mg, 20mg	Tier 1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate tabs 30mg	Tier 1	QL (30 tabs every 30 days), MO
guanfacine hcl (adhd) (generic of INTUNIV) TB24 1mg, 2mg, 3mg, 4mg	Tier 1	MO
methamphetamine hcl (generic of DESOXYN) TABS 5mg	Tier 1	QL (150 tabs every 30 days), MO
methylphenidate hcl chew 2.5mg, 5mg, 10mg	Tier 1	QL (180 chew tabs every 30 days), MO
methylphenidate hcl (generic of RITALIN LA) CP24 20mg, 30mg	Tier 1	QL (60 caps every 30 days), MO
methylphenidate hcl (generic of RITALIN LA) CP24 40mg	Tier 1	QL (30 caps every 30 days), MO
methylphenidate hcl cp24 60mg; cpcr 40mg, 50mg, 60mg	Tier 1	QL (30 caps every 30 days), MO
methylphenidate hcl cpcr 10mg, 20mg, 30mg	Tier 1	QL (60 caps every 30 days), MO
methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml	Tier 1	QL (1800 mL every 30 days), MO
methylphenidate hcl (generic of METHYLIN) SOLN 10mg/5ml	Tier 1	QL (900 mL every 30 days), MO
methylphenidate hcl (generic of RITALIN) TABS 5mg, 10mg	Tier 1	QL (180 tabs every 30 days), MO
methylphenidate hcl (generic of RITALIN) TABS 20mg	Tier 1	QL (90 tabs every 30 days), MO
methylphenidate hcl tbcr 10mg, 20mg	Tier 1	QL (90 tabs every 30 days), MO
methylphenidate hcl (generic of CONCERTA) TBCR 18mg, 27mg, 36mg	Tier 1	QL (60 tabs every 30 days), MO
methylphenidate hcl (generic of CONCERTA) TBCR 54mg	Tier 1	QL (30 tabs every 30 days), MO
VYVANSE CAPS 10MG, 20MG, 30MG	Tier 2	QL (60 caps every 30 days), MO
VYVANSE CAPS 40MG, 50MG, 60MG, 70MG	Tier 2	QL (30 caps every 30 days), MO
VYVANSE CHEW 10MG, 20MG, 30MG	Tier 2	QL (60 chew tabs every 30 days), MO
VYVANSE CHEW 40MG, 50MG, 60MG	Tier 2	QL (30 chew tabs every 30 days), MO
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
BELSOMRA TABS 5MG, 10MG, 15MG, 20MG	Tier 2	ST; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
eszopiclone (generic of LUNESTA) TABS 1mg, 2mg, 3mg	Tier 1	QL (15 tabs every 30 days)
ramelteon (generic of ROZEREM) TABS 8mg	Tier 1	QL (15 tabs every 30 days)
tasimelteon (generic of HETLIOZ) CAPS 20mg	Tier 4	SP, PA, QL (30 caps every 30 days)
temazepam (generic of RESTORIL) CAPS 7.5mg, 15mg, 22.5mg, 30mg	Tier 1	QL (15 caps every 30 days)
zaleplon caps 5mg, 10mg	Tier 1	QL (15 caps every 30 days)
zolpidem tartrate (generic of AMBIEN) TABS 5mg, 10mg	Tier 1	QL (15 tabs every 30 days)
zolpidem tartrate (generic of AMBIEN CR) TBCR 6.25mg, 12.5mg	Tier 1	QL (15 tabs every 30 days)
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
AJOVY SOAJ 225MG/1.5ML; SOSY 225MG/1.5ML	MB	
almotriptan malate tabs 6.25mg, 12.5mg	Tier 1	QL (12 tabs every 30 days)
dihydroergotamine mesylate soln 1mg/ml	MB	
eletriptan hydrobromide (generic of RELPAX) TABS 20mg, 40mg	Tier 1	QL (12 tabs every 30 days)
EMGALITY SOAJ 120MG/ML; SOSY 100MG/ML, 120MG/ML	MB	
ergotamine w/ caffeine tab 1-100 mg	Tier 3	
frovatriptan succinate (generic of FROVA) TABS 2.5mg	Tier 1	QL (18 tabs every 30 days)
naratriptan hcl tabs 1mg, 2.5mg	Tier 1	QL (12 tabs every 30 days)
QULIPTA TABS 10MG, 30MG, 60MG	Tier 2	ST, QL (30 tabs every 30 days), MO; PA**
rizatriptan benzoate tabs 5mg; tbdp 5mg	Tier 1	QL (18 tabs every 30 days)
rizatriptan benzoate (generic of MAXALT) TABS 10mg	Tier 1	QL (18 tabs every 30 days)
rizatriptan benzoate (generic of MAXALT-MLT) TBDP 10mg	Tier 1	QL (18 tabs every 30 days)
sumatriptan (generic of IMITREX) SOLN 5mg/act	Tier 1	QL (24 sprays every 30 days)
sumatriptan (generic of IMITREX) SOLN 20mg/act	Tier 1	QL (12 sprays every 30 days)
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 4mg/0.5ml	Tier 1	QL (18 syringes every 30 days)
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml	Tier 1	QL (12 units every 30 days)
sumatriptan succinate (generic of IMITREX STATDOSE REFILL) SOCT 4mg/0.5ml	Tier 1	QL (18 syringes every 30 days)
sumatriptan succinate (generic of IMITREX STATDOSE REFILL) SOCT 6mg/0.5ml	Tier 1	QL (12 units every 30 days)
sumatriptan succinate soln 6mg/0.5ml	Tier 1	QL (12 vials every 30 days)
sumatriptan succinate (generic of IMITREX) TABS 25mg, 50mg, 100mg	Tier 1	QL (12 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
UBRELVY TABS 50MG, 100MG	Tier 2	ST, QL (16 tabs every 30 days); PA**
zolmitriptan soln 2.5mg	Tier 1	QL (12 sprays every 30 days)
zolmitriptan (generic of ZOMIG) SOLN 5mg	Tier 1	QL (12 sprays every 30 days)
zolmitriptan (generic of ZOMIG) TABS 2.5mg, 5mg	Tier 1	QL (12 tabs every 30 days)
zolmitriptan tbdp 2.5mg, 5mg	Tier 1	QL (12 tabs every 30 days)
MISCELLANEOUS		
EVRYSDI SOLR .75MG/ML	Tier 4	PA, QL (2 bottles every 24 days)
LITHIUM SOLN 8MEQ/5ML	Tier 3	MO
lithium carbonate caps 150mg, 300mg, 600mg; tabs 300mg; tbcr 450mg	Tier 1	MO
lithium carbonate (generic of LITHOBID) TBCR 300mg	Tier 1	MO
pyridostigmine bromide (generic of MESTINON) SOLN 60mg/5ml; TABS 60mg	Tier 1	
pyridostigmine bromide (generic of MESTINON TIMESPAN) TBCR 180mg	Tier 1	
riluzole (generic of RILUTEK) TABS 50mg	Tier 1	MO
MOVEMENT DISORDERS		
tetrabenazine (generic of XENAZINE) TABS 12.5mg	Tier 4	SP, PA, QL (120 tabs every 30 days)
tetrabenazine (generic of XENAZINE) TABS 25mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BETASERON KIT .3MG	MB	
COPAXONE SOSY 20MG/ML, 40MG/ML	MB	
dalfampridine (generic of AMPYRA) TB12 10mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
dimethyl fumarate (generic of TECFIDERA) CPDR 120mg	Tier 4	SP, PA, QL (14 caps every 28 days)
dimethyl fumarate (generic of TECFIDERA) CPDR 240mg	Tier 4	SP, PA, QL (60 caps every 30 days)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg (generic of TECFIDERA STARTER PACK)	Tier 4	SP, PA, QL (1 kit every 30 days)
fingolimod hcl (generic of GILENYA) CAPS .5mg	Tier 4	SP, PA, QL (30 caps every 30 days)
glatiramer acetate (generic of COPAXONE) SOSY 20mg/ml, 40mg/ml	MB	
teriflunomide (generic of AUBAGIO) TABS 7mg, 14mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
TYSABRI CONC 300MG/15ML	MB	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
baclofen tabs 5mg, 10mg, 20mg	Tier 1	
carisoprodol (generic of SOMA) TABS 350mg	Tier 1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
chlorzoxazone tabs 500mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
cyclobenzaprine hcl tabs 5mg, 10mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
dantrolene sodium (generic of DANTRIUM) CAPS 25mg	Tier 1	
dantrolene sodium caps 50mg, 100mg	Tier 1	
metaxalone tabs 800mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
methocarbamol tabs 500mg, 750mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
orphenadrine citrate soln 60mg/2ml	MB	
orphenadrine citrate tb12 100mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
tizanidine hcl tabs 2mg	Tier 1	
tizanidine hcl (generic of ZANAFLEX) TABS 4mg	Tier 1	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil (generic of NUVIGIL) TABS 50mg	Tier 1	PA, QL (60 tabs every 30 days), MO
armodafinil (generic of NUVIGIL) TABS 150mg, 200mg, 250mg	Tier 1	PA, QL (30 tabs every 30 days), MO
modafinil (generic of PROVIGIL) TABS 100mg, 200mg	Tier 1	PA, QL (60 tabs every 30 days), MO
SODIUM OXYBATE SOLN 500MG/ML	Tier 4	PA, QL (540mL every 30 days)
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE)	Tier 1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE)	Tier 1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE)	Tier 1	QL (3 units every day)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE)	Tier 1	QL (2 units every day)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	Tier 1	QL (3 tabs every day)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	Tier 1	QL (3 tabs every day)
ZUBSOLV SUB 0.7-0.18	Tier 2	QL (3 units every day)
ZUBSOLV SUB 1.4-0.36	Tier 2	QL (3 units every day)
ZUBSOLV SUB 2.9-0.71	Tier 2	QL (3 units every day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZUBSOLV SUB 5.7-1.4	Tier 2	QL (3 units every day)
ZUBSOLV SUB 8.6-2.1	Tier 2	QL (2 units every day)
ZUBSOLV SUB 11.4-2.9	Tier 2	QL (1 unit every day)
OPIOID ANTAGONIST		
naloxone hcl liqd 4mg/0.1ml	Tier 1	
naloxone hcl soct .4mg/ml; soln .4mg/ml, 4mg/10ml; sosy 2mg/2ml	MB	
naltrexone hcl tabs 50mg	Tier 1	
OPIOID PARTIAL AGONISTS		
buprenorphine hcl subl 2mg, 8mg	Tier 1	QL (90 tabs every 30 days); Must obtain approval after the first 30 day supply
PSYCHOTHERAPEUTIC-MISC		
NUEDEXTA CAP 20-10MG	Tier 2	PA, MO
pimozide tabs 1mg, 2mg	Tier 1	MO
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent) tb12 150mg	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 polacrilex gum 2mg, 4mg; lozg 2mg, 4mg	PV	$0 limited to 2 treatment cycles/year
NICOTROL INHALER INHA 10MG	PV	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
NICOTROL NS SOLN 10MG/ML	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 (generic of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml, 500mcg/ml	MB	
octreotide acetate soln 200mcg/ml, 1000mcg/ml; sosy 50mcg/ml, 100mcg/ml, 500mcg/ml	MB	
SOMATULINE DEPOT SOLN 60MG/0.2ML, 90MG/0.3ML, 120MG/0.5ML	MB	
SOMAVERT SOLR 10MG, 15MG, 20MG, 25MG, 30MG	MB	
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
testosterone (generic of FORTESTA) GEL 10mg/act	Tier 1	PA, MO
testosterone gel 25mg/2.5gm	Tier 1	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
testosterone cypionate soln 100mg/ml, 200mg/ml	MB	
testosterone enanthate soln 200mg/ml	MB	
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tabs 25mg, 50mg, 100mg	Tier 1	MO
miglitol tabs 25mg, 50mg, 100mg	Tier 1	MO
ANTIDIABETICS, AMYLIN ANALOGS		
SYMLINPEN 60 SOPN 1500MCG/1.5ML	Tier 3	ST, MO; PA**
SYMLINPEN 120 SOPN 2700MCG/2.7ML	Tier 3	ST, MO; PA**
ANTIDIABETICS, BIGUANIDE		
metformin hcl tabs 500mg, 850mg, 1000mg; tb24 500mg, 750mg	Tier 1	MO
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
glipizide-metformin hcl tab 2.5-250 mg	Tier 1	MO
glipizide-metformin hcl tab 2.5-500 mg	Tier 1	MO
glipizide-metformin hcl tab 5-500 mg	Tier 1	MO
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 INHIBITORS		
alogliptin benzoate tabs 6.25mg, 12.5mg, 25mg	Tier 1	ST, MO; PA**
JANUVIA TABS 25MG, 50MG, 100MG	Tier 2	ST, MO; PA**
ANTIDIABETICS, DPP-4 INHIBITOR COMBINATIONS		
alogliptin-metformin hcl tab 12.5-500 mg	Tier 1	ST, MO; PA**
alogliptin-metformin hcl tab 12.5-1000 mg	Tier 1	ST, MO; PA**
JANUMET TAB 50-500MG	Tier 2	ST, MO; PA**
JANUMET TAB 50-1000	Tier 2	ST, MO; PA**
JANUMET XR TAB 50-500MG	Tier 2	ST, MO; PA**
JANUMET XR TAB 50-1000	Tier 2	ST, MO; PA**
JANUMET XR TAB 100-1000	Tier 2	ST, MO; PA**
JENTADUETO TAB XR	Tier 3	ST, MO; PA**
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
OZEMPIC SOPN 2MG/1.5ML	Tier 2	ST, QL (1.5 mL every 28 days), MO; PA**
OZEMPIC SOPN 2MG/3ML, 4MG/3ML	Tier 2	ST, QL (3 mL every 28 days), MO; PA**
OZEMPIC INJ 8MG/3ML	Tier 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	Tier 2	ST, QL (4 pens every 28 days), MO; PA**
VICTOZA SOPN 18MG/3ML	Tier 2	ST, QL (3 pens every 30 days), MO; PA**
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA INJ 100/33	Tier 2	MO; PA**
XULTOPHY INJ 100/3.6	Tier 2	MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN SOPN 100UNIT/ML	Tier 2	MO
BASAGLAR TEMPO PEN SOPN 100UNIT/ML	Tier 2	MO
FIASP FLEX INJ TOUCH	Tier 2	MO
FIASP INJ 100/ML	Tier 2	MO
FIASP PENFIL INJ U-100	Tier 2	MO
HUMULIN INJ 70/30	Tier 3	MO
HUMULIN INJ 70/30KWP	Tier 3	MO
HUMULIN N SUSP 100UNIT/ML	Tier 3	MO
HUMULIN N KWIKPEN SUPN 100UNIT/ML	Tier 3	MO
HUMULIN R SOLN 100UNIT/ML	Tier 3	MO
HUMULIN R U-500 (CONCENTR SOLN 500UNIT/ML	Tier 2	MO
HUMULIN R U-500 KWIKPEN SOPN 500UNIT/ML	Tier 2	MO
LEVEMIR SOLN 100UNIT/ML	Tier 2	MO
LEVEMIR FLEXPEN SOPN 100UNIT/ML	Tier 2	MO
NOVOLIN INJ 70/30	Tier 2	MO; RELION not covered
NOVOLIN INJ 70/30 FP	Tier 2	MO; RELION not covered
NOVOLIN N SUSP 100UNIT/ML	Tier 2	MO; RELION not covered
NOVOLIN N FLEXPEN SUPN 100UNIT/ML	Tier 2	MO; RELION not covered
NOVOLIN R SOLN 100UNIT/ML	Tier 2	MO; RELION not covered
NOVOLIN R FLEXPEN SOPN 100UNIT/ML	Tier 2	MO; RELION not covered
NOVOLOG SOLN 100UNIT/ML	Tier 2	MO
NOVOLOG FLEXPEN SOPN 100UNIT/ML	Tier 2	MO
NOVOLOG MIX INJ 70/30	Tier 2	MO
NOVOLOG MIX INJ FLEXPEN	Tier 2	MO
NOVOLOG PENFILL SOCT 100UNIT/ML	Tier 2	MO
TRESIBA SOLN 100UNIT/ML	Tier 2	MO
TRESIBA FLEXTOUCH SOPN 100UNIT/ML, 200UNIT/ML	Tier 2	MO
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl (generic of ACTOS) TABS 15mg, 30mg, 45mg	Tier 1	MO
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl tab 15-500 mg	Tier 1	MO
pioglitazone hcl-metformin hcl tab 15-850 mg (generic of ACTOPLUS MET)	Tier 1	MO
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride tab 30-2 mg (generic of DUETACT)	Tier 1	MO
pioglitazone hcl-glimepiride tab 30-4 mg (generic of DUETACT)	Tier 1	MO
ANTIDIABETICS, MEGLITINIDE		
nateglinide tabs 60mg, 120mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
repaglinide tabs .5mg, 1mg, 2mg	Tier 1	MO
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
SYNJARDY TAB	Tier 2	ST, MO; PA**
SYNJARDY TAB 5-500MG	Tier 2	ST, MO; PA**
SYNJARDY TAB 5-1000MG	Tier 2	ST, MO; PA**
SYNJARDY TAB 12.5-500	Tier 2	ST, MO; PA**
SYNJARDY XR TAB	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 5-1000MG	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 10-1000	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 25-1000	Tier 2	ST, MO; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI TAB 10-5 MG	Tier 2	ST, MO; PA**
GLYXAMBI TAB 25-5 MG	Tier 2	ST, MO; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
JARDIANCE TABS 10MG, 25MG	Tier 2	ST, MO; PA**
ANTIDIABETICS, SULFONYLUREA		
glimepiride tabs 1mg, 2mg, 4mg	Tier 1	MO
glipizide tabs 5mg, 10mg	Tier 1	MO
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg, 10mg	Tier 1	MO
BISPHOSPHONATES - DRUGS TO TREAT BONE LOSS		
alendronate sodium soln 70mg/75ml; tabs 5mg, 10mg, 35mg	Tier 1	MO
alendronate sodium (generic of FOSAMAX) TABS 70mg	Tier 1	MO
FOSAMAX + D TAB 70-2800	Tier 3	ST, MO; PA**
FOSAMAX + D TAB 70-5600	Tier 3	ST, MO; PA**
ibandronate sodium soln 3mg/3ml	MB	
ibandronate sodium tabs 150mg	Tier 1	MO
pamidronate disodium soln 30mg/10ml	MB	
risedronate sodium tabs 5mg	Tier 1	MO
risedronate sodium tabs 30mg	Tier 1	
risedronate sodium (generic of ACTONEL) TABS 35mg, 150mg	Tier 1	MO
risedronate sodium (generic of ATELVIA) TBEC 35mg	Tier 1	MO
zoledronic acid conc 4mg/5ml	MB	
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	MB	
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl (generic of SENSIPAR) TABS 30mg, 60mg	Tier 4	SP, PA, QL (60 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
cinacalcet hcl (generic of SENSIPAR) TABS 90mg	Tier 4	SP, PA, QL (120 tabs every 30 days)
CHELATING AGENTS		
ADDYI TABS 100MG	Tier 3	PA, MO
CHEMET CAPS 100MG	Tier 3	
deferiprone (generic of FERRIPROX) TABS 500mg, 1000mg	Tier 4	SP, PA
FERRIPROX SOLN 100MG/ML	Tier 4	PA
FERRIPROX TWICE-A-DAY TABS 1000MG	Tier 4	PA
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	Tier 4	SP, PA
sildenafil citrate (generic of VIAGRA) TABS 25mg, 50mg, 100mg	Tier 1	PA, QL (8 tabs every 21 days)
sodium polystyrene sulfonate susp 15gm/60ml	Tier 1	
tadalafil (generic of CIALIS) TABS 10mg, 20mg	Tier 1	PA, QL (8 tabs every 21 days)
vardenafil hcl tabs 2.5mg, 5mg, 10mg, 20mg; tbdp 10mg	Tier 1	PA, QL (8 tabs every 21 days)
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ANNOVERA MIS	PV	QL (1 every 300 days), MO
CAYA DPR	MB	
CONDOMS MIS	PV	QL (12 condoms every 30 days)
DEPO-SUBQ PROVERA 104 SUSY 104MG/0.65ML	MB	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	PV	MO
desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg	PV	MO
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg (generic of BEYAZ)	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg (generic of SAFYRAL)	PV	MO
drospirenone-ethinyl estradiol tab 3-0.02 mg (generic of YAZ)	PV	MO
drospirenone-ethinyl estradiol tab 3-0.03 mg (generic of YASMIN 28)	PV	MO
DUREX MIS REALFEEL	PV	QL (12 condoms every 30 days)
ELLA TABS 30MG	PV	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	PV	MO
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr (generic of NUVARING)	PV	QL (13 every 300 days), MO
FC2 FEMALE MIS CONDOM	PV	QL (12 condoms every 30 days)
FEMCAP MIS 22MM	MB	
FEMCAP MIS 26MM	MB	
FEMCAP MIS 30MM	MB	
KYLEENA IUD 19.5MG	MB	
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg	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)	PV	MO
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	PV	MO
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	PV	MO
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO
levonorgestrel (emergency oc) tabs 1.5mg	PV	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	PV	MO
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	PV	MO
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21) (generic of BALCOLTRA)	PV	MO
LILETTA IUD 20.1MCG/DAY	MB	
LO LOESTRIN TAB 1-10-10	PV	MO
medroxyprogesterone acetate (contraceptive) (generic of DEPO-PROVERA CONTRACEPTIV) SUSP 150mg/ml; SUSY 150mg/ml	MB	
MIRENA IUD 20MCG/DAY	MB	
NATAZIA TAB	PV	MO
NEXPLANON IMPL 68MG	MB	
NEXTSTELLIS TAB 3-14.2MG	PV	MO
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	PV	MO
norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg	PV	MO
norethindrone & ethinyl estradiol tab 0.5 mg-35 mcg	PV	MO
norethindrone & ethinyl estradiol tab 1 mg-35 mcg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	PV	MO
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	PV	MO
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	PV	MO
norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg	PV	MO
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24) (generic of MINASTRIN 24 FE)	PV	MO
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) (generic of TAYTULLA)	PV	MO
norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)	PV	MO
norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg	PV	MO
norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg	PV	MO
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	PV	MO
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg (generic of ORTHO TRI-CYCLEN LO)	PV	MO
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	PV	MO
norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg	PV	MO
OMNIFLEX DPR	MB	
PARAGARD IUD T380A	MB	
SKYLA IUD 13.5MG	MB	
SLYND TABS 4MG	PV	MO
TRUSTEX/RIA MIS NON-LUB	PV	QL (12 condoms every 30 days)
TRUSTX NON-9 MIS RIB/STUD	PV	QL (12 condoms every 30 days)
TWIRLA DIS 120-30	PV	MO
TYBLUME CHW 0.1-0.02	PV	MO
WIDE-SEAL SILICONE DIAPHR DPRH 2%	MB	
DIABETIC SUPPLIES		
ACCU-CHEK BLOOD GLUCOSE TEST KITS	MB	
ACCU-CHEK BLOOD GLUCOSE TEST STRIPS	MB	
AUTOLET PLAT MIS 1.8MM	MB	
BLOOD GLUCOSE CALIBRATION SOLUTION	MB	
DEXCOM G5 MIS RECEIVER	MB	
DEXCOM G5 MIS TRANSMIT	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DEXCOM G6 MIS RECEIVER	MB	
DEXCOM G6 MIS SENSOR	MB	
DEXCOM G6 MIS TRANSMIT	MB	
DEXCOM G7 MIS RECEIVER	MB	
DEXCOM G7 MIS SENSOR	MB	
G4 PLAT PED MIS RVC/SHAR	MB	
G4 PLATINUM MIS PEDIATRC	MB	
G4 PLATINUM MIS RCV/SHAR	MB	
G4 PLATINUM MIS RECEIVER	MB	
G4 PLATINUM MIS TRANSMIT	MB	
G4 SENSOR MIS	MB	
G5/G4 MIS SENSOR	MB	
INSULIN PEN NEEDLES	Tier 2	
INSULIN PEN NEEDLES/SYRINGES	Tier 2	
LANCETS	MB	
LANCING DEVICE	MB	
NOVOFINE PEN NEEDLES	Tier 2	
OMNIPOD 5 G6 KIT INTRO	MB	
OMNIPOD 5 G6 MIS PODS	MB	
OMNIPOD DASH KIT INTRO	MB	
OMNIPOD DASH KIT PDM	MB	
OMNIPOD DASH MIS PODS	MB	
OMNIPOD MIS CLASSIC	MB	
OMNIPOD PDM KIT CLASSIC	MB	
URINE GLUCOSE MONITORING SUPPLIES	MB	
V-GO 20 KIT	MB	
V-GO 30 KIT	MB	
V-GO 40 KIT	MB	
ENDOMETRIOSIS		
danazol caps 50mg, 100mg, 200mg	Tier 1	
ORILISSA TABS 150MG, 200MG	Tier 2	
ENZYME REPLACEMENTS - DRUGS TO TREAT ENZYME DEFICIENCIES		
betaine anhy pow (generic of CYSTADANE)	Tier 4	SP, PA
carglumic acid (generic of CARBAGLU) TBSO 200mg	Tier 4	SP, PA
CERDELGA CAPS 84MG	Tier 4	SP, PA, QL (56 caps every 28 days)
CYSTAGON CAPS 50MG, 150MG	Tier 4	SP, PA
sapropterin dihydrochloride (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	Tier 4	SP, PA
sodium phenylbutyrate (generic of BUPHENYL) POWD 3gm/tsp	Tier 4	SP, PA, QL (798g every 30 days)
sodium phenylbutyrate (generic of BUPHENYL) TABS 500mg	Tier 4	SP, PA, QL (1200 tabs every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
CLIMARA PRO DIS WEEKLY	Tier 2	MO
DEPO-ESTRADIOL OIL 5MG/ML	MB	
DUAVEE TAB 0.45-20	Tier 2	MO
ELESTRIN GEL .06%	Tier 3	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol (generic of DIVIGEL) GEL .25mg/0.25gm, .5mg/0.5gm, .75mg/0.75gm, 1mg/gm, 1.25mg/1.25gm	Tier 1	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol (generic of VIVELLE-DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	Tier 1	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol (generic of CLIMARA) PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	Tier 1	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol (generic of ESTRACE) TABS .5mg, 1mg, 2mg	Tier 1	PA, MO; High Risk Medications require PA for members age 70 and older
estradiol & norethindrone acetate tab 0.5-0.1 mg	Tier 1	MO
estradiol & norethindrone acetate tab 1-0.5 mg (generic of ACTIVELLA)	Tier 1	MO
estradiol vaginal (generic of ESTRACE) CREA .1mg/gm	Tier 1	MO
estradiol vaginal (generic of VAGIFEM) TABS 10mcg	Tier 1	MO
estradiol valerate (generic of DELESTROGEN) OIL 20mg/ml, 40mg/ml	MB	
ESTROGEL GEL .06%	Tier 3	PA, MO; High Risk Medications require PA for members age 70 and older
EVAMIST SOLN 1.53MG/SPRAY	Tier 3	PA, MO; High Risk Medications require PA for members age 70 and older
IMVEXXY MAINTENANCE PACK INST 4MCG, 10MCG	Tier 2	MO
IMVEXXY STARTER PACK INST 4MCG, 10MCG	Tier 2	MO
MENEST TABS .3MG, .625MG, 1.25MG, 2.5MG	Tier 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	Tier 1	MO
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	Tier 1	MO
PREMARIN CREA .625MG/GM	Tier 3	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PREMARIN TABS .3MG, .45MG, .625MG, .9MG, 1.25MG	Tier 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	MB	
dexamethasone elix .5mg/5ml; soln .5mg/5ml; tabs .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	Tier 1	
DEXAMETHASONE INTENSOL CONC 1MG/ML	Tier 2	
dexamethasone sodium phosphate soln 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	MB	
fludrocortisone acetate tabs .1mg	Tier 1	MO
hydrocortisone (generic of CORTEF) TABS 5mg, 10mg, 20mg	Tier 1	
MEDROL TABS 2MG	Tier 2	
methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg	Tier 1	
methylprednisolone tabs 32mg	Tier 1	
methylprednisolone (generic of MEDROL DOSEPAK) TBPK 4mg	Tier 1	
methylprednisolone acetate (generic of DEPO-MEDROL) SUSP 40mg/ml, 80mg/ml	MB	
methylprednisolone sod succ solr 125mg	MB	
methylprednisolone sod succ (generic of SOLU-MEDROL) SOLR 1000mg	MB	
prednisolone soln 15mg/5ml	Tier 1	
prednisolone sodium phosphate (generic of PEDIAPRED) SOLN 5mg/5ml	Tier 1	
prednisolone sodium phosphate soln 15mg/5ml, 25mg/5ml; tbdp 10mg, 15mg, 30mg	Tier 1	
prednisone soln 5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg; tbpk 5mg, 10mg	Tier 1	
PREDNISONE INTENSOL CONC 5MG/ML	Tier 2	
SOLU-CORTEF SOLR 100MG, 250MG, 500MG, 1000MG	MB	
SOLU-MEDROL SOLR 2GM	MB	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
glucagon (rdna) (generic of GLUCAGON EMERGENCY KIT) KIT 1mg	Tier 1	
HEREDITARY TYROSINEMIA TYPE 1 AGENTS		
nitisinone (generic of ORFADIN) CAPS 2mg, 5mg, 10mg	Tier 4	SP, PA
ORFADIN CAPS 20MG	Tier 4	SP, PA
ORFADIN SUSP 4MG/ML	Tier 4	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
GENOTROPIN CART 5MG, 12MG	MB	
GENOTROPIN MINIQUICK PRSY .2MG, .4MG, .6MG, .8MG, 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 2MG	MB	
NORDIPEN 5 MIS DEVICE	MB	
NORDIPEN DEL MIS SYSTEM	MB	
NORDITROPIN FLEXPRO SOPN 5MG/1.5ML, 10MG/1.5ML, 15MG/1.5ML, 30MG/3ML	MB	
LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS		
SYNAREL SOLN 2MG/ML	Tier 4	PA
TRIPTODUR SRER 22.5MG	MB	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TABS 10MG, 20MG	Tier 3	PA, MO
MISCELLANEOUS		
cabergoline tabs .5mg	Tier 1	
calcitonin (salmon) soln 200unit/act	Tier 1	MO
INCRELEX SOLN 40MG/4ML	MB	
INTRAROSA INST 6.5MG	Tier 3	MO
OSPHENA TABS 60MG	Tier 3	PA, MO
PROLIA SOSY 60MG/ML	MB	
raloxifene hcl (generic of EVISTA) TABS 60mg	Tier 1	MO; $0 copay ages 35 and older for the primary prevention of breast cancer
SIGNIFOR SOLN .3MG/ML, .6MG/ML, .9MG/ML	MB	
SUPPRELIN LA KIT 50MG	MB	
tolvaptan (generic of SAMSCA) TABS 15mg, 30mg	Tier 4	SP, PA
TYMLOS SOPN 3120MCG/1.56ML	MB	
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
calcium acetate (phosphate binder) caps 667mg; tabs 667mg	Tier 1	MO
FOSRENOL PACK 750MG, 1000MG	Tier 3	MO
PHOSLYRA SOLN 667MG/5ML	Tier 2	MO
sevelamer carbonate (generic of RENVELA) PACK .8gm, 2.4gm; TABS 800mg	Tier 1	MO
VELPHORO CHEW 500MG	Tier 3	MO
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
CRINONE GEL 4%	Tier 2	
CRINONE GEL 8%	Tier 2	PA
medroxyprogesterone acetate (generic of PROVERA) TABS 2.5mg, 5mg, 10mg	Tier 1	MO
megestrol acetate (appetite) susp 625mg/5ml	Tier 1	MO; OAC
norethindrone acetate tabs 5mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
progesterone (generic of PROMETRIUM) CAPS 100mg, 200mg	Tier 1	MO
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
levothyroxine sodium (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 1	MO
liothyronine sodium (generic of CYTOMEL) TABS 5mcg, 25mcg, 50mcg	Tier 1	MO
methimazole tabs 5mg, 10mg	Tier 1	MO
propylthiouracil tabs 50mg	Tier 1	MO
SYNTHROID TABS 25MCG, 50MCG, 75MCG, 88MCG, 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 300MCG	Tier 2	MO
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
desmopressin acetate (generic of DDAVP) SOLN 4mcg/ml	MB	
desmopressin acetate (generic of DDAVP) TABS .1mg, .2mg	Tier 1	MO
desmopressin acetate spray soln .01%	Tier 1	MO
desmopressin acetate spray refrigerated soln .01%	Tier 1	MO
ENDOCRINE AND METABOLIC AGENTS - MISC.		
METABOLIC MODIFIERS		
MYALEPT SOLR 11.3MG	MB	
FERTILITY REGULATORS		
FERTILITY REGULATORS		
clomiphene citrate tabs 50mg	Tier 1	Only covered if member has supplemental benefit. Limit 3 fills per lifetime
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
BAXDELA TABS 450MG	Tier 3	
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
atropine sulfate (generic of ATROPINE SULFATE) SOSY .25mg/5ml, 1mg/10ml	MB	
dicyclomine hcl caps 10mg; soln 10mg/5ml; tabs 20mg	Tier 1	
dicyclomine hcl (generic of BENTYL) SOLN 10mg/ml	MB	
glycopyrrolate (generic of CUVPOSA) SOLN 1mg/5ml	Tier 1	MO
glycopyrrolate soln 1mg/5ml, 4mg/20ml	MB	
glycopyrrolate (generic of ROBINUL) TABS 1mg	Tier 1	
glycopyrrolate (generic of ROBINUL FORTE) TABS 2mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methscopolamine bromide tabs 2.5mg, 5mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
ANTIDIARRHEALS		
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	Tier 1	
diphenoxylate w/ atropine tab 2.5-0.025 mg (generic of LOMOTIL)	Tier 1	
loperamide hcl caps 2mg	Tier 1	
MOTOFEN TAB 1-0.025	Tier 3	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
AKYNZEO CAP 300-0.5	Tier 3	QL (2 caps every 28 days)
aprepitant caps 40mg	Tier 1	QL (3 caps every 180 days)
aprepitant (generic of EMEND) CAPS 80mg	Tier 1	QL (4 caps every 28 days)
aprepitant caps 125mg	Tier 1	QL (2 caps every 28 days)
aprepitant capsule therapy pack 80 & 125 mg	Tier 1	QL (2 packs every 28 days)
dronabinol (generic of MARINOL) CAPS 2.5mg	Tier 1	QL (60 caps every 30 days)
dronabinol caps 5mg, 10mg	Tier 1	QL (60 caps every 30 days)
granisetron hcl soln 1mg/ml	MB	
granisetron hcl tabs 1mg	Tier 1	QL (12 tabs every 28 days)
meclizine hcl tabs 12.5mg, 25mg	Tier 1	
metoclopramide hcl soln 5mg/ml	MB	
metoclopramide hcl soln 10mg/10ml; tbdp 5mg	Tier 1	
metoclopramide hcl (generic of REGLAN) TABS 5mg, 10mg	Tier 1	
ondansetron tbdp 4mg, 8mg	Tier 1	QL (18 tabs every 28 days)
ondansetron hcl soln 4mg/2ml, 40mg/20ml; sosy 4mg/2ml	MB	
ondansetron hcl soln 4mg/5ml	Tier 1	QL (200 mL every 28 days)
ondansetron hcl tabs 4mg, 8mg	Tier 1	QL (18 tabs every 28 days)
ondansetron hcl tabs 24mg	Tier 1	QL (2 tabs every 28 days)
prochlorperazine supp 25mg	Tier 1	
prochlorperazine maleate tabs 5mg, 10mg	Tier 1	MO
promethazine hcl (generic of PHENERGAN) SOLN 25mg/ml, 50mg/ml	MB	
promethazine hcl supp 12.5mg, 25mg, 50mg	Tier 1	
promethazine hcl syrp 6.25mg/5ml; tabs 12.5mg, 25mg, 50mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
SANCUSO PTCH 3.1MG/24HR	Tier 2	QL (2 patches every 28 days)
scopolamine (generic of TRANSDERM-SCOP) PT72 1mg/3days	Tier 1	
trimethobenzamide hcl caps 300mg	Tier 1	
VARUBI TBPK 90MG	Tier 2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
cimetidine tabs 200mg	Tier 1	
cimetidine tabs 300mg, 400mg, 800mg	Tier 1	MO
cimetidine hcl soln 300mg/5ml	Tier 1	MO
famotidine soln 20mg/2ml	MB	
famotidine susr 40mg/5ml	Tier 1	MO
famotidine (generic of PEPCID) TABS 20mg, 40mg	Tier 1	MO
famotidine in nacl 0.9% iv soln 20 mg/50ml	MB	
nizatidine caps 150mg, 300mg	Tier 1	MO
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium (generic of COLAZAL) CAPS 750mg	Tier 1	
budesonide cpep 3mg	Tier 1	
budesonide (generic of UCERIS) TB24 9mg	Tier 1	
DIPENTUM CAPS 250MG	Tier 3	PA, MO
hydrocortisone (intrarectal) (generic of CORTENEMA) ENEM 100mg/60ml	Tier 1	
mesalamine (generic of APRISO) CP24 .375gm	Tier 1	MO
mesalamine (generic of DELZICOL) CPDR 400mg	Tier 1	MO
mesalamine enem 4gm; tbec 800mg	Tier 1	
mesalamine (generic of CANASA) SUPP 1000mg	Tier 1	
mesalamine (generic of LIALDA) TBEC 1.2gm	Tier 1	MO
sulfasalazine (generic of AZULFIDINE) TABS 500mg	Tier 1	MO
sulfasalazine (generic of AZULFIDINE EN-TABS) TBEC 500mg	Tier 1	MO
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS CAPS 72MCG, 145MCG, 290MCG	Tier 2	MO
lubiprostone (generic of AMITIZA) CAPS 8mcg, 24mcg	Tier 1	MO
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl (generic of LOTRONEX) TABS .5mg, 1mg	Tier 1	PA, MO
LAXATIVES		
CLENPIQ SOL	PV	$0 copay for members age 45 through 75, Tier 2 for all others
lactulose soln 10gm/15ml	Tier 1	MO
lactulose (encephalopathy) soln 10gm/15ml	Tier 1	MO
OSMOPREP TAB 1.5GM	Tier 3	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm (generic of GOLYTELY)	Tier 1	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm (generic of MOVIPREP)	PV	$0 copay for members age 45 through 75, otherwise not covered
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	Tier 1	
PEG-PREP KIT	PV	$0 copay for members age 45 through 75, otherwise not covered
PLENVU SOL	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 (generic of SUPREP BOWEL PREP KIT)	PV	$0 copay for members age 45 through 75, otherwise not covered
SUFLAVE SOL	PV	$0 copay for members age 45 through 75, otherwise not covered
SUTAB TAB	PV	$0 copay for members age 45 through 75, otherwise not covered
MISCELLANEOUS		
cromolyn sodium (mastocytosis) (generic of GASTROCROM) CONC 100mg/5ml	Tier 1	MO
misoprostol (generic of CYTOTEC) TABS 100mcg, 200mcg	Tier 1	MO
MOVANTIK TABS 12.5MG, 25MG	Tier 2	
SUCRAID SOLN 8500UNIT/ML	Tier 3	PA, QL (354 mL every 30 days), MO
sucralfate (generic of CARAFATE) TABS 1gm	Tier 1	MO
ursodiol caps 300mg	Tier 1	MO
ursodiol (generic of URSO 250) TABS 250mg	Tier 1	MO
ursodiol (generic of URSO FORTE) TABS 500mg	Tier 1	MO
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	Tier 2	PA, MO
CREON CAP 6000UNIT	Tier 2	PA, MO
CREON CAP 12000UNT	Tier 2	PA, MO
CREON CAP 24000UNT	Tier 2	PA, MO
CREON CAP 36000UNT	Tier 2	PA, MO
VIOKACE TAB 10440	Tier 2	PA, MO
VIOKACE TAB 20880	Tier 2	PA, MO
ZENPEP CAP 3000UNIT	Tier 2	PA, MO
ZENPEP CAP 5000UNIT	Tier 2	PA, MO
ZENPEP CAP 10000UNT	Tier 2	PA, MO
ZENPEP CAP 15000UNT	Tier 2	PA, MO
ZENPEP CAP 20000UNT	Tier 2	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZENPEP CAP 25000UNT	Tier 2	PA, MO
ZENPEP CAP 40000UNT	Tier 2	PA, MO
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
dexlansoprazole (generic of DEXILANT) CPDR 30mg, 60mg	Tier 1	QL (90 caps every 365 days), MO
esomeprazole magnesium (generic of NEXIUM) CPDR 20mg, 40mg	Tier 1	QL (90 caps every 365 days), MO
esomeprazole magnesium (generic of NEXIUM) PACK 10mg	Tier 1	QL (90 packets every 365 days), MO; Covered for age less than 1 year only
lansoprazole cpdr 15mg	Tier 1	QL (90 caps every 365 days), MO
lansoprazole (generic of PREVACID) CPDR 30mg	Tier 1	QL (90 caps every 365 days), MO
NEXIUM PACK 2.5MG, 5MG	Tier 3	QL (90 packets every 365 days), MO; Covered for age less than 1 year only
omeprazole cpdr 10mg, 20mg, 40mg	Tier 1	QL (90 caps every 365 days), MO
pantoprazole sodium (generic of PROTONIX) TBEC 20mg, 40mg	Tier 1	QL (90 tabs every 365 days), MO
rabeprazole sodium (generic of ACIPHEX) TBEC 20mg	Tier 1	QL (90 tabs every 365 days), MO
RECTAL, CORTICOSTEROIDS		
hydrocortisone (rectal) (generic of PROCTOCORT) CREA 1%	Tier 1	
hydrocortisone (rectal) (generic of ANUSOL-HC) CREA 2.5%	Tier 1	
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
alfuzosin hcl (generic of UROXATRAL) TB24 10mg	Tier 1	MO
CARDURA XL TB24 4MG, 8MG	Tier 3	ST, MO; PA**
doxazosin mesylate (generic of CARDURA) TABS 1mg, 2mg, 4mg, 8mg	Tier 1	MO
dutasteride (generic of AVODART) CAPS .5mg	Tier 1	MO
dutasteride-tamsulosin hcl cap 0.5-0.4 mg (generic of JALYN)	Tier 1	MO
finasteride (generic of PROSCAR) TABS 5mg	Tier 1	MO
silodosin (generic of RAPAFLO) CAPS 4mg, 8mg	Tier 1	MO
tadalafil (generic of CIALIS) TABS 2.5mg, 5mg	Tier 1	PA, QL (30 tabs every 30 days), MO
tamsulosin hcl (generic of FLOMAX) CAPS .4mg	Tier 1	MO
terazosin hcl caps 1mg, 2mg, 5mg, 10mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ENCARE SUPP 100MG	PV	
OPTIONS GYNOL II VAGINAL GEL 3%	PV	
PHEXXI GEL	PV	
TODAY SPONGE MISC 1000MG	PV	
VCF VAGINAL CONTRACEPTIVE FILM 28%; FOAM 12.5%; GEL 4%	PV	
MISCELLANEOUS		
bethanechol chloride tabs 5mg, 10mg, 25mg, 50mg	Tier 1	
ELMIRON CAPS 100MG	Tier 3	
potassium citrate (alkalinizer) (generic of UROCIT-K 15) TBCR 15meq	Tier 1	
potassium citrate (alkalinizer) (generic of UROCIT-K 5) TBCR 540mg	Tier 1	
potassium citrate (alkalinizer) (generic of UROCIT-K 10) TBCR 1080mg	Tier 1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
darifenacin hydrobromide tb24 7.5mg, 15mg	Tier 1	MO
fesoterodine fumarate (generic of TOVIAZ) TB24 4mg, 8mg	Tier 1	MO
oxybutynin chloride soln 5mg/5ml; tabs 5mg; tb24 5mg, 10mg, 15mg	Tier 1	MO
solifenacin succinate (generic of VESICARE) TABS 5mg, 10mg	Tier 1	MO
tolterodine tartrate (generic of DETROL LA) CP24 2mg, 4mg	Tier 1	MO
tolterodine tartrate (generic of DETROL) TABS 1mg, 2mg	Tier 1	MO
trospium chloride cp24 60mg; tabs 20mg	Tier 1	MO
VAGINAL ANTI-INFECTIVES		
CLEOCIN SUPP 100MG	Tier 2	
clindamycin phosphate vaginal (generic of CLEOCIN) CREA 2%	Tier 1	
GYNAZOLE-1 CREA 2%	Tier 3	
metronidazole vaginal gel .75%	Tier 1	
miconazole nitrate vaginal supp 200mg	Tier 1	
terconazole vaginal crea .4%, .8%; supp 80mg	Tier 1	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
dabigatran etexilate mesylate (generic of PRADAXA) CAPS 150mg	Tier 1	MO
ELIQUIS TABS 2.5MG, 5MG	Tier 2	MO
ELIQUIS STARTER PACK TBPK 5MG	Tier 2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
enoxaparin sodium (generic of LOVENOX) 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 (generic of ARIXTRA) SOLN 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	MB	
FRAGMIN SOLN 10000UNIT/4ML, 95000UNIT/3.8ML; SOSY 2500UNIT/0.2ML, 5000UNIT/0.2ML, 7500UNIT/0.3ML, 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML	MB	
heparin sodium (porcine) soln 1000unit/ml, 5000unit/0.5ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	MB	
PRADAXA CAPS 75MG, 110MG	Tier 3	MO
warfarin sodium tabs 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	Tier 1	MO
XARELTO SUSR 1MG/ML; TABS 2.5MG, 10MG, 15MG, 20MG	Tier 2	MO
XARELTO STAR TAB 15/20MG	Tier 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	MB	
DOPTELET TABS 20MG	Tier 4	SP, PA, QL (1 carton every 5 days)
DOPTELET TABS 20MG	Tier 4	SP, PA, QL (2 cartons every 30 days)
FYLNETRA SOSY 6MG/0.6ML	MB	
MIRCERA SOSY 30MCG/0.3ML, 50MCG/0.3ML, 75MCG/0.3ML, 100MCG/0.3ML, 120MCG/0.3ML, 150MCG/0.3ML, 200MCG/0.3ML	MB	
NIVESTYM SOLN 300MCG/ML, 480MCG/1.6ML; SOSY 300MCG/0.5ML, 480MCG/0.8ML	MB	
NYVEPRIA SOSY 6MG/0.6ML	MB	
RETACRIT SOLN 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML, 10000UNIT/ML, 20000UNIT/ML, 40000UNIT/ML	MB	
ZIEXTENZO SOSY 6MG/0.6ML	MB	
HEMOPHILIA A AGENTS		
HEMLIBRA SOLN 30MG/ML, 60MG/0.4ML, 105MG/0.7ML, 150MG/ML	MB	
MISCELLANEOUS		
anagrelide hcl caps 1mg	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
anagrelide hcl (generic of AGRYLIN) CAPS .5mg	Tier 1	MO
cilostazol tabs 50mg, 100mg	Tier 1	MO
DROXIA CAPS 200MG, 300MG, 400MG	Tier 2	MO; OAC
pentoxifylline tbcr 400mg	Tier 1	MO
tranexamic acid (generic of CYKLOKAPRON) SOLN 1000mg/10ml	MB	
tranexamic acid tabs 650mg	Tier 1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	Tier 1	MO
BRILINTA TABS 60MG, 90MG	Tier 2	MO
clopidogrel bisulfate (generic of PLAVIX) TABS 75mg	Tier 1	MO
clopidogrel bisulfate tabs 300mg	Tier 1	
dipyridamole tabs 25mg, 50mg, 75mg	Tier 1	PA, MO; High Risk Medications require PA for members age 70 and older
prasugrel hcl (generic of EFFIENT) TABS 5mg, 10mg	Tier 1	MO
ZONTIVITY TABS 2.08MG	Tier 2	MO
HEMATOPOIETIC AGENTS		
FOLIC ACID/FOLATES		
folic acid tabs 1mg	Tier 1	MO
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
ACTEMRA SOLN 80MG/4ML, 200MG/10ML, 400MG/20ML	MB	
SIMPONI ARIA SOLN 50MG/4ML	MB	
SKYRIZI SOLN 600MG/10ML	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ACTEMRA SOSY 162MG/0.9ML	MB	
COSENTYX SOSY 75MG/0.5ML, 150MG/ML	MB	
COSENTYX SENSOREADY PEN SOAJ 150MG/ML	MB	
ENBREL SOLN 25MG/0.5ML; SOSY 25MG/0.5ML, 50MG/ML	MB	
ENBREL MINI SOCT 50MG/ML	MB	
ENBREL SURECLICK SOAJ 50MG/ML	MB	
HUMIRA PSKT 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML	MB	
HUMIRA PEDIA INJ CROHNS	MB	
HUMIRA PEDIATRIC CROHNS D PSKT 80MG/0.8ML	MB	
HUMIRA PEN PNKT 40MG/0.4ML, 40MG/0.8ML, 80MG/0.8ML	MB	
HUMIRA PEN KIT PS/UV	MB	
KEVZARA SOAJ 150MG/1.14ML, 200MG/1.14ML; SOSY 150MG/1.14ML, 200MG/1.14ML	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OTEZLA TABS 30MG	Tier 4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA TAB 10/20/30	Tier 4	SP, PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
RINVOQ TB24 15MG	Tier 4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Psoriatic Arthritis, Rheumatoid Arthritis, and Ulcerative Colitis.
RINVOQ TB24 30MG	Tier 4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Atopic Dermatitis, Crohn's Disease and Ulcerative Colitis.
RINVOQ TB24 45MG	Tier 4	SP, PA, QL (One time induction dose for CD/UC diagnosis only); Preferred agent for Crohn's Disease and Ulcerative Colitis.
SIMPONI SOAJ 50MG/0.5ML, 100MG/ML; SOSY 50MG/0.5ML, 100MG/ML	MB	
SKYRIZI PSKT 75MG/0.83ML; SOCT 180MG/1.2ML, 360MG/2.4ML; SOSY 150MG/ML	MB	
SKYRIZI PEN SOAJ 150MG/ML	MB	
STELARA SOLN 45MG/0.5ML; SOSY 45MG/0.5ML, 90MG/ML	MB	
TALTZ SOAJ 80MG/ML; SOSY 80MG/ML	MB	
TREMFYA SOPN 100MG/ML; SOSY 100MG/ML	MB	
XELJANZ SOLN 1MG/ML	Tier 4	SP, PA, QL (240 mL every 24 days)
XELJANZ TABS 5MG	Tier 4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Rheumatoid Arthritis and Ulcerative Colitis.
XELJANZ TABS 10MG	Tier 4	SP, PA, QL (60 tabs every 30 days); Preferred agent for Ulcerative Colitis.
XELJANZ XR TB24 11MG	Tier 4	SP, PA, QL (30 tabs every 30 days); Preferred agent for Rheumatoid Arthritis and Ulcerative Colitis.

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XELJANZ XR TB24 22MG	Tier 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 (generic of PLAQUENIL) TABS 200mg	Tier 1	MO
leflunomide (generic of ARAVA) TABS 10mg, 20mg	Tier 1	MO
methotrexate sodium tabs 2.5mg	Tier 1	OAC
HEREDITARY ANGIOEDEMA		
HAEGARDA SOLR 2000UNIT, 3000UNIT	MB	
icatibant acetate (generic of FIRAZYR) SOSY 30mg/3ml	MB	
IMMUNOGLOBULIN		
HYQVIA INJ 2.5-200	MB	
HYQVIA INJ 5-400	MB	
HYQVIA INJ 10-800	MB	
HYQVIA INJ 20-1600	MB	
HYQVIA INJ 30-2400	MB	
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000UNIT/0.5ML	MB	
ARCALYST SOLR 220MG	MB	
INTRON A SOLR 10000000UNIT, 18000000UNIT, 50000000UNIT	MB	
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 .5MG, 1MG, 5MG	Tier 3	SP
azathioprine (generic of IMURAN) TABS 50mg	Tier 1	MO
azathioprine tabs 75mg, 100mg	Tier 1	MO
CELLCEPT CAPS 250MG; SUSR 200MG/ML; TABS 500MG	Tier 3	SP
CELLCEPT INTRAVENOUS SOLR 500MG	MB	
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg	Tier 1	SP
cyclosporine (generic of SANDIMMUNE) SOLN 50mg/ml	MB	
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 1	SP
cyclosporine modified (for microemulsion) caps 50mg	Tier 1	SP
ENVARSUS XR TB24 .75MG, 1MG, 4MG	Tier 3	SP
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg, .5mg, .75mg, 1mg	Tier 1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; SUSR 200mg/ml; TABS 500mg	Tier 1	SP
mycophenolate mofetil hcl (generic of CELLCEPT INTRAVENOUS) SOLR 500mg	MB	
mycophenolate sodium (generic of MYFORTIC) TBEC 180mg, 360mg	Tier 1	SP
MYFORTIC TBEC 180MG, 360MG	Tier 3	SP
NEORAL CAPS 25MG, 100MG; SOLN 100MG/ML	Tier 3	SP
NULOJIX SOLR 250MG	MB	
PROGRAF CAPS .5MG, 1MG, 5MG; PACK .2MG, 1MG	Tier 3	SP
PROGRAF SOLN 5MG/ML	MB	
RAPAMUNE SOLN 1MG/ML; TABS .5MG, 1MG, 2MG	Tier 3	SP
SANDIMMUNE CAPS 25MG, 100MG; SOLN 100MG/ML	Tier 3	SP
SANDIMMUNE SOLN 50MG/ML	MB	
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml; TABS .5mg, 1mg, 2mg	Tier 1	SP
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	Tier 1	SP
ZORTRESS TABS .25MG, .5MG, .75MG, 1MG	Tier 3	SP
VACCINES		
ABRYSVO SOLR 120MCG/0.5ML	MB	
ACTHIB INJ	MB	
ADACEL INJ	MB	
AREXVY SUSR 120MCG/0.5ML	MB	
BEXSERO INJ	MB	
BOOSTRIX INJ	MB	
DAPTACEL INJ	MB	
DENGVAXIA SUS	MB	
DIP/TET PED INJ 25-5LFU	MB	
ENGERIX-B SUSP 20MCG/ML; SUSY 10MCG/0.5ML, 20MCG/ML	MB	
FLUMIST QUAD SUS 2023-24	MB	
FLUZONE QUAD INJ 2023-24	MB	
GARDASIL 9 INJ	MB	
HAVRIX SUSP 720ELU/0.5ML, 1440ELU/ML	MB	
HEPLISAV-B SOSY 20MCG/0.5ML	MB	
HIBERIX SOLR 10MCG	MB	
INFANRIX INJ	MB	
IPOL INJ INACTIVE	MB	
KINRIX INJ	MB	
M-M-R II INJ	MB	
MENACTRA INJ	MB	
MENQUADFI INJ	MB	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MENVEO INJ	MB	
MENVEO SOL	MB	
PEDIARIX INJ 0.5ML	MB	
PEDVAX HIB SUSP 7.5MCG/0.5ML	MB	
PENTACEL INJ	MB	
PNEUMOVAX 23/1 DOSE INJ 25MCG/0.5ML	MB	
PREHEVBRIO SUSP 10MCG/ML	MB	
PREVNAR 13 INJ	MB	
PREVNAR 20 INJ	MB	
PRIORIX INJ	MB	
PROQUAD INJ	MB	
QUADRACEL INJ	MB	
QUADRACEL INJ 0.5ML	MB	
RECOMBIVAX HB SUSP 5MCG/0.5ML, 10MCG/ML, 40MCG/ML; SUSY 5MCG/0.5ML, 10MCG/ML	MB	
ROTARIX SUS	MB	
SHINGRIX SUSR 50MCG/0.5ML	MB	
TDVAX INJ 2-2 LF	MB	
TENIVAC INJ 5-2LF	MB	
TRUMENBA INJ	MB	
TWINRIX INJ	MB	
VAQTA SUSP 25UNIT/0.5ML, 50UNIT/ML	MB	
VARIVAX INJ 1350PFU/0.5ML	MB	
VAXELIS INJ	MB	
VAXNEUVANCE INJ	MB	
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
magnesium sulfate (generic of MAGNESIUM SULFATE) SOLN 2gm/50ml	MB	
magnesium sulfate soln 50%	MB	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml (generic of MAGNESIUM SULFATE IN D5W)	MB	
potassium bicarbonate tbef 25meq	Tier 1	MO
potassium chloride cpcr 8meq, 10meq; soln 10%, 20%; tbcr 8meq, 10meq	Tier 1	MO
potassium chloride (generic of K-TAB) TBCR 20meq	Tier 1	MO
potassium chloride microencapsulated crystals er tbcr 10meq, 15meq, 20meq	Tier 1	MO
sodium chloride soln 2.5meq/ml	MB	
sodium chloride flush soln .9%	MB	
sodium fluoride chew 1mg; tabs 1mg	Tier 1	MO
sodium fluoride chew .25mg, .5mg; soln .125mg/drop, .5mg/ml; tabs .5mg	PV	MO; $0 applies for ages 5 and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IV REPLACEMENT SOLUTIONS		
potassium chloride soln 2meq/ml	MB	
sodium chloride soln .45%, .9%, 3%, 5%	MB	
PRENATAL VITAMINS		
CITRANATAL CAP HARMONY	Tier 2	
CITRANATAL CAP MEDLEY	Tier 2	
CITRANATAL MIS 90 DHA	Tier 2	
CITRANATAL MIS B-CALM	Tier 2	
CITRANATAL PAK ASSURE	Tier 2	
CITRANATAL PAK DHA	Tier 2	
CITRANATAL TAB BLOOM	Tier 2	
pnv-dha cap	Tier 1	
pnv-select tab	Tier 1	
prenatal 19 chw tab	Tier 1	
prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg	Tier 1	
prenatal vit w/ iron carbonyl-fa tab 50-1.25 mg	Tier 1	
trinate tab	Tier 1	
VITAMINS		
calcitriol (generic of ROCALTROL) CAPS .25mcg, .5mcg; SOLN 1mcg/ml	Tier 1	MO
cyanocobalamin soln 1000mcg/ml	MB	
doxercalciferol caps .5mcg, 1mcg, 2.5mcg	Tier 1	MO
ergocalciferol (generic of DRISDOL) CAPS 50000unit	Tier 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
folic acid tabs 1mg	Tier 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 (generic of ZEMPLAR) CAPS 1mcg, 2mcg	Tier 1	MO
paricalcitol caps 4mcg	Tier 1	MO
phytonadione tabs 5mg	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	Tier 1	
BLEPHAMIDE OIN S.O.P.	Tier 2	
neomycin-polymyxin-dexamethasone ophth oint 0.1% (generic of MAXITROL)	Tier 1	
neomycin-polymyxin-dexamethasone ophth susp 0.1% (generic of MAXITROL)	Tier 1	
neomycin-polymyxin-hc ophth susp	Tier 1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	Tier 1	
TOBRADEX OIN 0.3-0.1%	Tier 2	
TOBRADEX ST SUS 0.3-0.05	Tier 2	
tobramycin-dexamethasone ophth susp 0.3-0.1%	Tier 1	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
AZASITE SOLN 1%	Tier 2	
bacitracin (ophthalmic) oint 500unit/gm	Tier 1	
bacitracin-polymyxin b ophth oint	Tier 1	
BESIVANCE SUSP .6%	Tier 3	
ciprofloxacin hcl (ophth) soln .3%	Tier 1	
erythromycin (ophth) oint 5mg/gm	Tier 1	
gatifloxacin (ophth) (generic of ZYMAXID) SOLN .5%	Tier 1	
gentamicin sulfate (ophth) oint .3%	Tier 1	
gentamicin sulfate (ophth) soln .3%	Tier 1	QL (20 mL every 30 days)
levofloxacin (ophth) soln .5%	Tier 1	
moxifloxacin hcl (ophth) soln .5%	Tier 1	
moxifloxacin hcl (ophth) (generic of VIGAMOX) SOLN .5%	Tier 1	
NATACYN SUSP 5%	Tier 2	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	Tier 1	
ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	Tier 1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	Tier 1	
sulfacetamide sodium (ophth) oint 10%; soln 10%	Tier 1	
tobramycin (ophth) soln .3%	Tier 1	
trifluridine soln 1%	Tier 1	
ZIRGAN GEL .15%	Tier 3	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL SOLN .45%	Tier 2	
bromfenac sodium (ophth) soln .09%	Tier 1	
dexamethasone sodium phosphate (ophth) soln .1%	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diclofenac sodium (ophth) soln .1%	Tier 1	
difluprednate (generic of DUREZOL) EMUL .05%	Tier 1	
flurbiprofen sodium soln .03%	Tier 1	
FML OINT .1%	Tier 2	
ILEVRO SUSP .3%	Tier 2	
ketorolac tromethamine (ophth) (generic of ACULAR LS) SOLN .4%	Tier 1	
ketorolac tromethamine (ophth) (generic of ACULAR) SOLN .5%	Tier 1	
loteprednol etabonate (generic of LOTEMAX) SUSP .5%	Tier 1	
NEVANAC SUSP .1%	Tier 2	
prednisolone acetate (ophth) (generic of PRED FORTE) SUSP 1%	Tier 1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	Tier 2	
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
ALOCRIL SOLN 2%	Tier 3	
ALOMIDE SOLN .1%	Tier 3	
azelastine hcl (ophth) soln .05%	Tier 1	
bepotastine besilate (generic of BEPREVE) SOLN 1.5%	Tier 1	
cromolyn sodium (ophth) soln 4%	Tier 1	
epinastine hcl (ophth) soln .05%	Tier 1	
olopatadine hcl soln .1%, .2%	Tier 1	
ZERVIATE SOLN .24%	Tier 3	
ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA		
ALPHAGAN P SOLN .1%	Tier 3	MO
apraclonidine hcl soln .5%	Tier 1	
betaxolol hcl (ophth) soln .5%	Tier 1	MO
BETIMOL SOLN .25%, .5%	Tier 3	MO
BETOPTIC-S SUSP .25%	Tier 2	MO
brimonidine tartrate (generic of ALPHAGAN P) SOLN .1%, .15%	Tier 1	MO
brimonidine tartrate soln .2%	Tier 1	MO
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5% (generic of COMBIGAN)	Tier 1	MO
brinzolamide (generic of AZOPT) SUSP 1%	Tier 1	MO
carteolol hcl (ophth) soln 1%	Tier 1	MO
dorzolamide hcl soln 2%	Tier 1	MO
dorzolamide hcl-timolol maleate ophth soln 2-0.5% (generic of COSOPT)	Tier 1	MO
IOPIDINE SOLN 1%	Tier 3	
latanoprost (generic of XALATAN) SOLN .005%	Tier 1	MO
levobunolol hcl soln .5%	Tier 1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LUMIGAN SOLN .01%	Tier 2	ST, MO; PA**
PHOSPHOLINE IODIDE SOLR .125%	Tier 3	MO
pilocarpine hcl soln 1%	Tier 1	MO
SIMBRINZA SUS 1-0.2%	Tier 2	MO
tafluprost (generic of ZIOPTAN) SOLN .015mg/ml	Tier 1	MO
timolol maleate (ophth) solg .25%, .5%; soln .25%, .5%	Tier 1	MO
timolol maleate (ophth) (generic of ISTALOL) SOLN .5%	Tier 1	MO
travoprost (generic of TRAVATAN Z) SOLN .004%	Tier 1	MO
DRY EYE DISEASE		
RESTASIS EMUL .05%	Tier 1	MO
RESTASIS MULTIDOSE EMUL .05%	Tier 2	MO; Multi-dose vial remains on preferred brand tier
MISCELLANEOUS		
atropine sulfate (ophthalmic) soln 1%	Tier 1	MO
CYSTARAN SOLN .44%	Tier 4	PA, QL (4 bottles every 28 days)
LACRISERT INST 5MG	Tier 3	
phenylephrine hcl (mydriatic) soln 2.5%, 10%	Tier 1	
tropicamide (generic of MYDRIACYL) SOLN 1%	Tier 1	MO
tropicamide soln .5%	Tier 1	MO
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS		
PROLASTIN-C SOLN 1000MG/20ML; SOLR 1000MG	MB	
ANAPHYLAXIS TREATMENT AGENTS		
epinephrine (anaphylaxis) soaj .3mg/0.3ml	Tier 1	QL (4 auto-injectors every 30 days)
epinephrine (anaphylaxis) (generic of EPIPEN-JR 2-PAK) SOAJ .15mg/0.3ml	Tier 1	QL (4 auto-injectors every 30 days)
epinephrine (anaphylaxis) soaj .15mg/0.15ml	Tier 1	QL (4 auto-injectors every 30 days); (generic of Adrenaclick)
EPIPEN 2-PAK SOAJ .3MG/0.3ML	Tier 2	QL (4 auto-injectors every 30 days)
EPIPEN-JR 2-PAK SOAJ .15MG/0.3ML	Tier 2	QL (4 auto-injectors every 30 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPT AER 62.5-25	Tier 2	QL (1 package every 30 days), MO
BEVESPI AER 9-4.8MCG	Tier 2	QL (1 package every 30 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	Tier 1	QL (6 boxes every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS		
TRELEGY AER 100MCG	Tier 2	QL (1 package every 30 days), MO
TRELEGY AER 200MCG	Tier 2	QL (1 package every 30 days), MO
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
ipratropium bromide soln .02%	Tier 1	QL (5 boxes every 30 days), MO
ipratropium bromide (nasal) soln .03%, .06%	Tier 1	MO
SPIRIVA HANDIHALER CAPS 18MCG	Tier 2	QL (1 package every 30 days), MO
SPIRIVA RESPIMAT AERS 1.25MCG/ACT, 2.5MCG/ACT	Tier 2	QL (1 package every 30 days), MO
tiotropium bromide monohydrate (generic of SPIRIVA HANDIHALER) CAPS 18mcg	Tier 1	QL (1 package every 30 days), MO
ANTIHISTAMINE COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act (generic of DYMISTA)	Tier 1	QL (1 package every 30 days)
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
azelastine hcl soln .1%, .15%	Tier 1	QL (2 bottles every 30 days)
carbinoxamine maleate soln 4mg/5ml; tabs 4mg	Tier 1	
clemastine fumarate tabs 2.68mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
cyproheptadine hcl syrp 2mg/5ml; tabs 4mg	Tier 1	
desloratadine (generic of CLARINEX) TABS 5mg	Tier 1	
desloratadine tbdp 2.5mg, 5mg	Tier 1	
diphenhydramine hcl soln 50mg/ml	MB	
hydroxyzine hcl soln 25mg/ml, 50mg/ml	MB	
hydroxyzine hcl syrp 10mg/5ml; tabs 10mg, 25mg, 50mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
hydroxyzine pamoate (generic of VISTARIL) CAPS 25mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
hydroxyzine pamoate caps 50mg, 100mg	Tier 1	PA; High Risk Medications require PA for members age 70 and older
levocetirizine dihydrochloride soln 2.5mg/5ml; tabs 5mg	Tier 1	
olopatadine hcl (nasal) soln .6%	Tier 1	QL (1 container every 30 days)
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate aers 108mcg/act	Tier 1	QL (2 inhalers every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
albuterol sulfate nebu 2.5mg/0.5ml	Tier 1	QL (120 vials every 30 days), MO
albuterol sulfate nebu .083%, .63mg/3ml, 1.25mg/3ml	Tier 1	QL (5 boxes every 30 days), MO
albuterol sulfate syrp 2mg/5ml; tabs 2mg, 4mg	Tier 1	MO
formoterol fumarate (generic of PERFOROMIST) NEBU 20mcg/2ml	Tier 1	QL (60 vials every 30 days), MO
levalbuterol hcl nebu 1.25mg/0.5ml	Tier 1	QL (45 mL every 30 days), MO
levalbuterol hcl nebu .31mg/3ml, .63mg/3ml, 1.25mg/3ml	Tier 1	QL (300 mL every 30 days), MO
levalbuterol tartrate aero 45mcg/act	Tier 1	QL (2 inhalers every 30 days), MO
STRIVERDI RESPIMAT AERS 2.5MCG/ACT	Tier 2	QL (1 package every 30 days), MO
terbutaline sulfate tabs 2.5mg, 5mg	Tier 1	MO
COLD/COUGH		
benzonatate caps 100mg, 200mg	Tier 1	
guaifenesin-codeine soln 100-10 mg/5ml	Tier 1	QL (60 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml (generic of HYCODAN)	Tier 1	QL (30 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg (generic of HYCODAN)	Tier 1	QL (6 tabs every day); Subject to initial 7-day limit
promethazine & phenylephrine syrup 6.25-5 mg/5ml	Tier 1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	Tier 1	QL (30 mL every day); Subject to initial 7-day limit
promethazine-dm syrup 6.25-15 mg/5ml	Tier 1	
promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml	Tier 1	QL (30 mL every day); Subject to initial 7-day limit
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	Tier 1	
TUZISTRA XR SUS	Tier 3	QL (20 mL every day); Subject to initial 7-day limit
CYSTIC FIBROSIS		
CAYSTON SOLR 75MG	Tier 4	SP, PA, QL (84 vials every 28 days)
KALYDECO PACK 13.4MG, 25MG, 50MG, 75MG	Tier 4	PA, QL (56 packets every 28 days)
KALYDECO TABS 150MG	Tier 4	PA, QL (56 tabs every 28 days); carton consists of 56 tablets
ORKAMBI GRA 75-94MG	Tier 4	PA, QL (56 packets every 28 days)
ORKAMBI GRA 100-125	Tier 4	PA, QL (56 packets every 28 days)
ORKAMBI GRA 150-188	Tier 4	PA, QL (56 packets every 28 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ORKAMBI TAB 100-125	Tier 4	PA, QL (112 tabs every 28 days)
ORKAMBI TAB 200-125	Tier 4	PA, QL (112 tabs every 28 days)
SYMDEKO TAB 50-75MG	Tier 4	PA, QL (56 tabs every 28 days)
SYMDEKO TAB 100-150	Tier 4	PA, QL (56 tabs every 28 days)
tobramycin (generic of BETHKIS) NEBU 300mg/4ml	Tier 4	SP, PA, QL (224 mL every 28 days)
tobramycin (generic of KITABIS PAK) NEBU 300mg/5ml	Tier 4	SP, PA, QL (280 mL every 28 days)
TRIKAFTA PAK 59.5MG	Tier 4	PA, QL (56 packets every 28 days)
TRIKAFTA PAK 75MG	Tier 4	PA, QL (56 packets every 28 days)
TRIKAFTA TAB	Tier 4	PA, QL (84 tabs every 28 days)
LEUKOTRIENE MODIFIERS		
zileuton tb12 600mg	Tier 2	PA, MO
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES		
montelukast sodium (generic of SINGULAIR) CHEW 4mg, 5mg; PACK 4mg; TABS 10mg	Tier 1	MO
zafirlukast (generic of ACCOLATE) TABS 10mg, 20mg	Tier 1	MO
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
cromolyn sodium nebu 20mg/2ml	Tier 1	QL (2 boxes every 30 days), MO
MISCELLANEOUS		
acetylcysteine soln 10%, 20%	Tier 1	
roflumilast (generic of DALIRESP) TABS 250mcg, 500mcg	Tier 1	PA, MO
sodium chloride (inhalant) nebu .9%, 3%, 7%, 10%	Tier 1	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) soln .025%	Tier 1	QL (3 containers every 30 days)
fluticasone propionate (nasal) susp 50mcg/act	Tier 1	QL (1 container every 30 days)
PULMONARY FIBROSIS AGENTS		
pirfenidone (generic of ESBRIET) CAPS 267mg	Tier 4	SP, PA, QL (270 caps every 30 days)
pirfenidone (generic of ESBRIET) TABS 267mg	Tier 4	SP, PA, QL (270 tabs every 30 days)
pirfenidone (generic of ESBRIET) TABS 801mg	Tier 4	SP, PA, QL (90 tabs every 30 days)
RESPIRATORY THERAPY SUPPLIES		
ADULT RESPIRATORY MASK	Tier 2	
HOLD CHAMBER MIS MEDIUM	Tier 2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PEDIATRIC RESPIRATORY MASK	Tier 2	
PEDIATRIC RESPIRATORY MASK	Tier 2	
SEVERE ASTHMA AGENTS		
FASENRA SOSY 30MG/ML	MB	
FASENRA PEN SOAJ 30MG/ML	MB	
XOLAIR SOLR 150MG; SOSY 75MG/0.5ML, 150MG/ML	MB	
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA AEPB 50MCG/ACT, 100MCG/ACT, 200MCG/ACT	Tier 3	QL (1 package every 30 days), MO
budesonide (inhalation) (generic of PULMICORT) SUSP 1mg/2ml	Tier 1	QL (1 box every 30 days), MO
budesonide (inhalation) (generic of PULMICORT) SUSP .5mg/2ml	Tier 1	QL (2 boxes every 30 days), MO
budesonide (inhalation) (generic of PULMICORT) SUSP .25mg/2ml	Tier 1	QL (3 boxes every 30 days), MO
PULMICORT FLEXHALER AEPB 90MCG/ACT	Tier 2	QL (3 packages every 30 days), MO
PULMICORT FLEXHALER AEPB 180MCG/ACT	Tier 2	QL (2 packages every 30 days), MO
QVAR REDIHALER AERB 40MCG/ACT, 80MCG/ACT	Tier 2	QL (2 packages every 30 days), MO
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
ADVAIR DISKU AER 100/50	Tier 1	QL (1 package every 30 days), MO
ADVAIR DISKU AER 250/50	Tier 1	QL (1 package every 30 days), MO
ADVAIR DISKU AER 500/50	Tier 1	QL (1 package every 30 days), MO
ADVAIR HFA AER 45/21	Tier 2	QL (1 package every 30 days), MO
ADVAIR HFA AER 115/21	Tier 2	QL (1 package every 30 days), MO
ADVAIR HFA AER 230/21	Tier 2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 50-25MCG	Tier 2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 100-25	Tier 2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 200-25	Tier 2	QL (1 package every 30 days), MO
SYMBICORT AER 80-4.5	Tier 2	QL (3 packages every 30 days), MO
SYMBICORT AER 160-4.5	Tier 2	QL (3 packages every 30 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XANTHINES - DRUGS TO TREAT COPD		
aminophylline soln 25mg/ml	MB	
theophylline elix 80mg/15ml; soln 80mg/15ml; tb12 300mg, 450mg; tb24 400mg, 600mg	Tier 1	MO
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
adapalene (generic of DIFFERIN) CREA .1%; GEL .3%	Tier 1	PA, QL (45g every 28 days); PA applies for members age 35 and older
adapalene gel .1%	Tier 1	PA, QL (45g every 28 days); PA applies for members age 35 and older
adapalene-benzoyl peroxide gel 0.1-2.5% (generic of EPIDUO)	Tier 1	
adapalene-benzoyl peroxide gel 0.3-2.5% (generic of EPIDUO FORTE)	Tier 1	
benzoyl peroxide-erythromycin gel 5-3% (generic of BENZAMYCIN)	Tier 1	QL (47g every 30 days)
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	Tier 1	QL (45g every 30 days)
clindamycin phosphate (topical) foam 1%; swab 1%	Tier 1	
clindamycin phosphate (topical) gel 1%	Tier 1	QL (75g every 30 days)
clindamycin phosphate (topical) (generic of CLEOCIN-T) LOTN 1%	Tier 1	QL (60 mL every 30 days)
clindamycin phosphate (topical) soln 1%	Tier 1	QL (60 mL every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1-5%	Tier 1	QL (50g every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5% (generic of ACANYA)	Tier 1	QL (50g every 30 days)
erythromycin (acne aid) (generic of ERYGEL) GEL 2%	Tier 1	QL (60g every 30 days)
erythromycin (acne aid) pads 2%	Tier 1	
erythromycin (acne aid) soln 2%	Tier 1	QL (60 mL every 30 days)
isotretinoin caps 10mg, 20mg, 30mg, 40mg	Tier 1	PA
sulfacetamide sodium (acne) (generic of KLARON) LOTN 10%	Tier 1	
tretinoin (generic of RETIN-A) CREA .025%, .05%, .1%; GEL .01%, .025%	Tier 1	PA; PA applies for members age 35 and older
tretinoin (generic of ATRALIN) GEL .05%	Tier 1	PA; PA applies for members age 35 and older
tretinoin microsphere gel .04%, .1%	Tier 1	PA; PA applies for members age 35 and older
DERMATOLOGY, ACTINIC KERATOSIS		
fluorouracil (topical) (generic of EFUDEX) CREA 5%	Tier 1	
fluorouracil (topical) soln 2%, 5%	Tier 1	
imiquimod crea 5%	Tier 1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
mupirocin oint 2%	Tier 1	QL (30g every 30 days)
silver sulfadiazine (generic of SILVADENE) CREA 1%	Tier 1	
SULFAMYLON CREA 85MG/GM	Tier 3	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox gel .77%	Tier 1	QL (120g every 30 days)
ciclopirox sham 1%	Tier 1	QL (120 mL every 30 days)
ciclopirox soln 8%	Tier 1	
ciclopirox olamine crea .77%	Tier 1	QL (120g every 30 days)
ciclopirox olamine susp .77%	Tier 1	QL (120 mL every 30 days)
clotrimazole (topical) crea 1%	Tier 1	QL (120g every 30 days)
clotrimazole (topical) soln 1%	Tier 1	QL (120 mL every 30 days)
clotrimazole w/ betamethasone cream 1-0.05%	Tier 1	QL (60g every 30 days)
clotrimazole w/ betamethasone lotion 1-0.05%	Tier 1	QL (60 mL every 30 days)
econazole nitrate crea 1%	Tier 1	QL (60g every 30 days)
ERTACZO CREA 2%	Tier 3	QL (60g every 30 days)
JUBLIA SOLN 10%	Tier 3	PA, QL (4 mL every 28 days)
ketoconazole (topical) crea 2%	Tier 1	QL (120g every 30 days)
MENTAX CREA 1%	Tier 3	QL (60g every 30 days)
naftifine hcl crea 1%, 2%	Tier 1	QL (60g every 30 days)
nystatin (topical) crea 100000unit/gm; oint 100000unit/gm; powd 100000unit/gm	Tier 1	QL (120g every 30 days)
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	Tier 1	QL (60g every 30 days)
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	Tier 1	QL (60g every 30 days)
oxiconazole nitrate (generic of OXISTAT) CREA 1%	Tier 1	QL (60g every 30 days)
sulconazole nitrate crea 1%	Tier 1	QL (60g every 30 days)
sulconazole nitrate soln 1%	Tier 1	QL (60 mL every 30 days)
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl (antipruritic) (generic of PRUDOXIN) CREA 5%	Tier 3	QL (45g every 30 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin caps 10mg, 17.5mg, 25mg	Tier 1	
calcipotriene soln .005%	Tier 1	ST, QL (60 mL every 30 days); PA**
calcitriol (topical) oint 3mcg/gm	Tier 3	ST, QL (100g every 30 days); PA**
methoxsalen rapid caps 10mg	Tier 1	
tazarotene (generic of TAZORAC) CREA .1%; GEL .05%, .1%	Tier 1	PA
TAZORAC CREA .05%	Tier 2	PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) sham 2%	Tier 1	QL (120 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
selenium sulfide lotn 2.5%	Tier 1	
DERMATOLOGY, ATOPIC DERMATITIS		
EUCRISA OINT 2%	Tier 2	ST, QL (60g every 30 days); PA**
tacrolimus (topical) oint .03%, .1%	Tier 3	ST; PA**
DERMATOLOGY, CORTICOSTEROIDS		
alclometasone dipropionate crea .05%; oint .05%	Tier 1	QL (120g every 30 days)
amcinonide crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
amcinonide lotn .1%	Tier 1	QL (120 mL every 30 days)
betamethasone dipropionate (topical) crea .05%	Tier 1	QL (120g every 30 days)
betamethasone dipropionate (topical) lotn .05%	Tier 1	QL (120 mL every 30 days)
betamethasone dipropionate augmented crea .05%; gel .05%	Tier 1	QL (120g every 30 days)
betamethasone dipropionate augmented lotn .05%	Tier 1	QL (120 mL every 30 days)
betamethasone dipropionate augmented (generic of DIPROLENE) OINT .05%	Tier 1	QL (120g every 30 days)
betamethasone valerate crea .1%; foam .12%; oint .1%	Tier 1	QL (120g every 30 days)
betamethasone valerate lotn .1%	Tier 1	QL (120 mL every 30 days)
calcipotriene-betamethasone dipropionate oint 0.005-0.064% (generic of TACLONEX)	Tier 2	ST, QL (60g every 30 days); PA**
clobetasol propionate crea .05%; foam .05%; gel .05%; oint .05%	Tier 1	QL (120g every 30 days)
clobetasol propionate (generic of CLOBEX) LIQD .05%; LOTN .05%; SHAM .05%	Tier 1	QL (120 mL every 30 days)
clobetasol propionate soln .05%	Tier 1	QL (120 mL every 30 days)
clobetasol propionate emollient base crea .05%	Tier 1	QL (120g every 30 days)
clocortolone pivalate (generic of CLODERM) CREA .1%	Tier 3	QL (120g every 30 days)
desonide (generic of DESOWEN) CREA .05%	Tier 1	QL (120g every 30 days)
desonide lotn .05%	Tier 1	QL (120 mL every 30 days)
desonide oint .05%	Tier 1	QL (120g every 30 days)
desoximetasone (generic of TOPICORT) CREA .05%, .25%; GEL .05%; OINT .25%	Tier 1	QL (120g every 30 days)
diflorasone diacetate crea .05%; oint .05%	Tier 3	QL (120g every 30 days)
fluocinolone acetonide crea .01%	Tier 1	QL (120g every 30 days)
fluocinolone acetonide (generic of SYNALAR) CREA .025%; OINT .025%	Tier 1	QL (120g every 30 days)
fluocinolone acetonide (generic of DERMA-SMOOTHE/FS BODY) OIL .01%	Tier 1	QL (120 mL every 30 days)
fluocinolone acetonide (generic of DERMA-SMOOTHE/FS SCALP) OIL .01%	Tier 1	QL (120 mL every 30 days)
fluocinolone acetonide (generic of SYNALAR) SOLN .01%	Tier 1	QL (120 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluocinonide crea .05%; gel .05%; oint .05%	Tier 1	QL (120g every 30 days)
fluocinonide soln .05%	Tier 1	QL (120 mL every 30 days)
fluticasone propionate crea .05%; oint .005%	Tier 1	QL (120g every 30 days)
fluticasone propionate lotn .05%	Tier 1	QL (120 mL every 30 days)
halobetasol propionate crea .05%; oint .05%	Tier 1	QL (120g every 30 days)
hydrocortisone (topical) crea 1%, 2.5%; oint 2.5%	Tier 1	QL (120g every 30 days)
hydrocortisone (topical) lotn 2.5%	Tier 1	QL (120 mL every 30 days)
hydrocortisone butyrate crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
hydrocortisone butyrate soln .1%	Tier 1	QL (120 mL every 30 days)
hydrocortisone valerate crea .2%; oint .2%	Tier 1	QL (120g every 30 days)
mometasone furoate crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
mometasone furoate soln .1%	Tier 1	QL (120 mL every 30 days)
prednicarbate oint .1%	Tier 1	QL (120g every 30 days)
triamcinolone acetonide (topical) crea .025%, .1%, .5%; oint .025%, .1%, .5%	Tier 1	QL (120g every 30 days)
triamcinolone acetonide (topical) lotn .025%, .1%	Tier 1	QL (120 mL every 30 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine oint 5%	Tier 1	QL (50g every 30 days)
lidocaine (generic of LIDODERM) PTCH 5%	Tier 1	PA, QL (90 patches every 30 days)
lidocaine hcl gel 2%; prsy 2%	MB	
lidocaine hcl soln 4%	Tier 1	QL (50 mL every 30 days)
lidocaine-prilocaine cream 2.5-2.5%	Tier 1	QL (30g every 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
bexarotene (topical) (generic of TARGRETIN) GEL 1%	Tier 4	SP, PA
CONDYLOX GEL .5%	Tier 3	
diclofenac sodium (topical) gel 1%	Tier 1	QL (300g every 30 days)
lactic acid (ammonium lactate) crea 12%; lotn 12%	Tier 1	
penciclovir (generic of DENAVIR) CREA 1%	Tier 1	
podofilox soln .5%	Tier 1	
RECTIV OINT .4%	Tier 3	
DERMATOLOGY, ROSACEA		
azelaic acid (generic of FINACEA) GEL 15%	Tier 1	
brimonidine tartrate (topical) (generic of MIRVASO) GEL .33%	Tier 1	PA
FINACEA FOAM 15%	Tier 2	
metronidazole (topical) (generic of METROCREAM) CREA .75%	Tier 1	QL (60g every 30 days)
metronidazole (topical) (generic of METROGEL) GEL 1%	Tier 1	QL (60g every 30 days)
metronidazole (topical) gel .75%	Tier 1	QL (60g every 30 days)
metronidazole (topical) (generic of METROLOTION) LOTN .75%	Tier 1	QL (60 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
crotamiton lotn 10%	Tier 1	
ivermectin (pediculicide) lotn .5%	Tier 1	
malathion lotn .5%	Tier 1	ST; PA**
permethrin crea 5%	Tier 1	
spinosad susp .9%	Tier 1	ST; PA**
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01%	Tier 3	PA, QL (30g every 30 days)
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl (generic of EVOXAC) CAPS 30mg	Tier 1	MO
clotrimazole troc 10mg	Tier 1	QL (90 lozenges every 30 days)
lidocaine hcl (mouth-throat) soln 2%	Tier 1	
nystatin (mouth-throat) susp 100000unit/ml	Tier 1	
ORAVIG TABS 50MG	Tier 3	QL (14 tabs every 30 days)
pilocarpine hcl (oral) (generic of SALAGEN) TABS 5mg, 7.5mg	Tier 1	MO
triamcinolone acetonide (mouth) pste .1%	Tier 1	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
acetic acid (otic) soln 2%	Tier 1	
ciprofloxacin hcl (otic) soln .2%	Tier 1	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	Tier 1	
CORTISPORIN SUS -TC OTIC	Tier 3	
fluocinolone acetonide (otic) (generic of DERMOTIC) OIL .01%	Tier 1	
hydrocortisone w/ acetic acid otic soln 1-2%	Tier 1	
neomycin-polymyxin-hc otic soln 1%	Tier 1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	Tier 1	
ofloxacin (otic) soln .3%	Tier 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	VRAYLAR
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of generic aripiprazole, asenapine, lurasidone, 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	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, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER, NUCYNTA ER, OXYCODONE HYDROCHLORIDE 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/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, 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	ORAL CGRP RECEPTOR ANTAGONISTS 3481-E
Drug Names	QULIPTA, UBRELVY
Step Therapy Criteria	For Qulipta: Coverage will be provided if the member has filled a prescription for at least a 56 day supply of divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, or venlafaxine within the past 730 days. For Ubrelvy: Coverage will be provided if the member has filled a prescription for at least a 30 day supply of two triptan 5-HT1 receptor agonists (include combinations) within the past 180 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, Harvoni, Vosevi.
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	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 COMBINATIONS 676-D
Drug Names	GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY 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	TACROLIMUS 1254-F
Drug Names	TACROLIMUS
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 14 day supply of at least one corticosteroid of medium or higher potency 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
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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