SHARP Health Plan

# 2024 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 7050/0%/0% + Child Dental (Pe/V/C), Sharp Bronze 60 HMO 6300/60/40% + 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 6300/60 + Child Dental, Sharp Performance Bronze 60 HMO 6300/60 + 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 7050/0% + Child Dental, Sharp Premier Bronze 60 HDHP HMO 7050/0% + 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 2850/25% + Child Dental, Sharp Premier Silver 70 HDHP HMO 2850/25% + 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 25% + 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 Health Plan online 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 12/01/2024.

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# Introduction

**December 2024**

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 foodins 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.

**"CARE Agreement"** means a voluntary settlement agreement entered into by the parties. A CARE Agreement includes the same elements as a CARE Plan to support the respondent in accessing community-based services and supports.

**"CARE Plan"** means an individualized, appropriate range of community-based services and supports, which include clinically appropriate behavioral health care and stabilization medications, housing and other supportive services, as appropriate.

**"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 Sharp Health Plan online account. When you create a Sharp Health Plan online 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 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 or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.

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 or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.

3. Over-the-counter medications or supplies, except for over-the-counter FDA-approved contraceptive drugs,devices and products, 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, except for over-the-counter FDA-approved contraceptive drugs, devices and products.

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, except for over-the-counter FDA-approved contraceptive drugs, devices and products.

The exclusions listed above do not apply to:

1. Coverage of an entire class of Prescription Drugs when one drug within that classbecomes available over-the-counter, except for FDA-approved contraceptive drugs, devices, and products.

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, including FDA-approved contraceptive drugs, devices, and products available over the counter. 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: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร** 1-800-359-2002 (TTY:711).

## Table of Contents

## Sharp CA 4T Effective 12/01/2024

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| **ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION** | | |
| ***COX-2 INHIBITORS*** | | |
| ***celecoxib caps 50mg, 100mg, 200mg*** | Tier 1 | MO |
| ***GOUT - DRUGS TO TREAT GOUT*** | | |
| ***allopurinol tabs 100mg, 300mg*** | Tier 1 | MO |
| ***colchicine tabs .6mg*** | Tier 1 | |
| ***colchicine w/ probenecid tab 0.5-500 mg*** | Tier 1 | MO |
| ***febuxostat 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 400mg, 500mg; tb24 400mg, 500mg, 600mg*** | Tier 1 | MO |
| ***fenoprofen calcium tabs 600mg*** | Tier 2 | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***meloxicam tabs 7.5mg, 15mg*** | Tier 1 | MO |
| ***nabumetone tabs 500mg, 750mg*** | Tier 1 | MO |
| ***naproxen tabs 250mg, 375mg, 500mg*** | Tier 1 | MO |
| ***oxaprozin tabs 600mg*** | Tier 1 | MO |
| ***piroxicam 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*** | Tier 1 | MO |
| ***diclofenac w/ misoprostol tab delayed release 75-0.2 mg*** | Tier 1 | MO |
| ***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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***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 |
| ***endocet tab 2.5-325*** | 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 |
| ***endocet tab 5-325mg*** | 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 |
| ***endocet tab 7.5-325*** | 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 |
| ***endocet tab 10-325mg*** | 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 |
| ***fentanyl pt72 12mcg/hr, 25mcg/hr, 37.5mcg/hr*** | Tier 1 | ST, QL (10 patches every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***fentanyl pt72 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/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 |
| ***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 soln 2mg/ml*** | MB | |
| ***hydromorphone hcl 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 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***hydromorphone hcl 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 conc 10mg/ml*** | Tier 1 | QL (30 mL every 30 days); (indicated for opioid addiction) |
| ***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) |
| ***methadone hydrochloride i conc 10mg/ml*** (Methadone Hydrochloride I) | Tier 1 | ST, QL (45 mL every 30 days); (generic of Methadone Intensol, indicated for pain) |
| ***methadose tbso 40mg*** (Methadose) | 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; tbcr 60mg, 100mg, 200mg*** | Tier 1 | ST, PA; High Strength Requires PA |
| ***morphine sulfate soln 4mg/ml, 10mg/ml*** | MB | |
| ***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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***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 tbcr 15mg, 30mg*** | Tier 1 | ST, QL (90 tabs every 30 days) |
| ***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 ***(tapentadol hcl)*** | 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 ***(tapentadol hcl)*** | 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 ***(tapentadol hcl)*** | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| NUCYNTA ER TB12 50mg, 100mg ***(tapentadol hcl)*** | Tier 3 | ST, QL (60 tabs every 30 days) |
| NUCYNTA ER TB12 150mg, 200mg, 250mg ***(tapentadol hcl)*** | Tier 3 | ST, PA; High Strength Requires PA |
| ***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 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 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***oxycodone w/ acetaminophen tab 2.5-325 mg*** | 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*** | 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*** | 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 |
| ***oxycodone w/ 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 |
| ***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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***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 ***(oxycodone)*** | Tier 2 | ST, QL (60 caps every 30 days) |
| XTAMPZA ER C12A 36mg ***(oxycodone)*** | Tier 2 | ST, PA; High Strength Requires Prior Auth |
| ***OPIOID PARTIAL AGONISTS*** | | |
| BELBUCA FILM 75mcg, 150mcg, 300mcg, 450mcg ***(buprenorphine hcl)*** | Tier 2 | ST, QL (60 films every 30 days) |
| BELBUCA FILM 600mcg, 750mcg, 900mcg ***(buprenorphine hcl)*** | Tier 2 | ST, PA; High Strength Requires Prior Auth |
| ***buprenorphine ptwk 5mcg/hr, 7.5mcg/hr, 10mcg/hr*** | Tier 1 | ST, QL (4 patches every 30 days) |
| ***buprenorphine ptwk 15mcg/hr, 20mcg/hr*** | Tier 1 | ST, PA; High Strength Requires Prior Auth |
| ***buprenorphine hcl soln .3mg/ml*** | MB | |
| SUBLOCADE SOSY 100mg/0.5ml, 300mg/1.5ml ***(buprenorphine)*** | MB | |
| ***SALICYLATES*** | | |
| ***aspirin ec adult low dose tbec 81mg*** (Aspirin Ec Adult Low Dose) | 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 |
| ***goodsense aspirin chew 81mg*** (Goodsense Aspirin) | PV | QL (100 tabs every 30 days); $0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| **ANESTHETICS - DRUGS FOR NUMBING** | | |
| ***LOCAL ANESTHETICS*** | | |
| ***lidocaine hcl (local anesth.) soln .5%, 1%, 2%*** | MB | |
| **ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS** | | |
| ***ANTHELMINTICS*** | | |
| EMVERM CHEW 100mg ***(mebendazole)*** | Tier 3 | QL (12 tabs every 365 days) |
| ***ivermectin tabs 3mg*** | Tier 1 | PA |
| ***praziquantel tabs 600mg*** | Tier 1 | QL (24 tabs every 365 days) |
| ***ANTI-BACTERIALS - MISCELLANEOUS*** | | |
| ***amikacin sulfate soln 1gm/4ml, 500mg/2ml*** | MB | |
| ***fosfomycin tromethamine pack 3gm*** | Tier 1 | |
| ***gentamicin sulfate soln 40mg/ml*** | MB | |
| ***neomycin sulfate tabs 500mg*** | Tier 1 | |
| ***sulfadiazine tabs 500mg*** | Tier 1 | |
| ***sulfamethoxazole-trimethoprim susp 200-40 mg/5ml*** | Tier 1 | |
| ***sulfamethoxazole-trimethoprim tab 400-80 mg*** | Tier 1 | |
| ***sulfamethoxazole-trimethoprim tab 800-160 mg*** | 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 ***(isavuconazonium sulfate)*** | Tier 3 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***fluconazole susr 10mg/ml, 40mg/ml; tabs 50mg, 100mg, 150mg, 200mg*** | Tier 1 | |
| ***griseofulvin microsize susp 125mg/5ml; tabs 500mg*** | Tier 1 | |
| ***griseofulvin ultramicrosize tabs 125mg, 250mg*** | Tier 1 | |
| ***itraconazole caps 100mg; soln 10mg/ml*** | Tier 1 | PA |
| ***nystatin tabs 500000unit*** | Tier 1 | |
| ***posaconazole susp 40mg/ml*** | Tier 1 | PA, MO |
| ***posaconazole tbec 100mg*** | Tier 2 | PA, MO |
| ***terbinafine hcl tabs 250mg*** | Tier 1 | |
| ***voriconazole susr 40mg/ml; tabs 50mg, 200mg*** | Tier 2 | PA |
| ***ANTIMALARIALS - DRUGS TO TREAT MALARIA*** | | |
| ***atovaquone-proguanil hcl tab 62.5-25 mg*** | Tier 1 | |
| ***atovaquone-proguanil hcl tab 250-100 mg*** | Tier 1 | |
| ***chloroquine phosphate tabs 250mg, 500mg*** | Tier 1 | MO |
| COARTEM TAB 20-120MG ***(artemether-lumefantrine)*** | Tier 3 | |
| ***mefloquine hcl tabs 250mg*** | Tier 1 | MO |
| ***primaquine phosphate tabs 26.3mg*** | Tier 1 | |
| ***quinine sulfate caps 324mg*** | Tier 1 | |
| ***ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION*** | | |
| ***abacavir sulfate soln 20mg/ml*** | Tier 1 | SP, QL (900 mL every 30 days) |
| ***abacavir sulfate tabs 300mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| APRETUDE SUER 600mg/3ml ***(cabotegravir)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| APTIVUS CAPS 250mg ***(tipranavir)*** | Tier 2 | SP, QL (120 caps every 30 days) |
| ***atazanavir sulfate caps 150mg, 300mg*** | Tier 1 | SP, QL (30 caps every 30 days) |
| ***atazanavir sulfate caps 200mg*** | Tier 1 | SP, QL (60 caps every 30 days) |
| ***darunavir tabs 600mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| ***darunavir tabs 800mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| EDURANT TABS 25mg ***(rilpivirine hcl)*** | Tier 2 | SP, QL (60 tabs every 30 days) |
| ***efavirenz caps 50mg, 200mg*** | Tier 1 | SP, QL (90 caps every 30 days) |
| ***efavirenz tabs 600mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***emtricitabine caps 200mg*** | Tier 1 | SP, QL (30 caps every 30 days) |
| EMTRIVA SOLN 10mg/ml ***(emtricitabine)*** | Tier 2 | SP, QL (680 ml every 28 days) |
| ***etravirine tabs 100mg*** | Tier 1 | SP, QL (120 tabs every 30 days) |
| ***etravirine tabs 200mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| ***fosamprenavir calcium tabs 700mg*** | Tier 1 | SP, QL (120 tabs every 30 days) |
| FUZEON SOLR 90mg ***(enfuvirtide)*** | MB | |
| INTELENCE TABS 25mg ***(etravirine)*** | Tier 2 | SP, QL (120 tabs every 30 days) |
| ISENTRESS CHEW 25mg, 100mg ***(raltegravir potassium)*** | Tier 2 | SP, QL (180 tabs every 30 days) |
| ISENTRESS PACK 100mg ***(raltegravir potassium)*** | Tier 2 | SP, QL (60 packets every 30 days) |
| ISENTRESS TABS 400mg ***(raltegravir potassium)*** | Tier 2 | SP, QL (120 tabs every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ISENTRESS HD TABS 600mg ***(raltegravir potassium)*** | Tier 2 | SP, QL (60 tabs every 30 days) |
| ***lamivudine soln 10mg/ml*** | Tier 1 | SP, QL (960 ml every 30 days) |
| ***lamivudine tabs 150mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| ***lamivudine tabs 300mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| LEXIVA SUSP 50mg/ml ***(fosamprenavir calcium)*** | Tier 2 | SP, QL (1575 mL every 28 days) |
| ***maraviroc tabs 150mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| ***maraviroc 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 ***(ritonavir)*** | Tier 2 | SP, QL (360 packets every 30 days) |
| PREZISTA SUSP 100mg/ml ***(darunavir)*** | Tier 2 | SP, QL (400 ml every 30 days) |
| PREZISTA TABS 75mg ***(darunavir)*** | Tier 2 | SP, QL (300 tabs every 30 days) |
| PREZISTA TABS 150mg ***(darunavir)*** | Tier 2 | SP, QL (180 tabs every 30 days) |
| RETROVIR IV INFUSION SOLN 10mg/ml ***(zidovudine)*** | MB | |
| REYATAZ PACK 50mg ***(atazanavir sulfate)*** | Tier 2 | SP, QL (180 packets every 30 days) |
| ***ritonavir tabs 100mg*** | Tier 1 | SP, QL (360 tabs every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SELZENTRY SOLN 20mg/ml ***(maraviroc)*** | Tier 2 | SP, QL (1840 mL every 30 days) |
| SELZENTRY TABS 25mg ***(maraviroc)*** | Tier 2 | SP, QL (240 tabs every 30 days) |
| SELZENTRY TABS 75mg ***(maraviroc)*** | 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 tabs 300mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| TIVICAY TABS 10mg ***(dolutegravir sodium)*** | Tier 2 | SP, QL (240 tabs every 30 days) |
| TIVICAY TABS 25mg, 50mg ***(dolutegravir sodium)*** | Tier 2 | SP, QL (60 tabs every 30 days) |
| TIVICAY PD TBSO 5mg ***(dolutegravir sodium)*** | Tier 2 | SP, QL (360 tabs every 30 days) |
| TROGARZO SOLN 200mg/1.33ml ***(ibalizumab-uiyk)*** | MB | |
| TYBOST TABS 150mg ***(cobicistat)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| VIRACEPT TABS 250mg ***(nelfinavir mesylate)*** | Tier 2 | SP, QL (300 tabs every 30 days) |
| VIRACEPT TABS 625mg ***(nelfinavir mesylate)*** | Tier 2 | SP, QL (120 tabs every 30 days) |
| VIREAD POWD 40mg/gm ***(tenofovir disoproxil fumarate)*** | Tier 2 | SP, QL (240 gm every 30 days) |
| VIREAD TABS 150mg, 200mg, 250mg ***(tenofovir disoproxil fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| ***zidovudine caps 100mg*** | Tier 1 | SP, QL (180 caps every 30 days) |
| ***zidovudine syrp 50mg/5ml*** | Tier 1 | SP, QL (1920 ml every 30 days) |
| ***zidovudine tabs 300mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION*** | | |
| ***abacavir sulfate-lamivudine tab 600-300 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| CABENUVA SUS 400-600 ***(cabotegravir & rilpivirine)*** | MB | |
| CABENUVA SUS 600-900 ***(cabotegravir & rilpivirine)*** | MB | |
| CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| DESCOVY TAB 120-15MG ***(emtricitabine-tenofovir alafenamide fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days); $0 copay for PrEP |
| DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| ***efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***efavirenz-lamivudine-tenofovir df tab 400-300-300 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***efavirenz-lamivudine-tenofovir df tab 600-300-300 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg*** | Tier 1 | SP, QL (30 tabs every 30 days) |
| ***emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg*** | Tier 1 | SP, QL (30 tabs every 30 days); $0 copay for PrEP |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| EVOTAZ TAB 300-150 ***(atazanavir sulfate-cobicistat)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| GENVOYA TAB ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| ***lamivudine-zidovudine tab 150-300 mg*** | Tier 1 | SP, QL (60 tabs every 30 days) |
| ***lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)*** | Tier 1 | SP, QL (480 ml every 30 days) |
| ***lopinavir-ritonavir tab 100-25 mg*** | Tier 1 | SP, QL (240 tabs every 30 days) |
| ***lopinavir-ritonavir tab 200-50 mg*** | Tier 1 | SP, QL (120 tabs every 30 days) |
| ODEFSEY TAB ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| PREZCOBIX TAB 800-150 ***(darunavir-cobicistat)*** | Tier 2 | SP, QL (30 tabs every 30 days) |
| TRIUMEQ PD TAB ***(abacavir-dolutegravir-lamivudine)*** | Tier 3 | SP, QL (180 tabs every 30 days) |
| TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)*** | Tier 3 | SP, QL (30 tabs every 30 days) |
| ***ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS*** | | |
| ***cycloserine caps 250mg*** | Tier 1 | |
| ***ethambutol hcl tabs 100mg, 400mg*** | Tier 1 | |
| ***isoniazid soln 100mg/ml*** | MB | |
| ***isoniazid syrp 50mg/5ml; tabs 100mg, 300mg*** | Tier 1 | MO |
| PRIFTIN TABS 150mg ***(rifapentine)*** | Tier 2 | |
| ***pyrazinamide tabs 500mg*** | Tier 1 | |
| ***rifabutin caps 150mg*** | Tier 1 | |
| ***rifampin caps 150mg, 300mg*** | Tier 1 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***rifampin solr 600mg*** | MB | |
| SIRTURO TABS 20mg, 100mg ***(bedaquiline fumarate)*** | Tier 3 | |
| TRECATOR TABS 250mg ***(ethionamide)*** | Tier 2 | |
| ***ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS*** | | |
| ***acyclovir caps 200mg; susp 200mg/5ml; tabs 400mg, 800mg*** | Tier 1 | |
| ***cidofovir soln 75mg/ml*** | MB | |
| ***famciclovir tabs 125mg, 250mg, 500mg*** | Tier 1 | |
| ***oseltamivir phosphate caps 30mg*** | Tier 1 | QL (40 caps every 90 days) |
| ***oseltamivir phosphate caps 45mg, 75mg*** | Tier 1 | QL (20 caps every 90 days) |
| ***oseltamivir phosphate susr 6mg/ml*** | Tier 1 | QL (360 mL every 90 days) |
| PAXLOVID TAB 150-100 ***(nirmatrelvir-ritonavir)*** | Tier 3 | QL (40 tabs every 30 days) |
| PAXLOVID TAB 300-100 ***(nirmatrelvir-ritonavir)*** | Tier 3 | QL (60 tabs every 30 days) |
| RELENZA DISKHALER AEPB 5mg/blister ***(zanamivir)*** | Tier 2 | QL (2 inhalers every 90 days) |
| ***rimantadine hydrochloride tabs 100mg*** | Tier 1 | |
| ***valacyclovir hcl tabs 500mg, 1000mg*** | Tier 1 | |
| ***valganciclovir hcl solr 50mg/ml*** | Tier 4 | PA, QL (1000 mL every 30 days) |
| ***valganciclovir hcl 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 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***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 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 ***(cefixime)*** | Tier 2 | |
| ***tazicef solr 1gm*** (Tazicef) | MB | |
| ***ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS*** | | |
| ***azithromycin pack 1gm; susr 100mg/5ml, 200mg/5ml; tabs 250mg, 500mg, 600mg*** | Tier 1 | |
| ***clarithromycin susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg; tb24 500mg*** | Tier 1 | |
| DIFICID SUSR 40mg/ml; TABS 200mg ***(fidaxomicin)*** | Tier 2 | PA |
| ***ery-tab tbec 250mg, 333mg, 500mg*** (Ery-tab) | Tier 1 | |
| ***erythrocin stearate tabs 250mg*** (Erythrocin Stearate) | Tier 1 | |
| ***erythromycin base cpep 250mg; tabs 250mg, 500mg*** | Tier 1 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***erythromycin ethylsuccinate susr 200mg/5ml, 400mg/5ml; tabs 400mg*** | Tier 1 | |
| ***FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS*** | | |
| CIPRO SUSR 500mg/5ml ***(ciprofloxacin)*** | Tier 3 | |
| ***ciprofloxacin hcl tabs 100mg, 250mg, 500mg, 750mg*** | Tier 1 | |
| ***levofloxacin soln 25mg/ml*** | MB | |
| ***levofloxacin soln 25mg/ml; tabs 250mg, 500mg, 750mg*** | Tier 1 | |
| ***moxifloxacin hcl tabs 400mg*** | Tier 1 | |
| ***ofloxacin tabs 300mg, 400mg*** | Tier 1 | |
| ***HEPATITIS B*** | | |
| ***adefovir dipivoxil tabs 10mg*** | Tier 4 | SP |
| BARACLUDE SOLN .05mg/ml ***(entecavir)*** | Tier 4 | SP, PA, QL (630 mL every 30 days) |
| ***entecavir tabs .5mg, 1mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days) |
| ***lamivudine (hbv) tabs 100mg*** | Tier 1 | SP |
| ***HEPATITIS C*** | | |
| EPCLUSA PAK 150-37.5 ***(sofosbuvir-velpatasvir)*** | Tier 3 | SP, PA, QL (28 pellets every 28 days) |
| EPCLUSA PAK 200-50MG ***(sofosbuvir-velpatasvir)*** | Tier 3 | SP, PA, QL (56 pellets every 28 days) |
| EPCLUSA TAB 200-50MG ***(sofosbuvir-velpatasvir)*** | Tier 3 | SP, PA, QL (28 tabs every 28 days) |
| EPCLUSA TAB 400-100 ***(sofosbuvir-velpatasvir)*** | Tier 3 | SP, PA, QL (28 tabs every 28 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| HARVONI PAK ***(ledipasvir-sofosbuvir)*** | Tier 3 | SP, PA, QL (28 pellets every 28 days) |
| HARVONI PAK 45-200MG ***(ledipasvir-sofosbuvir)*** | Tier 3 | SP, PA, QL (56 pellets every 28 days) |
| HARVONI TAB 45-200MG ***(ledipasvir-sofosbuvir)*** | Tier 3 | SP, PA, QL (28 tabs every 28 days) |
| HARVONI TAB 90-400MG ***(ledipasvir-sofosbuvir)*** | Tier 3 | SP, PA, QL (28 tabs every 28 days) |
| PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml ***(peginterferon alfa-2a)*** | MB | |
| ***ribavirin (hepatitis c) caps 200mg; tabs 200mg*** | Tier 1 | SP, PA |
| SOVALDI PACK 150mg ***(sofosbuvir)*** | Tier 4 | SP, PA, QL (28 pellets every 28 days) |
| SOVALDI PACK 200mg ***(sofosbuvir)*** | Tier 4 | SP, PA, QL (56 pellets every 28 days) |
| SOVALDI TABS 200mg, 400mg ***(sofosbuvir)*** | Tier 4 | SP, PA, QL (28 tabs every 28 days) |
| VOSEVI TAB ***(sofosbuvir-velpatasvir-voxilaprevir)*** | Tier 3 | SP, PA, QL (28 tabs every 28 days) |
| ***MISCELLANEOUS*** | | |
| ALINIA SUSR 100mg/5ml ***(nitazoxanide)*** | Tier 3 | QL (540 mL every 30 days) |
| ***atovaquone susp 750mg/5ml*** | Tier 1 | |
| ***aztreonam solr 1gm, 2gm*** | MB | |
| ***clindamycin hcl caps 75mg, 150mg, 300mg*** | Tier 1 | |
| ***clindamycin palmitate hydrochloride solr 75mg/5ml*** | Tier 1 | |
| ***clindamycin phosphate soln 9gm/60ml, 300mg/2ml, 600mg/4ml, 9000mg/60ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***dapsone tabs 25mg, 100mg*** | Tier 1 | MO |
| ***ertapenem sodium solr 1gm*** | MB | |
| ***linezolid soln 600mg/300ml*** | MB | |
| ***linezolid susr 100mg/5ml; tabs 600mg*** | Tier 1 | |
| ***meropenem solr 1gm, 500mg*** | MB | |
| ***methenamine hippurate tabs 1gm*** | Tier 1 | |
| ***metronidazole caps 375mg; tabs 250mg, 500mg*** | Tier 1 | |
| ***metronidazole soln 500mg/100ml*** | MB | |
| ***nitazoxanide 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 caps 25mg, 50mg, 100mg*** | Tier 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***nitrofurantoin monohyd macro caps 100mg*** | Tier 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***pentamidine isethionate solr 300mg*** | Tier 1 | |
| ***pentamidine isethionate solr 300mg*** | MB | |
| ***polymyxin b sulfate solr 500000unit*** | MB | |
| ***pyrimethamine tabs 25mg*** | Tier 2 | PA |
| ***trimethoprim tabs 100mg*** | Tier 1 | |
| ***vancomycin hcl caps 125mg, 250mg*** | Tier 1 | QL (80 caps every 10 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***vancomycin hcl solr 1gm, 5gm, 10gm, 500mg, 750mg*** | MB | |
| ***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 | |
| ***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*** | Tier 1 | |
| ***amoxicillin & k clavulanate tab 250-125 mg*** | Tier 1 | |
| ***amoxicillin & k clavulanate tab 500-125 mg*** | 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 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***penicillin v potassium solr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg*** | Tier 1 | |
| ***pfizerpen solr 20000000unit*** (Pfizerpen) | MB | |
| ***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*** | | |
| ***avidoxy tabs 100mg*** (Avidoxy) | Tier 1 | |
| ***demeclocycline hcl tabs 150mg, 300mg*** | Tier 1 | |
| ***doxy 100 solr 100mg*** (Doxy 100) | MB | |
| ***doxycycline (monohydrate) caps 50mg, 100mg; susr 25mg/5ml; tabs 50mg, 75mg, 150mg*** | Tier 1 | |
| ***doxycycline hyclate caps 50mg, 100mg; tabs 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) |
| **ANTIASTHMATIC AND BRONCHODILATOR AGENTS** | | |
| ***STEROID INHALANTS - DRUGS TO TREAT ASTHMA*** | | |
| FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act ***(fluticasone propionate hfa)*** | Tier 3 | QL (6 inhalers per 75 days), MO |
| ***fluticasone propionate hfa aero 44mcg/act, 110mcg/act, 220mcg/act*** | Tier 1 | QL (6 inhalers per 75 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| **ANTICONVULSANTS - DRUGS TO TREAT SEIZURES** | | |
| ***ANTICONVULSANTS - MISC.*** | | |
| BRIVIACT SOLN 10mg/ml; TABS 10mg, 25mg, 50mg, 75mg, 100mg ***(brivaracetam)*** | Tier 3 | MO |
| **ANTIMYASTHENIC/CHOLINERGIC AGENTS** | | |
| ***ANTIMYASTHENIC/CHOLINERGIC AGENTS*** | | |
| ***neostigmine methylsulfate soln 10mg/10ml*** | MB | |
| **ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER** | | |
| ***ALKYLATING AGENTS*** | | |
| ***busulfan soln 6mg/ml*** | MB | |
| ***carmustine solr 100mg*** | MB | |
| ***cyclophosphamide caps 25mg, 50mg*** | Tier 1 | OAC |
| ***cyclophosphamide solr 1gm, 2gm, 500mg*** | MB | |
| ***dacarbazine solr 100mg, 200mg*** | MB | |
| EMCYT CAPS 140mg ***(estramustine phosphate sodium)*** | Tier 4 | OAC |
| GLEOSTINE CAPS 10mg, 40mg, 100mg ***(lomustine)*** | Tier 4 | SP; OAC |
| GLIADEL WAF 7.7MG ***(carmustine in polifeprosan)*** | MB | |
| ***ifosfamide soln 1gm/20ml, 3gm/60ml; solr 1gm*** | MB | |
| LEUKERAN TABS 2mg ***(chlorambucil)*** | Tier 2 | OAC |
| MATULANE CAPS 50mg ***(procarbazine hcl)*** | Tier 2 | OAC |
| ***melphalan tabs 2mg*** | Tier 1 | OAC |
| ***melphalan hcl solr 50mg*** | MB | |
| TEMODAR SOLR 100mg ***(temozolomide)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg*** | Tier 4 | SP, PA; OAC |
| ***ANTIBIOTICS*** | | |
| ***adriamycin solr 50mg*** (Adriamycin) | MB | |
| ***bleomycin sulfate solr 15unit, 30unit*** | MB | |
| ***daunorubicin hcl soln 20mg/4ml*** | MB | |
| ***doxorubicin hcl soln 2mg/ml; solr 10mg*** | MB | |
| ***doxorubicin hcl liposomal susp 2mg/ml*** | MB | |
| ***idarubicin hcl soln 5mg/5ml, 10mg/10ml, 20mg/20ml*** | MB | |
| ***mitomycin solr 5mg, 20mg, 40mg*** | MB | |
| ***mitoxantrone hcl conc 2mg/ml*** | MB | |
| ***ANTIMETABOLITES*** | | |
| ***azacitidine susr 100mg*** | MB | |
| ***capecitabine tabs 150mg, 500mg*** | Tier 4 | SP, PA; OAC |
| ***cladribine soln 10mg/10ml*** | MB | |
| ***clofarabine soln 1mg/ml*** | MB | |
| ***cytarabine soln 20mg/ml, 100mg/ml*** | MB | |
| ***decitabine solr 50mg*** | MB | |
| ***fludarabine phosphate soln 50mg/2ml; solr 50mg*** | MB | |
| ***fluorouracil soln 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml*** | MB | |
| ***gemcitabine hcl soln 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; solr 1gm, 2gm, 200mg*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***mercaptopurine tabs 50mg*** | Tier 1 | OAC |
| ***methotrexate sodium soln 1gm/40ml, 50mg/2ml, 250mg/10ml; solr 1gm*** | MB | |
| ***pemetrexed disodium solr 100mg, 500mg*** | MB | |
| TABLOID TABS 40mg ***(thioguanine)*** | Tier 2 | OAC |
| ***ANTIMITOTIC, TAXOIDS*** | | |
| ***docetaxel conc 20mg/ml, 80mg/4ml, 160mg/8ml; soln 20mg/2ml, 80mg/8ml, 160mg/16ml*** | MB | |
| ***paclitaxel conc 30mg/5ml, 100mg/16.7ml, 150mg/25ml, 300mg/50ml*** | MB | |
| ***ANTIMITOTIC, VINCA ALKALOIDS*** | | |
| ***vinblastine sulfate soln 1mg/ml*** | MB | |
| ***vincristine sulfate soln 1mg/ml*** | MB | |
| ***vinorelbine tartrate soln 10mg/ml, 50mg/5ml*** | MB | |
| ***ANTINEOPLASTIC, BCL-2 INHIBITORS*** | | |
| VENCLEXTA TABS 10mg, 50mg ***(venetoclax)*** | Tier 4 | PA, QL (120 every 30 days); OAC |
| VENCLEXTA TABS 100mg ***(venetoclax)*** | Tier 4 | PA, QL (180 every 30 days); OAC |
| VENCLEXTA TAB START PK ***(venetoclax)*** | Tier 4 | PA, QL (1 pack every 28 days); OAC |
| ***BIOLOGIC RESPONSE MODIFIERS*** | | |
| ERBITUX SOLN 100mg/50ml, 200mg/100ml ***(cetuximab)*** | MB | |
| ERIVEDGE CAPS 150mg ***(vismodegib)*** | Tier 4 | SP, PA, QL (30 caps every 30 days); OAC |
| GAZYVA SOLN 1000mg/40ml ***(obinutuzumab)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| KADCYLA SOLR 100mg, 160mg ***(ado-trastuzumab emtansine)*** | MB | |
| KEYTRUDA SOLN 100mg/4ml ***(pembrolizumab)*** | MB | |
| PADCEV SOLR 20mg, 30mg ***(enfortumab vedotin-ejfv)*** | MB | |
| POLIVY SOLR 30mg, 140mg ***(polatuzumab vedotin-piiq)*** | MB | |
| POMALYST CAPS 1mg, 2mg, 3mg, 4mg ***(pomalidomide)*** | Tier 4 | SP, PA, QL (21 caps every 28 days); OAC |
| REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg ***(lenalidomide)*** | Tier 4 | SP, PA, QL (28 caps every 28 days); OAC |
| REVLIMID CAPS 20mg, 25mg ***(lenalidomide)*** | Tier 4 | SP, PA, QL (21 caps every 28 days); OAC |
| RUXIENCE SOLN 100mg/10ml, 500mg/50ml ***(rituximab-pvvr)*** | MB | |
| THALOMID CAPS 50mg ***(thalidomide)*** | Tier 4 | SP, PA, QL (28 caps every 28 days); OAC |
| THALOMID CAPS 100mg ***(thalidomide)*** | Tier 4 | SP, PA, QL (112 caps every 28 days); OAC |
| THALOMID CAPS 150mg, 200mg ***(thalidomide)*** | Tier 4 | SP, PA, QL (56 caps every 28 days); OAC |
| TICE BCG SUSR 50mg ***(bcg live intravesical)*** | MB | |
| ***HORMONAL ANTINEOPLASTIC AGENTS*** | | |
| ***abiraterone acetate tabs 250mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| ***abiraterone acetate tabs 500mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***anastrozole tabs 1mg*** | Tier 1 | MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer |
| ***bicalutamide tabs 50mg*** | Tier 1 | OAC |
| ELIGARD KIT 7.5mg ***(leuprolide acetate)*** | MB | |
| ELIGARD KIT 22.5mg ***(leuprolide acetate (3 month))*** | MB | |
| ELIGARD KIT 30mg ***(leuprolide acetate (4 month))*** | MB | |
| ELIGARD KIT 45mg ***(leuprolide acetate (6 month))*** | MB | |
| ERLEADA TABS 60mg ***(apalutamide)*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| ERLEADA TABS 240mg ***(apalutamide)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| ***exemestane tabs 25mg*** | Tier 1 | MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer |
| ***fulvestrant sosy 250mg/5ml*** | MB | |
| ***letrozole tabs 2.5mg*** | Tier 1 | MO; OAC |
| ***leuprolide acetate kit 1mg/0.2ml*** | MB | |
| LYSODREN TABS 500mg ***(mitotane)*** | Tier 2 | OAC |
| ***megestrol acetate tabs 20mg, 40mg*** | Tier 1 | OAC |
| ***nilutamide tabs 150mg*** | Tier 1 | OAC |
| NUBEQA TABS 300mg ***(darolutamide)*** | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***toremifene citrate tabs 60mg*** | Tier 1 | MO; OAC |
| XTANDI CAPS 40mg ***(enzalutamide)*** | Tier 4 | SP, PA, QL (120 caps every 30 days); OAC |
| XTANDI TABS 40mg ***(enzalutamide)*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| XTANDI TABS 80mg ***(enzalutamide)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| YONSA TABS 125mg ***(abiraterone acetate micronized)*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| ***KINASE INHIBITORS*** | | |
| ALECENSA CAPS 150mg ***(alectinib hcl)*** | Tier 4 | SP, PA, QL (240 caps every 30 days); OAC |
| CABOMETYX TABS 20mg, 40mg, 60mg ***(cabozantinib s-malate)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| CALQUENCE TABS 100mg ***(acalabrutinib maleate)*** | Tier 4 | PA, QL (60 tabs every 30 days); OAC |
| CAPRELSA TABS 100mg ***(vandetanib)*** | Tier 4 | PA, QL (60 tabs every 30 days); OAC |
| CAPRELSA TABS 300mg ***(vandetanib)*** | Tier 4 | PA, QL (30 tabs every 30 days); OAC |
| COMETRIQ KIT 20mg ***(cabozantinib s-malate)*** | Tier 4 | SP, PA, QL (1 kit every 28 days); OAC |
| COMETRIQ KIT 100MG ***(cabozantinib s-malate)*** | Tier 4 | SP, PA, QL (1 kit every 28 days); OAC |
| COMETRIQ KIT 140MG ***(cabozantinib s-malate)*** | Tier 4 | SP, PA, QL (1 kit every 28 days); OAC |
| ***dasatinib tabs 20mg*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| ***dasatinib tabs 50mg, 70mg, 80mg, 100mg, 140mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***erlotinib hcl tabs 25mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| ***erlotinib hcl tabs 100mg, 150mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| ***everolimus tabs 2.5mg, 5mg, 7.5mg, 10mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| ***everolimus tbso 2mg, 5mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| ***everolimus tbso 3mg*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| ***imatinib mesylate tabs 100mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| ***imatinib mesylate tabs 400mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| IMBRUVICA CAPS 70mg ***(ibrutinib)*** | Tier 4 | PA, QL (30 caps every 30 days); OAC |
| IMBRUVICA CAPS 140mg ***(ibrutinib)*** | Tier 4 | PA, QL (90 caps every 30 days); OAC |
| IMBRUVICA SUSP 70mg/ml ***(ibrutinib)*** | Tier 4 | PA, QL (216 ml every 36 days); OAC |
| IMBRUVICA TABS 140mg, 280mg, 420mg ***(ibrutinib)*** | Tier 4 | PA, QL (30 tabs every 30 days); OAC |
| INLYTA TABS 1mg ***(axitinib)*** | Tier 4 | SP, PA, QL (240 tabs every 30 days); OAC |
| INLYTA TABS 5mg ***(axitinib)*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg ***(ruxolitinib phosphate)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| KISQALI TBPK 200mg ***(ribociclib succinate)*** | Tier 4 | SP, PA, QL (21 tabs every 28 days); 200 mg dose; OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| KISQALI TBPK 200mg ***(ribociclib succinate)*** | Tier 4 | SP, PA, QL (42 tabs every 28 days); 400 mg dose; OAC |
| KISQALI TBPK 200mg ***(ribociclib succinate)*** | Tier 4 | SP, PA, QL (63 tabs every 28 days); 600 mg dose; OAC |
| ***lapatinib ditosylate tabs 250mg*** | Tier 4 | SP, PA, QL (180 tabs every 30 days); OAC |
| LENVIMA 4 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (30 caps every 30 days); OAC |
| LENVIMA 8 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (60 caps every 30 days); OAC |
| LENVIMA 10 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (30 caps every 30 days); OAC |
| LENVIMA 12MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (90 caps every 30 days); OAC |
| LENVIMA 20 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (60 caps every 30 days); OAC |
| LENVIMA CAP 14 MG ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (60 caps every 30 days); OAC |
| LENVIMA CAP 18 MG ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (90 caps every 30 days); OAC |
| LENVIMA CAP 24 MG ***(lenvatinib mesylate)*** | Tier 4 | SP, PA, QL (90 caps every 30 days); OAC |
| LORBRENA TABS 25mg ***(lorlatinib)*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| LORBRENA TABS 100mg ***(lorlatinib)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| MEKINIST SOLR .05mg/ml ***(trametinib dimethyl sulfoxide)*** | Tier 4 | SP, PA, QL (12 bottles every 28 days); OAC |
| MEKINIST TABS 2mg ***(trametinib dimethyl sulfoxide)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| MEKINIST TABS .5mg ***(trametinib dimethyl sulfoxide)*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| ***pazopanib hcl tabs 200mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| RYDAPT CAPS 25mg ***(midostaurin)*** | Tier 4 | SP, PA, QL (224 caps every 28 days); OAC |
| ***sorafenib tosylate tabs 200mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| SPRYCEL TABS 20mg ***(dasatinib)*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg ***(dasatinib)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| STIVARGA TABS 40mg ***(regorafenib)*** | Tier 4 | SP, PA, QL (84 tabs every 28 days); OAC |
| ***sunitinib malate caps 12.5mg, 25mg, 37.5mg, 50mg*** | Tier 4 | SP, PA, QL (30 caps every 30 days); OAC |
| TAFINLAR CAPS 50mg, 75mg ***(dabrafenib mesylate)*** | Tier 4 | SP, PA, QL (120 caps every 30 days); OAC |
| TAFINLAR TBSO 10mg ***(dabrafenib mesylate)*** | Tier 4 | SP, PA, QL (4 bottles every 28 days); OAC |
| TUKYSA TABS 50mg, 150mg ***(tucatinib)*** | Tier 4 | PA, QL (120 tabs every 30 days); OAC |
| VERZENIO TABS 50mg, 100mg, 150mg, 200mg ***(abemaciclib)*** | Tier 4 | SP, PA, QL (56 tabs every 28 days); OAC |
| VITRAKVI CAPS 25mg ***(larotrectinib sulfate)*** | Tier 4 | SP, PA, QL (180 caps every 30 days); OAC |
| VITRAKVI CAPS 100mg ***(larotrectinib sulfate)*** | Tier 4 | SP, PA, QL (60 caps every 30 days); OAC |
| VITRAKVI SOLN 20mg/ml ***(larotrectinib sulfate)*** | Tier 4 | SP, PA, QL (300 mL every 30 days); OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| XALKORI CAPS 200mg, 250mg ***(crizotinib)*** | Tier 4 | SP, PA, QL (120 caps every 30 days); OAC |
| XALKORI CPSP 20mg, 50mg ***(crizotinib)*** | Tier 4 | SP, PA, QL (120 pellets every 30 days); OAC |
| XALKORI CPSP 150mg ***(crizotinib)*** | Tier 4 | SP, PA, QL (180 pellets every 30 days); OAC |
| ZELBORAF TABS 240mg ***(vemurafenib)*** | Tier 4 | SP, PA, QL (240 tabs every 30 days); OAC |
| ZYDELIG TABS 100mg, 150mg ***(idelalisib)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); OAC |
| ZYKADIA TABS 150mg ***(ceritinib)*** | Tier 4 | SP, PA, QL (90 tabs every 30 days); OAC |
| ***MISCELLANEOUS*** | | |
| ***arsenic trioxide soln 10mg/10ml, 12mg/6ml*** | MB | |
| ***bexarotene caps 75mg*** | Tier 4 | SP, PA; OAC |
| ***hydroxyurea caps 500mg*** | Tier 1 | OAC |
| IDHIFA TABS 50mg, 100mg ***(enasidenib mesylate)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| LYNPARZA TABS 100mg, 150mg ***(olaparib)*** | Tier 4 | SP, PA, QL (120 tabs every 30 days); OAC |
| NIPENT SOLR 10mg ***(pentostatin)*** | MB | |
| ODOMZO CAPS 200mg ***(sonidegib phosphate)*** | Tier 4 | SP, PA, QL (30 caps every 30 days); OAC |
| ONCASPAR SOLN 750unit/ml ***(pegaspargase)*** | MB | |
| PHOTOFRIN SOLR 75mg ***(porfimer sodium)*** | MB | |
| ***tretinoin (chemotherapy) caps 10mg*** | Tier 1 | OAC |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| VISTOGARD PACK 10gm ***(uridine triacetate (emergency treatment))*** | Tier 4 | QL (20 packets every 5 days); OAC |
| ZEJULA CAPS 100mg ***(niraparib tosylate)*** | Tier 4 | SP, PA, QL (90 caps every 30 days); OAC |
| ZEJULA TABS 100mg, 200mg, 300mg ***(niraparib tosylate)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); OAC |
| ZOLINZA CAPS 100mg ***(vorinostat)*** | Tier 4 | SP, PA, QL (120 caps every 30 days); OAC |
| ***PLATINUM-BASED AGENTS*** | | |
| ***carboplatin soln 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml*** | MB | |
| ***cisplatin soln 50mg/50ml, 100mg/100ml, 200mg/200ml*** | MB | |
| ***oxaliplatin soln 50mg/10ml, 100mg/20ml; solr 50mg, 100mg*** | MB | |
| ***paraplatin soln 1000mg/100ml*** (Paraplatin) | 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 soln 100mg/ml*** | MB | |
| MESNEX TABS 400mg ***(mesna)*** | Tier 4 | OAC |
| ***TOPOISOMERASE INHIBITORS*** | | |
| ***etoposide caps 50mg*** | Tier 1 | OAC |
| ***etoposide soln 1gm/50ml, 100mg/5ml, 500mg/25ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***irinotecan hcl soln 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml*** | MB | |
| ***topotecan hcl solr 4mg*** | MB | |
| **ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS** | | |
| ***ANTIVIRAL COMBINATIONS*** | | |
| PAXLOVID TAB 300-100 ***(nirmatrelvir-ritonavir)*** | PV | QL (30 tabs every 30 days) |
| ***HEPATITIS AGENTS*** | | |
| PEGINTRON KIT 50mcg/0.5ml ***(peginterferon alfa-2b)*** | MB | |
| ***MISC. ANTIVIRALS*** | | |
| LAGEVRIO CAPS 200mg ***(molnupiravir)*** | PV | QL (40 caps every 30 days) |
| **CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS** | | |
| ***ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE*** | | |
| ***amlodipine besylate-benazepril hcl cap 2.5-10 mg*** | Tier 1 | MO |
| ***amlodipine besylate-benazepril hcl cap 5-10 mg*** | Tier 1 | MO |
| ***amlodipine besylate-benazepril hcl cap 5-20 mg*** | Tier 1 | MO |
| ***amlodipine besylate-benazepril hcl cap 5-40 mg*** | Tier 1 | MO |
| ***amlodipine besylate-benazepril hcl cap 10-20 mg*** | Tier 1 | MO |
| ***amlodipine besylate-benazepril hcl cap 10-40 mg*** | Tier 1 | MO |
| ***benazepril & hydrochlorothiazide tab 5-6.25 mg*** | Tier 1 | MO |
| ***benazepril & hydrochlorothiazide tab 10-12.5 mg*** | Tier 1 | MO |
| ***benazepril & hydrochlorothiazide tab 20-12.5 mg*** | Tier 1 | MO |
| ***benazepril & hydrochlorothiazide tab 20-25 mg*** | Tier 1 | MO |
| ***enalapril maleate & hydrochlorothiazide tab 5-12.5 mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***enalapril maleate & hydrochlorothiazide tab 10-25 mg*** | 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*** | Tier 1 | MO |
| ***lisinopril & hydrochlorothiazide tab 20-12.5 mg*** | Tier 1 | MO |
| ***lisinopril & hydrochlorothiazide tab 20-25 mg*** | Tier 1 | MO |
| ***quinapril-hydrochlorothiazide tab 10-12.5 mg*** | Tier 1 | MO |
| ***quinapril-hydrochlorothiazide tab 20-12.5 mg*** | 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 |
| ***trandolapril-verapamil hcl tab er 4-240 mg*** | Tier 1 | MO |
| ***ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE*** | | |
| ***benazepril hcl tabs 5mg, 10mg, 20mg, 40mg*** | Tier 1 | MO |
| ***captopril tabs 12.5mg, 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***enalapril maleate tabs 2.5mg, 5mg, 10mg, 20mg*** | Tier 1 | MO |
| ***fosinopril sodium tabs 10mg, 20mg, 40mg*** | Tier 1 | MO |
| ***lisinopril tabs 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg*** | Tier 1 | MO |
| ***moexipril hcl tabs 7.5mg, 15mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***perindopril erbumine tabs 2mg, 4mg, 8mg*** | Tier 1 | MO |
| ***quinapril hcl tabs 5mg, 10mg, 20mg, 40mg*** | Tier 1 | MO |
| ***ramipril 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 tabs 25mg, 50mg*** | Tier 1 | MO |
| ***spironolactone tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE*** | | |
| ***prazosin hcl 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*** | Tier 1 | MO |
| ***amlodipine besylate-olmesartan medoxomil tab 5-40 mg*** | Tier 1 | MO |
| ***amlodipine besylate-olmesartan medoxomil tab 10-20 mg*** | Tier 1 | MO |
| ***amlodipine besylate-olmesartan medoxomil tab 10-40 mg*** | Tier 1 | MO |
| ***amlodipine besylate-valsartan tab 5-160 mg*** | Tier 1 | MO |
| ***amlodipine besylate-valsartan tab 5-320 mg*** | Tier 1 | MO |
| ***amlodipine besylate-valsartan tab 10-160 mg*** | Tier 1 | MO |
| ***amlodipine besylate-valsartan tab 10-320 mg*** | Tier 1 | MO |
| ***candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg*** | Tier 1 | MO |

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

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

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***flecainide acetate tabs 50mg, 100mg, 150mg*** | Tier 1 | MO |
| ***lidocaine hcl (cardiac) sosy 50mg/5ml, 100mg/5ml*** | MB | |
| MULTAQ TABS 400mg ***(dronedarone hcl)*** | Tier 3 | PA, MO |
| NORPACE CR CP12 100mg, 150mg ***(disopyramide phosphate)*** | Tier 2 | MO |
| ***pacerone tabs 100mg, 200mg*** (Pacerone) | Tier 1 | MO |
| ***procainamide hcl soln 100mg/ml*** | MB | |
| ***propafenone hcl cp12 225mg, 325mg, 425mg; tabs 150mg, 225mg, 300mg*** | Tier 1 | MO |
| ***sotalol hcl tabs 80mg, 120mg, 160mg, 240mg*** | Tier 1 | MO |
| ***sotalol hcl (afib/afl) tabs 80mg, 120mg, 160mg*** | Tier 1 | MO |
| ***ANTILIPEMICS, BILE ACID RESINS*** | | |
| ***cholestyramine pack 4gm; powd 4gm/dose*** | Tier 1 | MO |
| ***cholestyramine light pack 4gm; powd 4gm/dose*** | Tier 1 | MO |
| ***colestipol hcl gran 5gm; pack 5gm; tabs 1gm*** | Tier 1 | MO |
| ***prevalite powd 4gm/dose*** (Prevalite) | Tier 1 | MO |
| ***ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR*** | | |
| ***ezetimibe tabs 10mg*** | Tier 1 | MO |
| ***ANTILIPEMICS, FIBRATES*** | | |
| ***choline fenofibrate cpdr 45mg, 135mg*** | Tier 1 | MO |
| ***fenofibrate caps 150mg; tabs 48mg, 54mg, 145mg, 160mg*** | Tier 1 | MO |
| ***fenofibrate micronized caps 43mg, 67mg, 134mg, 200mg*** | Tier 1 | MO |
| ***gemfibrozil tabs 600mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS*** | | |
| ***atorvastatin calcium tabs 10mg, 20mg*** | Tier 1 | MO; $0 copay for members age 40 through 75 |
| ***atorvastatin calcium 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; tb24 80mg*** | Tier 1 | MO; $0 copay for members age 40 through 75 |
| ***lovastatin tabs 10mg, 20mg, 40mg*** | Tier 1 | MO; $0 copay for members age 40 through 75 |
| ***pitavastatin calcium tabs 1mg, 2mg, 4mg*** | 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 tabs 5mg, 10mg*** | Tier 1 | MO; $0 copay for members age 40 through 75 |
| ***rosuvastatin calcium 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, 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS*** | | |
| ***ezetimibe-simvastatin tab 10-10 mg*** | Tier 1 | MO |
| ***ezetimibe-simvastatin tab 10-20 mg*** | Tier 1 | MO |
| ***ezetimibe-simvastatin tab 10-40 mg*** | Tier 1 | MO |
| ***ezetimibe-simvastatin tab 10-80 mg*** | Tier 1 | MO |
| ***ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL*** | | |
| ***niacin (antihyperlipidemic) tbcr 500mg, 750mg, 1000mg*** | Tier 1 | MO |
| ***ANTILIPEMICS, OMEGA-3 FATTY ACIDS*** | | |
| ***icosapent ethyl 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 caps .5gm*** | Tier 1 | MO |
| ***omega-3-acid ethyl esters cap 1 gm*** | Tier 1 | MO |
| ***ANTILIPEMICS, PCSK9 INHIBITORS*** | | |
| REPATHA SOSY 140mg/ml ***(evolocumab)*** | MB | |
| REPATHA PUSHTRONEX SYSTEM SOCT 420mg/3.5ml ***(evolocumab)*** | MB | |
| REPATHA SURECLICK SOAJ 140mg/ml ***(evolocumab)*** | MB | |
| ***BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS*** | | |
| ***atenolol & chlorthalidone tab 50-25 mg*** | Tier 1 | MO |
| ***atenolol & chlorthalidone tab 100-25 mg*** | Tier 1 | MO |
| ***bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***bisoprolol & hydrochlorothiazide tab 5-6.25 mg*** | Tier 1 | MO |
| ***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 tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***betaxolol hcl tabs 10mg, 20mg*** | Tier 1 | MO |
| ***bisoprolol fumarate tabs 5mg, 10mg*** | Tier 1 | MO |
| ***carvedilol tabs 3.125mg, 6.25mg, 12.5mg, 25mg*** | Tier 1 | MO |
| ***carvedilol phosphate cp24 10mg, 20mg, 40mg, 80mg*** | Tier 1 | MO |
| ***labetalol hcl tabs 100mg, 200mg, 300mg*** | Tier 1 | MO |
| ***metoprolol succinate tb24 25mg, 50mg, 100mg, 200mg*** | Tier 1 | MO |
| ***metoprolol tartrate tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***nadolol tabs 20mg, 40mg, 80mg*** | Tier 1 | MO |
| ***nebivolol hcl tabs 2.5mg, 5mg, 10mg, 20mg*** | Tier 1 | MO |
| ***pindolol tabs 5mg, 10mg*** | Tier 1 | MO |
| ***propranolol hcl cp24 60mg, 80mg, 120mg, 160mg; soln 20mg/5ml, 40mg/5ml; tabs 10mg, 20mg, 40mg, 60mg, 80mg*** | Tier 1 | MO |
| ***timolol maleate tabs 5mg, 10mg, 20mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS*** | | |
| ***amlodipine besylate-atorvastatin calcium tab 2.5-10 mg*** | 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*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 5-20 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 5-40 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 5-80 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 10-10 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 10-20 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 10-40 mg*** | Tier 1 | MO |
| ***amlodipine besylate-atorvastatin calcium tab 10-80 mg*** | Tier 1 | MO |
| ***CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS*** | | |
| ***amlodipine besylate tabs 2.5mg, 5mg, 10mg*** | Tier 1 | MO |
| ***cartia xt cp24 120mg, 180mg, 240mg, 300mg*** (Cartia Xt) | Tier 1 | MO |
| ***dilt-xr cp24 120mg, 180mg, 240mg*** (Dilt-xr) | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***diltiazem hcl cp12 60mg, 90mg, 120mg; tabs 30mg, 60mg, 90mg, 120mg; tb24 120mg*** | Tier 1 | MO |
| ***diltiazem hcl soln 25mg/5ml, 125mg/25ml*** | MB | |
| ***diltiazem hcl coated beads cp24 120mg, 180mg, 240mg, 300mg, 360mg*** | Tier 1 | MO |
| ***diltiazem hcl extended release beads 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 |
| ***matzim la tb24 180mg, 240mg, 300mg, 360mg, 420mg*** (Matzim La) | Tier 1 | MO |
| ***nicardipine hcl caps 20mg, 30mg*** | Tier 1 | MO |
| ***nifedipine tb24 30mg, 60mg, 90mg*** | Tier 1 | MO |
| ***nimodipine caps 30mg*** | Tier 1 | |
| ***nisoldipine tb24 8.5mg, 17mg, 20mg, 25.5mg, 30mg, 34mg, 40mg*** | Tier 1 | MO |
| ***verapamil hcl cp24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; tabs 40mg, 80mg, 120mg; tbcr 120mg, 180mg, 240mg*** | Tier 1 | MO |
| ***DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS*** | | |
| ***digoxin soln .05mg/ml; tabs 62.5mcg, 125mcg, 250mcg*** | Tier 1 | MO |
| ***DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS*** | | |
| ***aliskiren fumarate tabs 150mg, 300mg*** | Tier 1 | MO |
| ***DIURETICS - DRUGS TO TREAT HEART CONDITIONS*** | | |
| ***acetazolamide cp12 500mg; tabs 125mg, 250mg*** | Tier 1 | MO |
| ***amiloride & hydrochlorothiazide tab 5-50 mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***amiloride hcl tabs 5mg*** | Tier 1 | MO |
| ***bumetanide tabs .5mg, 1mg, 2mg*** | Tier 1 | MO |
| ***chlorthalidone tabs 25mg, 50mg*** | Tier 1 | MO |
| DIURIL SUSP 250mg/5ml ***(chlorothiazide)*** | Tier 3 | MO |
| ***ethacrynic acid tabs 25mg*** | Tier 2 | MO |
| ***furosemide soln 10mg/ml*** | MB | |
| ***furosemide soln 10mg/ml, 40mg/5ml; 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 & hydrochlorothiazide tab 25-25 mg*** | Tier 1 | MO |
| ***torsemide tabs 5mg, 10mg, 20mg, 100mg*** | Tier 1 | MO |
| ***triamterene caps 50mg, 100mg*** | Tier 1 | MO |
| ***triamterene & hydrochlorothiazide cap 37.5-25 mg*** | Tier 1 | MO |
| ***triamterene & hydrochlorothiazide tab 37.5-25 mg*** | Tier 1 | MO |
| ***triamterene & hydrochlorothiazide tab 75-50 mg*** | Tier 1 | MO |
| ***HEART FAILURE*** | | |
| ENTRESTO CAP 6-6MG ***(sacubitril-valsartan)*** | Tier 2 | MO |
| ENTRESTO CAP 15-16MG ***(sacubitril-valsartan)*** | Tier 2 | MO |
| ENTRESTO TAB 24-26MG ***(sacubitril-valsartan)*** | Tier 2 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ENTRESTO TAB 49-51MG ***(sacubitril-valsartan)*** | Tier 2 | MO |
| ENTRESTO TAB 97-103MG ***(sacubitril-valsartan)*** | Tier 2 | MO |
| ***isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg*** | Tier 1 | MO |
| ***MISCELLANEOUS*** | | |
| ***clonidine ptwk .1mg/24hr, .2mg/24hr, .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 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 tabs 5mg, 10mg, 20mg, 30mg*** | Tier 1 | MO |
| ***isosorbide mononitrate tabs 10mg, 20mg; tb24 30mg, 60mg, 120mg*** | Tier 1 | MO |
| NITRO-BID OINT 2% ***(nitroglycerin)*** | Tier 3 | MO |
| NITRO-DUR PT24 .3mg/hr, .8mg/hr ***(nitroglycerin)*** | Tier 2 | MO |
| ***nitroglycerin pt24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; soln .4mg/spray; subl .3mg, .4mg, .6mg*** | Tier 1 | MO |
| ***PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION*** | | |
| ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg ***(riociguat)*** | Tier 4 | SP, PA, QL (90 tabs every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ambrisentan tabs 5mg, 10mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days) |
| ***bosentan tabs 62.5mg, 125mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| OPSUMIT TABS 10mg ***(macitentan)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days) |
| ORENITRAM TBCR .125mg, .25mg, 1mg, 2.5mg, 5mg ***(treprostinil diolamine)*** | Tier 4 | SP, PA |
| ORENITRAM TAB MONTH 1 ***(treprostinil diolamine)*** | Tier 4 | SP, PA |
| ORENITRAM TAB MONTH 2 ***(treprostinil diolamine)*** | Tier 4 | SP, PA |
| ORENITRAM TAB MONTH 3 ***(treprostinil diolamine)*** | Tier 4 | SP, PA |
| REMODULIN SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml ***(treprostinil)*** | MB | |
| ***sildenafil citrate (pulmonary hypertension) soln 10mg/12.5ml*** | MB | |
| ***sildenafil citrate (pulmonary hypertension) tabs 20mg*** | Tier 4 | SP, PA, QL (360 tabs every 30 days) |
| ***tadalafil (pulmonary hypertension) tabs 20mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| TYVASO SOLN .6mg/ml ***(treprostinil)*** | Tier 4 | SP, PA, QL (28 ampules every 28 days) |
| TYVASO REFILL KIT SOLN .6mg/ml ***(treprostinil)*** | Tier 4 | SP, PA, QL (28 ampules every 28 days) |
| TYVASO STARTER KIT SOLN .6mg/ml ***(treprostinil)*** | Tier 4 | SP, PA, QL (28 ampules every 28 days) |
| UPTRAVI SOLR 1800mcg ***(selexipag)*** | MB | |
| UPTRAVI TABS 200mcg ***(selexipag)*** | Tier 4 | SP, PA, QL (140 tabs every 28 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| UPTRAVI TABS 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg ***(selexipag)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| UPTRAVI PACK TAB 200/800 ***(selexipag)*** | Tier 4 | SP, PA, QL (1 pack every 28 days) |
| VENTAVIS SOLN 10mcg/ml, 20mcg/ml ***(iloprost)*** | Tier 4 | SP, PA, QL (270 ampules every 30 days) |
| **CARDIOVASCULAR AGENTS - MISC.** | | |
| ***IMPOTENCE AGENTS*** | | |
| ***sildenafil citrate tabs 25mg, 50mg, 100mg*** | Tier 1 | PA, QL (8 tabs every 21 days) |
| ***tadalafil 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) |
| **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 tabs .25mg, .5mg, 1mg, 2mg; tbdp .25mg, .5mg, 1mg, 2mg*** | Tier 1 | QL (150 tabs every 30 days) |
| ALPRAZOLAM INTENSOL CONC 1mg/ml ***(alprazolam)*** | Tier 2 | QL (300 mL every 30 days) |
| ***buspirone hcl tabs 5mg, 7.5mg, 10mg, 15mg, 30mg*** | Tier 1 | |
| ***clomipramine hcl caps 25mg, 50mg*** | Tier 1 | QL (150 caps every 30 days), MO; QL applies to members age 65 and older |
| ***clomipramine hcl 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***lorazepam conc 2mg/ml*** | Tier 1 | QL (150 mL every 30 days) |
| ***lorazepam 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) |
| ***ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS*** | | |
| ***donepezil hydrochloride tabs 5mg, 10mg, 23mg; tbdp 5mg, 10mg*** | Tier 1 | MO |
| ***galantamine hydrobromide cp24 8mg, 16mg, 24mg; soln 4mg/ml; tabs 4mg, 8mg, 12mg*** | Tier 1 | MO |
| ***memantine hcl cp24 7mg, 14mg, 21mg, 28mg; soln 2mg/ml; tabs 5mg, 10mg*** | Tier 1 | MO |
| ***memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack*** | Tier 1 | |
| ***rivastigmine pt24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr*** | Tier 1 | MO |
| ***rivastigmine tartrate caps 1.5mg, 3mg, 4.5mg, 6mg*** | Tier 1 | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***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; tb12 100mg, 150mg, 200mg; tb24 150mg, 300mg*** | Tier 1 | MO |
| ***citalopram hydrobromide soln 10mg/5ml; tabs 10mg, 20mg, 40mg*** | Tier 1 | MO |
| ***desipramine hcl tabs 10mg, 25mg, 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 tb24 25mg, 50mg, 100mg*** | Tier 1 | MO; (generic of Pristiq) |
| ***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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***duloxetine hcl cpep 20mg, 30mg, 60mg*** | Tier 1 | MO |
| EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr ***(selegiline)*** | Tier 3 | PA, MO |
| ***escitalopram oxalate soln 5mg/5ml; tabs 5mg, 10mg, 20mg*** | Tier 1 | MO |
| FETZIMA CP24 20mg, 40mg, 80mg, 120mg ***(levomilnacipran hcl)*** | Tier 3 | MO |
| FETZIMA CAP TITRATIO ***(levomilnacipran hcl)*** | Tier 3 | |
| ***fluoxetine hcl caps 10mg, 20mg, 40mg; cpdr 90mg; soln 20mg/5ml*** | Tier 1 | MO |
| ***fluoxetine hcl tabs 10mg, 20mg*** | Tier 1 | MO; (generic Sarafem not covered) |
| ***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 ***(isocarboxazid)*** | Tier 3 | MO |
| ***mirtazapine tabs 7.5mg, 15mg, 30mg, 45mg; tbdp 15mg, 30mg, 45mg*** | Tier 1 | MO |
| ***nefazodone hcl tabs 50mg, 100mg, 150mg, 200mg, 250mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***nortriptyline hcl caps 10mg*** | Tier 1 | QL (150 caps every 30 days), MO; QL applies to members age 65 and older |
| ***nortriptyline hcl caps 25mg*** | Tier 1 | QL (60 caps every 30 days), MO; QL applies to members age 65 and older |
| ***nortriptyline hcl caps 50mg*** | Tier 1 | QL (30 caps every 30 days), MO; QL applies to members age 65 and older |
| ***nortriptyline hcl 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 tabs 10mg, 20mg, 30mg, 40mg; tb24 12.5mg, 25mg, 37.5mg*** | Tier 1 | MO |
| ***phenelzine sulfate 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 |
| ***sertraline hcl conc 20mg/ml; tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***tranylcypromine sulfate 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***trimipramine maleate caps 100mg*** | Tier 1 | QL (30 caps every 30 days), MO; QL applies to members age 65 and older |
| ***venlafaxine hcl cp24 37.5mg, 75mg, 150mg; tabs 25mg, 37.5mg, 50mg, 75mg, 100mg; tb24 37.5mg, 75mg, 150mg*** | 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 ***(apomorphine hydrochloride)*** | MB | |
| ***benztropine mesylate soln 1mg/ml*** | MB | |
| ***benztropine mesylate tabs .5mg, 1mg, 2mg*** | Tier 1 | MO |
| ***bromocriptine mesylate 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*** | Tier 1 | MO |
| ***carbidopa & levodopa tab 25-100 mg*** | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***carbidopa-levodopa-entacapone tabs 12.5-50-200 mg*** | Tier 1 | MO |
| ***carbidopa-levodopa-entacapone tabs 18.75-75-200 mg*** | Tier 1 | MO |
| ***carbidopa-levodopa-entacapone tabs 25-100-200 mg*** | Tier 1 | MO |
| ***carbidopa-levodopa-entacapone tabs 31.25-125-200 mg*** | Tier 1 | MO |
| ***carbidopa-levodopa-entacapone tabs 37.5-150-200 mg*** | Tier 1 | MO |
| ***carbidopa-levodopa-entacapone tabs 50-200-200 mg*** | Tier 1 | MO |
| ***entacapone tabs 200mg*** | Tier 1 | MO |
| INBRIJA CAPS 42mg ***(levodopa)*** | Tier 4 | PA, QL (300 caps every 30 days) |
| NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr ***(rotigotine)*** | Tier 2 | MO |
| ***pramipexole dihydrochloride tabs .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg; tb24 .375mg, .75mg, 1.5mg, 2.25mg, 3mg, 3.75mg, 4.5mg*** | Tier 1 | MO |
| ***rasagiline mesylate 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; tabs 2mg, 5mg, 10mg, 15mg, 20mg, 30mg; tbdp 10mg, 15mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml, 1064mg/3.9ml ***(aripiprazole lauroxil)*** | MB | |
| ARISTADA INITIO PRSY 675mg/2.4ml ***(aripiprazole lauroxil)*** | MB | |
| ***asenapine maleate subl 2.5mg, 5mg, 10mg*** | Tier 1 | MO |
| ***chlorpromazine hcl soln 25mg/ml, 50mg/2ml*** | MB | |
| ***chlorpromazine hcl tabs 10mg, 25mg, 50mg, 100mg, 200mg*** | Tier 1 | MO |
| ***clozapine tabs 25mg, 50mg, 100mg, 200mg; 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 soln 50mg/ml, 100mg/ml*** | MB | |
| ***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 tabs 20mg, 40mg, 60mg, 80mg, 120mg*** | Tier 1 | MO |
| ***olanzapine solr 10mg*** | MB | |
| ***olanzapine tabs 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg; tbdp 5mg, 10mg, 15mg, 20mg*** | Tier 1 | MO |
| ***paliperidone tb24 1.5mg, 3mg, 6mg, 9mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***perphenazine tabs 2mg, 4mg, 8mg, 16mg*** | Tier 1 | MO |
| ***quetiapine fumarate tabs 25mg, 50mg, 100mg, 200mg, 300mg, 400mg; tb24 50mg, 150mg, 200mg, 300mg, 400mg*** | Tier 1 | MO |
| ***risperidone soln 1mg/ml; tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg; 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 ***(cariprazine hcl)*** | Tier 2 | ST, MO; PA** |
| VRAYLAR CAP 1.5-3MG ***(cariprazine hcl)*** | Tier 2 | ST; PA** |
| ***ziprasidone hcl caps 20mg, 40mg, 60mg, 80mg*** | Tier 1 | MO |
| ***ANTISEIZURE AGENTS*** | | |
| ***carbamazepine chew 100mg; cp12 100mg, 200mg, 300mg; susp 100mg/5ml; tabs 200mg; tb12 100mg, 200mg, 400mg*** | Tier 1 | MO |
| ***clobazam susp 2.5mg/ml; tabs 10mg, 20mg*** | Tier 1 | MO |
| ***clonazepam tabs .5mg, 1mg, 2mg*** | Tier 1 | |
| ***clorazepate dipotassium tabs 3.75mg, 7.5mg, 15mg*** | Tier 1 | QL (180 tabs every 30 days) |
| ***diazepam soln 5mg/5ml*** | Tier 1 | QL (1200 mL every 30 days) |
| ***diazepam soln 5mg/ml*** | MB | |
| ***diazepam tabs 2mg, 5mg, 10mg*** | Tier 1 | QL (120 tabs every 30 days) |
| ***diazepam intensol conc 5mg/ml*** (Diazepam Intensol) | Tier 1 | QL (240 mL every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| DILANTIN CAPS 30mg ***(phenytoin sodium extended)*** | Tier 3 | MO |
| ***divalproex sodium csdr 125mg; tb24 250mg, 500mg; tbec 125mg, 250mg, 500mg*** | Tier 1 | MO |
| ***epitol tabs 200mg*** (Epitol) | Tier 1 | MO |
| ***ethosuximide caps 250mg; soln 250mg/5ml*** | Tier 1 | MO |
| ***felbamate susp 600mg/5ml; tabs 400mg, 600mg*** | Tier 1 | MO |
| ***fosphenytoin sodium soln 100mgpe/2ml, 500mgpe/10ml*** | MB | |
| ***gabapentin caps 100mg, 300mg, 400mg*** | Tier 1 | QL (6 caps every day), MO |
| ***gabapentin soln 250mg/5ml*** | Tier 1 | QL (72 mL every day), MO |
| ***gabapentin tabs 600mg*** | Tier 1 | QL (6 tabs every day), MO |
| ***gabapentin tabs 800mg*** | Tier 1 | QL (4 tabs every day), MO |
| ***lacosamide soln 10mg/ml; tabs 50mg, 100mg, 150mg, 200mg*** | Tier 1 | MO |
| ***lacosamide soln 200mg/20ml*** | MB | |
| ***lamotrigine chew 5mg, 25mg; tabs 25mg, 100mg, 150mg, 200mg; tb24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg; tbdp 25mg, 50mg, 100mg, 200mg*** | Tier 1 | MO |
| ***lamotrigine kit 25mg*** | Tier 1 | |
| ***lamotrigine tab 25 mg (42) & 100 mg (7) starter kit*** | Tier 1 | |
| ***lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit*** | Tier 1 | |
| ***levetiracetam soln 100mg/ml; tabs 250mg, 500mg, 750mg, 1000mg; tb24 500mg, 750mg*** | Tier 1 | MO |
| ***levetiracetam soln 500mg/5ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***levetiracetam in sodium chloride iv soln 500 mg/100ml*** | MB | |
| ***levetiracetam in sodium chloride iv soln 1000 mg/100ml*** | MB | |
| ***levetiracetam in sodium chloride iv soln 1500 mg/100ml*** | MB | |
| ***methsuximide caps 300mg*** | Tier 1 | MO |
| NAYZILAM SOLN 5mg/0.1ml ***(midazolam (anticonvulsant))*** | Tier 2 | QL (10 units every 30 days) |
| ***oxcarbazepine 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 susp 125mg/5ml*** | Tier 1 | MO |
| ***phenytoin infatabs chew 50mg*** (Phenytoin Infatabs) | Tier 1 | MO |
| ***phenytoin sodium soln 50mg/ml*** | MB | |
| ***phenytoin sodium extended caps 100mg, 200mg, 300mg*** | Tier 1 | MO |
| ***pregabalin caps 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg; soln 20mg/ml*** | Tier 1 | ST, MO; PA** |
| ***primidone tabs 50mg, 250mg*** | Tier 1 | MO |
| ***tiagabine hcl tabs 2mg, 4mg, 12mg, 16mg*** | Tier 1 | MO |
| ***topiramate cpsp 15mg, 25mg; tabs 25mg, 50mg, 100mg, 200mg*** | Tier 1 | MO |
| ***valproate sodium soln 100mg/ml*** | MB | |
| ***valproate sodium soln 250mg/5ml*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***valproic acid caps 250mg*** | Tier 1 | MO |
| ***vigabatrin pack 500mg*** | Tier 4 | SP, PA, QL (180 packets every 30 days) |
| ***vigabatrin tabs 500mg*** | Tier 4 | SP, PA, QL (180 tabs every 30 days) |
| XCOPRI TABS 25mg, 50mg, 100mg, 150mg, 200mg ***(cenobamate)*** | Tier 2 | MO |
| XCOPRI PAK 12.5-25 ***(cenobamate)*** | Tier 2 | |
| XCOPRI PAK 50-100MG ***(cenobamate)*** | Tier 2 | |
| XCOPRI PAK 100-150 ***(cenobamate)*** | Tier 2 | MO |
| XCOPRI PAK 150-200 ***(cenobamate)*** | Tier 2 | |
| XCOPRI PAK 150-200 ***(cenobamate)*** | Tier 2 | MO |
| ***zonisamide caps 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD*** | | |
| ***amphetamine-dextroamphetamine cap er 24hr 5 mg*** | Tier 1 | QL (90 caps every 30 days), MO |
| ***amphetamine-dextroamphetamine cap er 24hr 10 mg*** | Tier 1 | QL (90 caps every 30 days), MO |
| ***amphetamine-dextroamphetamine cap er 24hr 15 mg*** | Tier 1 | QL (30 caps every 30 days), MO |
| ***amphetamine-dextroamphetamine cap er 24hr 20 mg*** | Tier 1 | QL (30 caps every 30 days), MO |
| ***amphetamine-dextroamphetamine cap er 24hr 25 mg*** | Tier 1 | QL (30 caps every 30 days), MO |
| ***amphetamine-dextroamphetamine cap er 24hr 30 mg*** | Tier 1 | QL (30 caps every 30 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***amphetamine-dextroamphetamine tab 5 mg*** | Tier 1 | QL (90 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 7.5 mg*** | Tier 1 | QL (90 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 10 mg*** | Tier 1 | QL (90 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 12.5 mg*** | Tier 1 | QL (90 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 15 mg*** | Tier 1 | QL (60 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 20 mg*** | Tier 1 | QL (60 tabs every 30 days), MO |
| ***amphetamine-dextroamphetamine tab 30 mg*** | Tier 1 | QL (30 tabs every 30 days), MO |
| ***atomoxetine hcl caps 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg*** | Tier 1 | MO |
| AZSTARYS CAP 26.1-5.2 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)*** | Tier 2 | QL (30 caps every 30 days), MO |
| AZSTARYS CAP 39.2-7.8 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)*** | Tier 2 | QL (30 caps every 30 days), MO |
| AZSTARYS CAP 52.3-10. ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)*** | Tier 2 | QL (30 caps every 30 days), MO |
| ***dexmethylphenidate hcl cp24 5mg, 10mg, 15mg, 20mg*** | Tier 1 | QL (60 caps every 30 days), MO |
| ***dexmethylphenidate hcl cp24 25mg, 30mg, 35mg, 40mg*** | Tier 1 | QL (30 caps every 30 days), MO |
| ***dexmethylphenidate hcl tabs 2.5mg, 5mg*** | Tier 1 | QL (120 tabs every 30 days), MO |
| ***dexmethylphenidate hcl tabs 10mg*** | Tier 1 | QL (60 tabs every 30 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***dextroamphetamine sulfate cp24 5mg, 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 |
| ***dextroamphetamine sulfate tabs 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) tb24 1mg, 2mg, 3mg, 4mg*** | Tier 1 | MO |
| ***methamphetamine hcl 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 cp24 20mg, 30mg; cpcr 10mg, 20mg, 30mg*** | Tier 1 | QL (60 caps every 30 days), MO |
| ***methylphenidate hcl cp24 40mg, 60mg; cpcr 40mg, 50mg, 60mg*** | Tier 1 | QL (30 caps every 30 days), MO |
| ***methylphenidate hcl soln 5mg/5ml*** | Tier 1 | QL (1800 mL every 30 days), MO |
| ***methylphenidate hcl soln 10mg/5ml*** | Tier 1 | QL (900 mL every 30 days), MO |
| ***methylphenidate hcl tabs 5mg, 10mg*** | Tier 1 | QL (180 tabs every 30 days), MO |
| ***methylphenidate hcl tabs 20mg; tbcr 10mg, 20mg*** | Tier 1 | QL (90 tabs every 30 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***methylphenidate hcl tbcr 18mg, 27mg, 36mg*** | Tier 1 | QL (60 tabs every 30 days), MO |
| ***methylphenidate hcl tbcr 54mg*** | Tier 1 | QL (30 tabs every 30 days), MO |
| VYVANSE CAPS 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)*** | Tier 2 | QL (60 caps every 30 days), MO |
| VYVANSE CAPS 40mg, 50mg, 60mg, 70mg ***(lisdexamfetamine dimesylate)*** | Tier 2 | QL (30 caps every 30 days), MO |
| VYVANSE CHEW 10mg, 20mg, 30mg ***(lisdexamfetamine dimesylate)*** | Tier 2 | QL (60 chew tabs every 30 days), MO |
| VYVANSE CHEW 40mg, 50mg, 60mg ***(lisdexamfetamine dimesylate)*** | Tier 2 | QL (30 chew tabs every 30 days), MO |
| ***zenzedi tabs 2.5mg, 7.5mg*** (Zenzedi) | Tier 1 | QL (120 tabs every 30 days), MO |
| ***HYPNOTICS - DRUGS TO TREAT INSOMNIA*** | | |
| BELSOMRA TABS 5mg, 10mg, 15mg, 20mg ***(suvorexant)*** | Tier 2 | ST; PA** |
| ***eszopiclone tabs 1mg, 2mg, 3mg*** | Tier 1 | QL (15 tabs every 30 days) |
| ***ramelteon tabs 8mg*** | Tier 1 | QL (15 tabs every 30 days) |
| ***tasimelteon caps 20mg*** | Tier 4 | SP, PA, QL (30 caps every 30 days) |
| ***temazepam 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 tabs 5mg, 10mg; 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 ***(fremanezumab-vfrm)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***almotriptan malate tabs 6.25mg, 12.5mg*** | Tier 1 | QL (12 tabs every 30 days) |
| ***dihydroergotamine mesylate soln 1mg/ml*** | MB | |
| ***eletriptan hydrobromide tabs 20mg, 40mg*** | Tier 1 | QL (12 tabs every 30 days) |
| EMGALITY SOAJ 120mg/ml; SOSY 100mg/ml, 120mg/ml ***(galcanezumab-gnlm)*** | MB | |
| ***ergotamine w/ caffeine tab 1-100 mg*** | Tier 2 | |
| ***frovatriptan succinate 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 ***(atogepant)*** | Tier 2 | ST, QL (30 tabs every 30 days), MO; PA** |
| ***rizatriptan benzoate tabs 5mg, 10mg; tbdp 5mg, 10mg*** | Tier 1 | QL (18 tabs every 30 days) |
| ***sumatriptan soln 5mg/act*** | Tier 1 | QL (24 sprays every 30 days) |
| ***sumatriptan soln 20mg/act*** | Tier 1 | QL (12 sprays every 30 days) |
| ***sumatriptan succinate soaj 4mg/0.5ml; soct 4mg/0.5ml*** | Tier 1 | QL (18 syringes every 30 days) |
| ***sumatriptan succinate soaj 6mg/0.5ml; 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 tabs 25mg, 50mg, 100mg*** | Tier 1 | QL (12 tabs every 30 days) |
| UBRELVY TABS 50mg, 100mg ***(ubrogepant)*** | Tier 2 | ST, QL (16 tabs every 30 days); PA** |
| ***zolmitriptan soln 5mg*** | Tier 1 | QL (12 sprays every 30 days) |
| ***zolmitriptan tabs 2.5mg, 5mg; tbdp 2.5mg, 5mg*** | Tier 1 | QL (12 tabs every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***MISCELLANEOUS*** | | |
| EVRYSDI SOLR .75mg/ml ***(risdiplam)*** | Tier 4 | PA, QL (2 bottles every 24 days) |
| ***lithium soln 8meq/5ml*** | Tier 1 | MO |
| ***lithium carbonate caps 150mg, 300mg, 600mg; tabs 300mg; tbcr 300mg, 450mg*** | Tier 1 | MO |
| ***pyridostigmine bromide soln 60mg/5ml; tabs 60mg; tbcr 180mg*** | Tier 1 | |
| ***riluzole tabs 50mg*** | Tier 1 | MO |
| ***MOVEMENT DISORDERS*** | | |
| ***tetrabenazine tabs 12.5mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days) |
| ***tetrabenazine tabs 25mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| ***MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS*** | | |
| BETASERON KIT .3mg ***(interferon beta-1b)*** | MB | |
| COPAXONE SOSY 40mg/ml ***(glatiramer acetate)*** | MB | |
| ***dalfampridine tb12 10mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| ***dimethyl fumarate cpdr 120mg*** | Tier 4 | SP, PA, QL (14 caps every 28 days) |
| ***dimethyl fumarate cpdr 240mg*** | Tier 4 | SP, PA, QL (60 caps every 30 days) |
| ***dimethyl fumarate capsule dr starter pack 120 mg & 240 mg*** | Tier 4 | SP, PA, QL (1 kit every 30 days) |
| ***fingolimod hcl caps .5mg*** | Tier 4 | SP, PA, QL (30 caps every 30 days) |
| ***glatiramer acetate sosy 40mg/ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***glatopa sosy 20mg/ml*** (Glatopa) | MB | |
| ***teriflunomide tabs 7mg, 14mg*** | Tier 4 | SP, PA, QL (30 tabs every 30 days) |
| TYSABRI CONC 300mg/15ml ***(natalizumab)*** | MB | |
| ***MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS*** | | |
| ***baclofen tabs 5mg, 10mg, 20mg*** | Tier 1 | |
| ***carisoprodol tabs 350mg*** | Tier 1 | PA |
| ***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 caps 25mg, 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 30mg/ml*** | MB | |
| ***orphenadrine citrate tb12 100mg*** | Tier 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***tizanidine hcl tabs 2mg, 4mg*** | Tier 1 | |
| ***NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS*** | | |
| ***armodafinil tabs 50mg*** | Tier 1 | PA, QL (60 tabs every 30 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***armodafinil tabs 150mg, 200mg, 250mg*** | Tier 1 | PA, QL (30 tabs every 30 days), MO |
| ***modafinil 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)*** | Tier 1 | QL (3 units every day) |
| ***buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)*** | Tier 1 | QL (3 units every day) |
| ***buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)*** | Tier 1 | QL (3 units every day) |
| ***buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)*** | 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 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (3 units every day) |
| ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (3 units every day) |
| ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (3 units every day) |
| ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (3 units every day) |
| ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (2 units every day) |
| ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)*** | Tier 2 | QL (1 unit every day) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***OPIOID ANTAGONIST*** | | |
| ***naloxone hcl liqd 4mg/0.1ml*** | Tier 1 | |
| ***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 | |
| NARCAN LIQD 4mg/0.1ml ***(naloxone hcl)*** | 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 ***(dextromethorphan hbr-quinidine sulfate)*** | 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 |
| ***goodsense nicotine polacr gum 4mg; lozg 4mg*** (Goodsense Nicotine Polacr) | 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*** | PV | $0 limited to 2 treatment cycles/year |
| ***nicotine step 3 pt24 7mg/24hr*** (Nicotine Step 3) | PV | $0 limited to 2 treatment cycles/year |
| NICOTROL INHALER INHA 10mg ***(nicotine)*** | PV | QL (max 168 days every year); $0 limited to 2 treatment cycles/year |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| NICOTROL NS SOLN 10mg/ml ***(nicotine)*** | PV | QL (max 168 days every year); $0 limited to 2 treatment cycles/year |
| ***sm nicotine transdermal s pt24 7mg/24hr, 14mg/24hr, 21mg/24hr*** (Sm Nicotine Transdermal S) | PV | $0 limited to 2 treatment cycles/year |
| ***varenicline tartrate tabs .5mg, 1mg*** | PV | $0 limited to 2 treatment cycles/year |
| ***varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack*** | PV | $0 limited to 2 treatment cycles/year |
| **ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES** | | |
| ***ACROMEGALY*** | | |
| ***octreotide acetate soln 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; sosy 50mcg/ml, 100mcg/ml, 500mcg/ml*** | MB | |
| SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml ***(lanreotide acetate)*** | MB | |
| SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg ***(pegvisomant)*** | MB | |
| ***ANDROGENS - DRUGS TO REGULATE MALE HORMONES*** | | |
| ***testosterone gel 10mg/act, 25mg/2.5gm*** | Tier 1 | PA, MO |
| ***testosterone cypionate soln 100mg/ml, 200mg/ml*** | MB | |
| ***testosterone enanthate soln 200mg/ml*** | MB | |
| ***ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS*** | | |
| ***acarbose tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***miglitol tabs 25mg, 50mg, 100mg*** | Tier 1 | MO |
| ***ANTIDIABETICS, AMYLIN ANALOGS*** | | |
| SYMLINPEN 60 SOPN 1500mcg/1.5ml ***(pramlintide acetate)*** | Tier 3 | ST, MO; PA** |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SYMLINPEN 120 SOPN 2700mcg/2.7ml ***(pramlintide acetate)*** | 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 (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 ***(sitagliptin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| JANUMET TAB 50-1000 ***(sitagliptin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| JANUMET XR TAB 50-500MG ***(sitagliptin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| JANUMET XR TAB 50-1000 ***(sitagliptin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| JANUMET XR TAB 100-1000 ***(sitagliptin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| JENTADUETO TAB XR ***(linagliptin-metformin hcl)*** | Tier 3 | ST, MO; PA** |
| ***ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** | | |
| ***alogliptin benzoate tabs 6.25mg, 12.5mg, 25mg*** | Tier 1 | ST, MO; PA** |
| JANUVIA TABS 25mg, 50mg, 100mg ***(sitagliptin phosphate)*** | Tier 2 | ST, MO; PA** |
| ***ANTIDIABETICS, INCRETIN MIMETIC AGENTS*** | | |
| ***liraglutide sopn 18mg/3ml*** | Tier 1 | ST, QL (3 pens every 30 days), MO; PA** |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| MOUNJARO SOAJ 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml ***(tirzepatide)*** | Tier 2 | ST, QL (4 pens every 28 days), MO; PA** |
| OZEMPIC SOPN 2mg/3ml, 4mg/3ml, 8mg/3ml ***(semaglutide)*** | Tier 2 | ST, QL (3 mL every 28 days), MO; PA** |
| TRULICITY SOAJ .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml ***(dulaglutide)*** | Tier 2 | ST, QL (4 pens every 28 days), MO; PA** |
| VICTOZA SOPN 18mg/3ml ***(liraglutide)*** | Tier 2 | ST, QL (3 pens every 30 days), MO; PA** |
| ***ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS*** | | |
| SOLIQUA INJ 100/33 ***(insulin glargine-lixisenatide)*** | Tier 2 | MO; PA** |
| XULTOPHY INJ 100/3.6 ***(insulin degludec-liraglutide)*** | Tier 2 | MO; PA** |
| ***ANTIDIABETICS, INSULIN*** | | |
| BASAGLAR KWIKPEN SOPN 100unit/ml ***(insulin glargine)*** | Tier 2 | MO |
| BASAGLAR TEMPO PEN SOPN 100unit/ml ***(insulin glargine)*** | Tier 2 | MO |
| FIASP SOLN 100unit/ml ***(insulin aspart (with niacinamide))*** | Tier 2 | MO |
| FIASP FLEXTOUCH SOPN 100unit/ml ***(insulin aspart (with niacinamide))*** | Tier 2 | MO |
| FIASP PENFILL SOCT 100unit/ml ***(insulin aspart (with niacinamide))*** | Tier 2 | MO |
| HUMULIN INJ 70/30 ***(insulin nph isophane & reg (human))*** | Tier 3 | MO |
| HUMULIN INJ 70/30KWP ***(insulin nph isophane & reg (human))*** | Tier 3 | MO |
| HUMULIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))*** | Tier 3 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| HUMULIN N KWIKPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))*** | Tier 3 | MO |
| HUMULIN R SOLN 100unit/ml ***(insulin regular (human))*** | Tier 3 | MO |
| HUMULIN R U-500 (CONCENTR SOLN 500unit/ml ***(insulin regular (human))*** | Tier 2 | MO |
| HUMULIN R U-500 KWIKPEN SOPN 500unit/ml ***(insulin regular (human))*** | Tier 2 | MO |
| LEVEMIR SOLN 100unit/ml ***(insulin detemir)*** | Tier 2 | MO |
| LEVEMIR FLEXPEN SOPN 100unit/ml ***(insulin detemir)*** | Tier 2 | MO |
| NOVOLIN INJ 70/30 ***(insulin nph isophane & reg (human))*** | Tier 2 | MO; RELION not covered |
| NOVOLIN INJ 70/30 FP ***(insulin nph isophane & reg (human))*** | Tier 2 | MO; RELION not covered |
| NOVOLIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))*** | Tier 2 | MO; RELION not covered |
| NOVOLIN N FLEXPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))*** | Tier 2 | MO; RELION not covered |
| NOVOLIN R SOLN 100unit/ml ***(insulin regular (human))*** | Tier 2 | MO; RELION not covered |
| NOVOLIN R FLEXPEN SOPN 100unit/ml ***(insulin regular (human))*** | Tier 2 | MO; RELION not covered |
| NOVOLOG SOLN 100unit/ml ***(insulin aspart)*** | Tier 2 | MO |
| NOVOLOG FLEXPEN SOPN 100unit/ml ***(insulin aspart)*** | Tier 2 | MO |
| NOVOLOG MIX INJ 70/30 ***(insulin aspart protamine & aspart (human))*** | Tier 2 | MO |
| NOVOLOG MIX INJ FLEXPEN ***(insulin aspart protamine & aspart (human))*** | Tier 2 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| NOVOLOG PENFILL SOCT 100unit/ml ***(insulin aspart)*** | Tier 2 | MO |
| TRESIBA SOLN 100unit/ml ***(insulin degludec)*** | Tier 2 | MO |
| TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml ***(insulin degludec)*** | Tier 2 | MO |
| ***ANTIDIABETICS, INSULIN SENSITIZER*** | | |
| ***pioglitazone hcl 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*** | Tier 1 | MO |
| ***ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION*** | | |
| ***pioglitazone hcl-glimepiride tab 30-2 mg*** | Tier 1 | MO |
| ***pioglitazone hcl-glimepiride tab 30-4 mg*** | Tier 1 | MO |
| ***ANTIDIABETICS, MEGLITINIDE*** | | |
| ***nateglinide tabs 60mg, 120mg*** | Tier 1 | MO |
| ***repaglinide tabs .5mg, 1mg, 2mg*** | Tier 1 | MO |
| ***ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS*** | | |
| SYNJARDY TAB ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY TAB 5-500MG ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY TAB 5-1000MG ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY TAB 12.5-500 ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY XR TAB ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY XR TAB 5-1000MG ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SYNJARDY XR TAB 10-1000 ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| SYNJARDY XR TAB 25-1000 ***(empagliflozin-metformin hcl)*** | Tier 2 | ST, MO; PA** |
| ***ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS*** | | |
| GLYXAMBI TAB 10-5 MG ***(empagliflozin-linagliptin)*** | Tier 2 | ST, MO; PA** |
| GLYXAMBI TAB 25-5 MG ***(empagliflozin-linagliptin)*** | Tier 2 | ST, MO; PA** |
| ***ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS*** | | |
| JARDIANCE TABS 10mg, 25mg ***(empagliflozin)*** | Tier 2 | ST, MO; PA** |
| ***ANTIDIABETICS, SULFONYLUREA*** | | |
| ***glimepiride tabs 1mg, 2mg, 4mg*** | Tier 1 | MO |
| ***glipizide tabs 5mg, 10mg; tb24 2.5mg, 5mg, 10mg*** | Tier 1 | MO |
| ***CALCIUM RECEPTOR AGONISTS*** | | |
| ***cinacalcet hcl tabs 30mg, 60mg*** | Tier 4 | SP, PA, QL (60 tabs every 30 days) |
| ***cinacalcet hcl tabs 90mg*** | Tier 4 | SP, PA, QL (120 tabs every 30 days) |
| ***CALCIUM REGULATORS, BISPHOSPHONATES*** | | |
| ***alendronate sodium soln 70mg/75ml; tabs 5mg, 10mg, 35mg, 70mg*** | Tier 1 | MO |
| FOSAMAX + D TAB 70-2800 ***(alendronate sodium-cholecalciferol)*** | Tier 3 | ST, MO; PA** |
| FOSAMAX + D TAB 70-5600 ***(alendronate sodium-cholecalciferol)*** | Tier 3 | ST, MO; PA** |
| ***ibandronate sodium soln 3mg/3ml*** | MB | |
| ***ibandronate sodium tabs 150mg*** | Tier 1 | MO |
| ***pamidronate disodium soln 30mg/10ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***risedronate sodium tabs 5mg, 35mg, 150mg; tbec 35mg*** | Tier 1 | MO |
| ***risedronate sodium tabs 30mg*** | Tier 1 | |
| ***zoledronic acid conc 4mg/5ml; soln 5mg/100ml*** | MB | |
| ***CALCIUM REGULATORS, MISCELLANEOUS*** | | |
| ***calcitonin (salmon) soln 200unit/act*** | Tier 1 | MO |
| PROLIA SOSY 60mg/ml ***(denosumab)*** | MB | |
| ***CALCIUM REGULATORS, PARATHYROID HORMONES*** | | |
| TYMLOS SOPN 3120mcg/1.56ml ***(abaloparatide)*** | MB | |
| ***CHELATING AGENTS*** | | |
| CHEMET CAPS 100mg ***(succimer)*** | Tier 3 | |
| ***deferiprone tabs 500mg, 1000mg*** | Tier 4 | SP, PA |
| FERRIPROX SOLN 100mg/ml ***(deferiprone)*** | Tier 4 | PA |
| FERRIPROX TWICE-A-DAY TABS 1000mg ***(deferiprone)*** | Tier 4 | PA |
| ***penicillamine tabs 250mg*** | Tier 4 | SP |
| ***CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL*** | | |
| ***altavera*** (Altavera) | PV | MO |
| ***alyacen 1/35*** (Alyacen 1/35) | PV | MO |
| ***alyacen 7/7/7*** (Alyacen 7/7/7) | PV | MO |
| ***amethyst*** (Amethyst) | PV | MO |
| ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)*** | PV | QL (1 every 300 days), MO |
| ***apri*** (Apri) | PV | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***aranelle*** (Aranelle) | PV | MO |
| ***ashlyna*** (Ashlyna) | PV | MO |
| ***aviane*** (Aviane) | PV | MO |
| ***azurette*** (Azurette) | PV | MO |
| ***camila tabs .35mg*** (Camila) | PV | MO |
| ***camrese*** (Camrese) | PV | MO |
| CAYA DPR ***(diaphragm arc-spring)*** | MB | |
| ***chateal eq*** (Chateal Eq) | PV | MO |
| CONDOMS MIS | PV | QL (12 condoms every 30 days) |
| ***cryselle-28*** (Cryselle-28) | PV | MO |
| ***dasetta 1/35*** (Dasetta 1/35) | PV | MO |
| ***dasetta 7/7/7*** (Dasetta 7/7/7) | PV | MO |
| ***delyla*** (Delyla) | PV | MO |
| DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml ***(medroxyprogesterone acetate (contraceptive))*** | MB | |
| ***drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg*** | PV | MO |
| ***drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg*** | PV | MO |
| ***drospirenone-ethinyl estradiol tab 3-0.02 mg*** | PV | MO |
| ***drospirenone-ethinyl estradiol tab 3-0.03 mg*** | PV | MO |
| DUREX MIS REALFEEL ***(condoms non-latex lubricated - male)*** | PV | QL (12 condoms every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***elinest*** (Elinest) | PV | MO |
| ELLA TABS 30mg ***(ulipristal acetate)*** | PV | |
| ***enpresse-28*** (Enpresse-28) | PV | MO |
| ***enskyce*** (Enskyce) | PV | MO |
| ***errin tabs .35mg*** (Errin) | PV | MO |
| ***ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg*** | PV | MO |
| ***etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr*** | PV | QL (13 every 300 days), MO |
| ***falmina*** (Falmina) | PV | MO |
| FC2 FEMALE MIS CONDOM ***(condoms - female)*** | PV | QL (12 condoms every 30 days) |
| FEMCAP MIS 22MM ***(cervical caps)*** | MB | |
| FEMCAP MIS 26MM ***(cervical caps)*** | MB | |
| FEMCAP MIS 30MM ***(cervical caps)*** | MB | |
| ***gemmily*** (Gemmily) | PV | MO |
| ***heather tabs .35mg*** (Heather) | PV | MO |
| ***introvale*** (Introvale) | PV | MO |
| ***jolessa*** (Jolessa) | PV | MO |
| ***junel 1.5/30*** (Junel 1.5/30) | PV | MO |
| ***junel 1/20*** (Junel 1/20) | PV | MO |
| ***junel fe 1.5/30*** (Junel Fe 1.5/30) | PV | MO |
| ***junel fe 1/20*** (Junel Fe 1/20) | PV | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***junel fe 24*** (Junel Fe 24) | PV | MO |
| ***kariva*** (Kariva) | PV | MO |
| ***kelnor 1/35*** (Kelnor 1/35) | PV | MO |
| ***kurvelo*** (Kurvelo) | PV | MO |
| KYLEENA IUD 19.5mg ***(levonorgestrel (iud))*** | MB | |
| ***larin 1.5/30*** (Larin 1.5/30) | PV | MO |
| ***leena*** (Leena) | PV | MO |
| ***lessina*** (Lessina) | PV | MO |
| ***levonest*** (Levonest) | PV | MO |
| ***levonorg-eth est tab 0.1-0.02mg(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-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)*** | PV | MO |
| ***levora 0.15/30-28*** (Levora 0.15/30-28) | PV | MO |
| LILETTA IUD 20.1mcg/day ***(levonorgestrel (iud))*** | MB | |
| LO LOESTRIN TAB 1-10-10 ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))*** | PV | MO |
| ***loryna*** (Loryna) | PV | MO |
| ***low-ogestrel*** (Low-ogestrel) | PV | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***lutera*** (Lutera) | PV | MO |
| ***marlissa*** (Marlissa) | PV | MO |
| ***medroxyprogesterone acetate (contraceptive) susp 150mg/ml; susy 150mg/ml*** | MB | |
| ***microgestin 1.5/30*** (Microgestin 1.5/30) | PV | MO |
| MIRENA IUD 20mcg/day ***(levonorgestrel (iud))*** | MB | |
| ***mono-linyah*** (Mono-linyah) | PV | MO |
| NATAZIA TAB ***(estradiol valerate-dienogest)*** | PV | MO |
| ***necon 0.5/35-28*** (Necon 0.5/35-28) | PV | MO |
| NEXPLANON IMPL 68mg ***(etonogestrel)*** | MB | |
| NEXTSTELLIS TAB 3-14.2MG ***(drospirenone-estetrol)*** | PV | MO |
| ***nikki*** (Nikki) | PV | MO |
| ***nora-be tabs .35mg*** (Nora-be) | PV | MO |
| ***norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg*** | PV | MO |
| ***norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg*** | PV | MO |
| ***norethindrone (contraceptive) tabs .35mg*** | PV | MO |
| ***norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg*** | PV | MO |
| ***norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)*** | PV | MO |
| ***norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)*** | PV | MO |
| ***norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg*** | PV | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg*** | PV | MO |
| ***norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg*** | PV | MO |
| ***nortrel 0.5/35 (28)*** (Nortrel 0.5/35 (28)) | PV | MO |
| ***nortrel 1/35*** (Nortrel 1/35) | PV | MO |
| ***nortrel 7/7/7*** (Nortrel 7/7/7) | PV | MO |
| ***nylia 1/35*** (Nylia 1/35) | PV | MO |
| ***ocella*** (Ocella) | PV | MO |
| OMNIFLEX DPR ***(diaphragms)*** | MB | |
| OPILL TABS .075mg ***(norgestrel)*** | PV | MO |
| PARAGARD IUD T380A ***(copper (iud))*** | MB | |
| ***portia-28*** (Portia-28) | PV | MO |
| ***reclipsen*** (Reclipsen) | PV | MO |
| ***rivelsa*** (Rivelsa) | PV | MO |
| SKYLA IUD 13.5mg ***(levonorgestrel (iud))*** | MB | |
| SLYND TABS 4mg ***(drospirenone)*** | PV | MO |
| ***sprintec 28*** (Sprintec 28) | PV | MO |
| ***sronyx*** (Sronyx) | PV | MO |
| ***syeda*** (Syeda) | PV | MO |
| ***take action tabs 1.5mg*** (Take Action) | PV | |
| ***tilia fe*** (Tilia Fe) | PV | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***tri-linyah*** (Tri-linyah) | PV | MO |
| ***tri-sprintec*** (Tri-sprintec) | PV | MO |
| ***trivora-28*** (Trivora-28) | PV | MO |
| TRUSTEX/RIA MIS NON-LUB ***(condoms latex non-lubricated - male)*** | PV | QL (12 condoms every 30 days) |
| TRUSTX NON-9 MIS RIB/STUD ***(condoms latex lubricated - male)*** | PV | QL (12 condoms every 30 days) |
| TWIRLA DIS 120-30 ***(levonorgestrel-ethinyl estradiol)*** | PV | MO |
| TYBLUME CHW 0.1-0.02 ***(levonorgestrel & eth estradiol)*** | PV | MO |
| ***velivet*** (Velivet) | PV | MO |
| ***viorele*** (Viorele) | PV | MO |
| ***vyfemla*** (Vyfemla) | PV | MO |
| ***wera*** (Wera) | PV | MO |
| WIDE-SEAL SILICONE DIAPHR DPRH 2% ***(diaphragm wide seal)*** | MB | |
| ***xulane*** (Xulane) | PV | MO |
| ***zovia 1/35*** (Zovia 1/35) | PV | MO |
| ***DIABETIC SUPPLIES*** | | |
| ACCU-CHEK BLOOD GLUCOSE TEST KITS ***(blood glucose monitoring supplies)*** | MB | |
| ACCU-CHEK BLOOD GLUCOSE TEST STRIPS ***(glucose blood)*** | MB | |
| AUTOLET PLAT MIS 1.8MM ***(lancets misc.)*** | MB | |
| BLOOD GLUCOSE CALIBRATION SOLUTION ***(blood glucose calibration)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| DEXCOM G5 MIS RECEIVER ***(continuous glucose system receiver)*** | MB | |
| DEXCOM G5 MIS TRANSMIT ***(continuous glucose system transmitter)*** | MB | |
| DEXCOM G6 MIS RECEIVER ***(continuous glucose system receiver)*** | MB | |
| DEXCOM G6 MIS SENSOR ***(continuous glucose system sensor)*** | MB | |
| DEXCOM G6 MIS TRANSMIT ***(continuous glucose system transmitter)*** | MB | |
| DEXCOM G7 MIS RECEIVER ***(continuous glucose system receiver)*** | MB | |
| DEXCOM G7 MIS SENSOR ***(continuous glucose system sensor)*** | MB | |
| INSULIN PEN NEEDLES ***(insulin pen needle)*** | Tier 2 | |
| INSULIN PEN NEEDLES/SYRINGES ***(insulin syringe/needle u-100)*** | Tier 2 | |
| LANCETS ***(lancets)*** | MB | |
| LANCING DEVICE | MB | |
| NOVOFINE PEN NEEDLES ***(insulin pen needle)*** | Tier 2 | |
| OMNIPOD 5 DX KIT INT G7G6 ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD 5 DX MIS POD G7G6 ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD 5 G7 KIT INTRO ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD 5 G7 MIS PODS ***(insulin infusion disposable pump)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| OMNIPOD DASH KIT INTRO ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD DASH KIT PDM ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD DASH MIS PODS ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD MIS CLASSIC ***(insulin infusion disposable pump)*** | MB | |
| OMNIPOD PDM KIT CLASSIC ***(insulin infusion disposable pump)*** | MB | |
| ONETOUCH BLOOD GLUCOSE TEST KITS ***(blood glucose monitoring supplies)*** | MB | |
| ONETOUCH BLOOD GLUCOSE TEST STRIPS ***(glucose blood)*** | MB | |
| ONETOUCH SOL KIT COMPLETE ***(blood glucose monitoring supplies)*** | MB | |
| ONETOUCH SOL KIT FIT ***(blood glucose monitoring supplies)*** | MB | |
| ONETOUCH SOL KIT STARTER ***(blood glucose monitoring supplies)*** | MB | |
| URINE GLUCOSE MONITORING SUPPLIES ***(urine glucose monitoring supplies)*** | MB | |
| V-GO 20 KIT ***(insulin infusion disposable pump)*** | MB | |
| V-GO 30 KIT ***(insulin infusion disposable pump)*** | MB | |
| V-GO 40 KIT ***(insulin infusion disposable pump)*** | MB | |
| ***ENDOMETRIOSIS*** | | |
| ***danazol caps 50mg, 100mg, 200mg*** | Tier 1 | |
| ORILISSA TABS 150mg, 200mg ***(elagolix sodium)*** | Tier 2 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ENZYME REPLACEMENTS - DRUGS TO TREAT ENZYME DEFICIENCIES*** | | |
| ***betaine anhy pow*** | Tier 4 | SP, PA |
| ***carglumic acid tbso 200mg*** | Tier 4 | SP, PA |
| CERDELGA CAPS 84mg ***(eliglustat tartrate)*** | Tier 4 | SP, PA, QL (56 caps every 28 days) |
| ***sapropterin dihydrochloride pack 100mg, 500mg; tabs 100mg*** | Tier 4 | SP, PA |
| ***sodium phenylbutyrate powd 3gm/tsp*** | Tier 4 | SP, PA, QL (798g every 30 days) |
| ***sodium phenylbutyrate tabs 500mg*** | Tier 4 | SP, PA, QL (1200 tabs every 30 days) |
| ***ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES*** | | |
| CLIMARA PRO DIS WEEKLY ***(estradiol-levonorgestrel)*** | Tier 2 | MO |
| DEPO-ESTRADIOL OIL 5mg/ml ***(estradiol cypionate)*** | MB | |
| DUAVEE TAB 0.45-20 ***(conjugated estrogens-bazedoxifene)*** | Tier 2 | MO |
| ELESTRIN GEL .06% ***(estradiol)*** | Tier 3 | PA, MO; High Risk Medications require PA for members age 70 and older |
| ***estradiol gel .06%, .25mg/0.25gm, .5mg/0.5gm, .75mg/0.75gm, 1mg/gm, 1.25mg/1.25gm; pttw .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; ptwk .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr; tabs .5mg, 1mg, 2mg*** | 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*** | Tier 1 | MO |
| ***estradiol vaginal crea .1mg/gm*** | Tier 1 | MO |
| ***estradiol valerate oil 20mg/ml, 40mg/ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| EVAMIST SOLN 1.53mg/spray ***(estradiol)*** | Tier 3 | PA, MO; High Risk Medications require PA for members age 70 and older |
| IMVEXXY MAINTENANCE PACK INST 4mcg, 10mcg ***(estradiol vaginal)*** | Tier 2 | MO |
| IMVEXXY STARTER PACK INST 4mcg, 10mcg ***(estradiol vaginal)*** | Tier 2 | MO |
| ***jinteli*** (Jinteli) | Tier 1 | MO |
| MENEST TABS .3mg, .625mg, 1.25mg, 2.5mg ***(esterified estrogens)*** | Tier 3 | PA, MO; High Risk Medications require PA for members age 70 and older |
| ***mimvey*** (Mimvey) | Tier 1 | MO |
| ***norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg*** | Tier 1 | MO |
| PREMARIN CREA .625mg/gm ***(estrogens, conjugated vaginal)*** | Tier 3 | MO |
| PREMARIN TABS .3mg, .45mg, .625mg, .9mg, 1.25mg ***(estrogens, conjugated)*** | Tier 3 | PA, MO; High Risk Medications require PA for members age 70 and older |
| ***yuvafem tabs 10mcg*** (Yuvafem) | Tier 1 | MO |
| ***GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE*** | | |
| DEPO-MEDROL SUSP 20mg/ml ***(methylprednisolone acetate)*** | MB | |
| ***dexamethasone elix .5mg/5ml; soln .5mg/5ml; tabs .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg*** | Tier 1 | |
| DEXAMETHASONE INTENSOL CONC 1mg/ml ***(dexamethasone)*** | Tier 2 | |
| ***dexamethasone sodium phosphate soln 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml; sosy 4mg/ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***fludrocortisone acetate tabs .1mg*** | Tier 1 | MO |
| ***hydrocortisone tabs 5mg, 10mg, 20mg*** | Tier 1 | |
| MEDROL TABS 2mg ***(methylprednisolone)*** | Tier 2 | |
| ***methylprednisolone tabs 4mg, 8mg, 16mg, 32mg; tbpk 4mg*** | Tier 1 | |
| ***methylprednisolone acetate susp 40mg/ml, 80mg/ml*** | MB | |
| ***methylprednisolone sod succ solr 125mg, 1000mg*** | MB | |
| ***prednisolone soln 15mg/5ml*** | Tier 1 | |
| ***prednisolone sodium phosphate soln 5mg/5ml, 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 ***(prednisone)*** | Tier 2 | |
| SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg ***(hydrocortisone sod succinate)*** | MB | |
| SOLU-MEDROL SOLR 2gm ***(methylprednisolone sod succ)*** | MB | |
| ***GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR*** | | |
| ***glucagon (rdna) kit 1mg*** | Tier 1 | |
| GVOKE HYPOPEN 1-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml ***(glucagon)*** | Tier 2 | |
| GVOKE KIT SOLN 1mg/0.2ml ***(glucagon)*** | Tier 2 | |
| GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml ***(glucagon)*** | Tier 2 | |
| ***HEREDITARY TYROSINEMIA TYPE 1 AGENTS*** | | |
| ***nitisinone caps 2mg, 5mg, 10mg, 20mg*** | Tier 4 | SP, PA |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ORFADIN SUSP 4mg/ml ***(nitisinone)*** | Tier 4 | PA |
| ***HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES*** | | |
| GENOTROPIN CART 5mg, 12mg ***(somatropin)*** | MB | |
| GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg ***(somatropin)*** | MB | |
| NORDIPEN 5 MIS DEVICE ***(injection device)*** | MB | |
| NORDIPEN DEL MIS SYSTEM ***(injection device)*** | MB | |
| NORDITROPIN FLEXPRO SOPN 5mg/1.5ml, 10mg/1.5ml, 15mg/1.5ml, 30mg/3ml ***(somatropin)*** | MB | |
| ***LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS*** | | |
| SYNAREL SOLN 2mg/ml ***(nafarelin acetate)*** | Tier 4 | PA |
| TRIPTODUR SRER 22.5mg ***(triptorelin pamoate (cpp))*** | MB | |
| ***MINERALOCORTICOID RECEPTOR ANTAGONISTS*** | | |
| KERENDIA TABS 10mg, 20mg ***(finerenone)*** | Tier 3 | PA, MO |
| ***MISCELLANEOUS*** | | |
| ***cabergoline tabs .5mg*** | Tier 1 | |
| CYSTAGON CAPS 50mg, 150mg ***(cysteamine bitartrate)*** | Tier 4 | SP, PA |
| INCRELEX SOLN 40mg/4ml ***(mecasermin)*** | MB | |
| INTRAROSA INST 6.5mg ***(prasterone vaginal)*** | Tier 3 | MO |
| OSPHENA TABS 60mg ***(ospemifene)*** | Tier 3 | PA, MO |
| ***raloxifene hcl 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 ***(pasireotide diaspartate)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SUPPRELIN LA KIT 50mg ***(histrelin acetate (cpp))*** | MB | |
| ***tolvaptan tabs 15mg, 30mg*** | Tier 4 | SP, PA |
| ***PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS*** | | |
| ***calcium acetate (phosphate binder) caps 667mg; tabs 667mg*** | Tier 1 | MO |
| PHOSLYRA SOLN 667mg/5ml ***(calcium acetate (phosphate binder))*** | Tier 2 | MO |
| ***sevelamer carbonate pack .8gm, 2.4gm; tabs 800mg*** | Tier 1 | MO |
| VELPHORO CHEW 500mg ***(sucroferric oxyhydroxide)*** | Tier 2 | MO |
| ***POTASSIUM-REMOVING AGENTS*** | | |
| ***sps susp 15gm/60ml*** (Sps) | Tier 1 | |
| ***PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES*** | | |
| CRINONE GEL 4% ***(progesterone (vaginal))*** | Tier 2 | |
| CRINONE GEL 8% ***(progesterone (vaginal))*** | Tier 2 | PA |
| ***medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg*** | Tier 1 | MO |
| ***megestrol acetate susp 40mg/ml*** | Tier 1 | OAC |
| ***megestrol acetate (appetite) susp 625mg/5ml*** | Tier 1 | MO |
| ***norethindrone acetate tabs 5mg*** | Tier 1 | MO |
| ***progesterone caps 100mg, 200mg*** | Tier 1 | MO |
| ***THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS*** | | |
| ***levothyroxine sodium tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg*** | Tier 1 | MO |
| ***levoxyl tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg*** (Levoxyl) | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***liothyronine sodium 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 ***(levothyroxine sodium)*** | Tier 2 | MO |
| ***unithroid tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 200mcg, 300mcg*** (Unithroid) | Tier 1 | MO |
| ***VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES*** | | |
| ***desmopressin acetate soln 4mcg/ml*** | MB | |
| ***desmopressin acetate 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.** | | |
| ***FERTILITY REGULATORS*** | | |
| ***clomiphene citrate tabs 50mg*** | Tier 1 | Only covered if member has supplemental benefit. Limit 3 fills per lifetime |
| ***METABOLIC MODIFIERS*** | | |
| MYALEPT SOLR 11.3mg ***(metreleptin)*** | MB | |
| **FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS** | | |
| ***FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS*** | | |
| BAXDELA TABS 450mg ***(delafloxacin meglumine)*** | Tier 3 | |
| **GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS** | | |
| ***ANTICHOLINERGICS - DRUGS TO TREAT COPD*** | | |
| ***atropine sulfate sosy .25mg/5ml, 1mg/10ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***dicyclomine hcl caps 10mg; soln 10mg/5ml; tabs 20mg*** | Tier 1 | |
| ***dicyclomine hcl soln 10mg/ml*** | MB | |
| ***glycopyrrolate soln 1mg/5ml*** | Tier 1 | MO |
| ***glycopyrrolate soln 1mg/5ml, 4mg/20ml*** | MB | |
| ***glycopyrrolate tabs 1mg, 2mg*** | Tier 1 | |
| ***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*** | Tier 1 | |
| ***loperamide hcl caps 2mg*** | Tier 1 | |
| MOTOFEN TAB 1-0.025 ***(difenoxin w/ atropine)*** | Tier 3 | |
| ***ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING*** | | |
| AKYNZEO CAP 300-0.5 ***(netupitant-palonosetron)*** | Tier 3 | QL (2 caps every 28 days) |
| ***aprepitant caps 40mg*** | Tier 1 | QL (3 caps every 180 days) |
| ***aprepitant 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) |
| ***compro supp 25mg*** (Compro) | Tier 1 | |
| ***dronabinol caps 2.5mg, 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) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***meclizine hcl tabs 12.5mg, 25mg*** | Tier 1 | |
| ***metoclopramide hcl soln 5mg/ml*** | MB | |
| ***metoclopramide hcl soln 10mg/10ml; tabs 5mg, 10mg; tbdp 5mg*** | 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 soln 6.25mg/5ml; tabs 12.5mg, 25mg, 50mg*** | Tier 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***promethazine hcl soln 25mg/ml, 50mg/ml*** | MB | |
| ***promethazine hcl supp 12.5mg, 25mg*** | Tier 1 | |
| ***promethegan supp 12.5mg, 25mg, 50mg*** (Promethegan) | Tier 1 | |
| SANCUSO PTCH 3.1mg/24hr ***(granisetron)*** | Tier 2 | QL (2 patches every 28 days) |
| ***scopolamine pt72 1mg/3days*** | Tier 1 | |
| ***trimethobenzamide hcl caps 300mg*** | Tier 1 | |
| VARUBI TBPK 90mg ***(rolapitant hcl)*** | 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 |
| ***famotidine soln 20mg/2ml*** | MB | |
| ***famotidine susr 40mg/5ml; 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 caps 750mg*** | Tier 1 | |
| ***budesonide cpep 3mg; tb24 9mg*** | Tier 1 | |
| DIPENTUM CAPS 250mg ***(olsalazine sodium)*** | Tier 3 | MO |
| ***hydrocortisone (intrarectal) enem 100mg/60ml*** | Tier 1 | |
| ***mesalamine cp24 .375gm; cpdr 400mg; tbec 1.2gm*** | Tier 1 | MO |
| ***mesalamine enem 4gm; supp 1000mg; tbec 800mg*** | Tier 1 | |
| ***sulfasalazine tabs 500mg; tbec 500mg*** | Tier 1 | MO |
| ***IRRITABLE BOWEL SYNDROME WITH CONSTIPATION*** | | |
| LINZESS CAPS 72mcg, 145mcg, 290mcg ***(linaclotide)*** | Tier 2 | MO |
| ***lubiprostone caps 8mcg, 24mcg*** | Tier 1 | MO |
| ***IRRITABLE BOWEL SYNDROME WITH DIARRHEA*** | | |
| ***alosetron hcl tabs .5mg, 1mg*** | Tier 1 | PA, MO |
| VIBERZI TABS 75mg, 100mg ***(eluxadoline)*** | Tier 2 | PA, MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***LAXATIVES*** | | |
| CLENPIQ SOL ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)*** | PV | $0 copay for members age 45 through 75, Tier 2 for all others |
| ***enulose soln 10gm/15ml*** (Enulose) | Tier 1 | MO |
| ***gavilyte-c*** (Gavilyte-c) | Tier 1 | |
| ***gavilyte-g*** (Gavilyte-g) | Tier 1 | |
| ***generlac soln 10gm/15ml*** (Generlac) | Tier 1 | MO |
| ***lactulose soln 10gm/15ml*** | Tier 1 | MO |
| OSMOPREP TAB 1.5GM ***(sodium phosphate monobasic-sodium phosphate dibasic)*** | Tier 3 | |
| ***peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm*** | Tier 1 | |
| ***peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm*** | PV | $0 copay for members age 45 through 75, otherwise not covered |
| ***peg 3350-kcl-sod bicarb-nacl for soln 420 gm*** | Tier 1 | |
| PEG-PREP KIT ***(bisacodyl-peg 3350-pot chloride-sod bicarb-sod chloride)*** | PV | $0 copay for members age 45 through 75, otherwise not covered |
| PLENVU SOL ***(peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid)*** | PV | $0 copay for members age 45 through 75, otherwise not covered |
| ***sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml*** | PV | $0 copay for members age 45 through 75, otherwise not covered |
| SUFLAVE SOL ***(peg 3350-kcl-sod chloride-sod sulfate-magnesium sulfate)*** | PV | $0 copay for members age 45 through 75, otherwise not covered |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SUTAB TAB ***(sodium sulfate-magnesium sulfate-potassium chloride)*** | PV | $0 copay for members age 45 through 75, otherwise not covered |
| ***MISCELLANEOUS*** | | |
| ***cromolyn sodium (mastocytosis) conc 100mg/5ml*** | Tier 1 | MO |
| ***misoprostol tabs 100mcg, 200mcg*** | Tier 1 | MO |
| MOVANTIK TABS 12.5mg, 25mg ***(naloxegol oxalate)*** | Tier 2 | |
| SUCRAID SOLN 8500unit/ml ***(sacrosidase)*** | Tier 3 | PA, QL (354 mL every 30 days), MO |
| ***sucralfate tabs 1gm*** | Tier 1 | MO |
| ***ursodiol caps 300mg; tabs 250mg, 500mg*** | Tier 1 | MO |
| ***PANCREATIC ENZYMES*** | | |
| CREON CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| CREON CAP 6000UNIT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| CREON CAP 12000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| CREON CAP 24000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| CREON CAP 36000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| VIOKACE TAB 10440 ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| VIOKACE TAB 20880 ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ZENPEP CAP 5000UNIT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 10000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 15000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 20000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 25000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 40000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ZENPEP CAP 60000UNT ***(pancrelipase (lipase-protease-amylase))*** | Tier 2 | PA, MO |
| ***PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID*** | | |
| ***esomeprazole magnesium cpdr 20mg, 40mg*** | Tier 1 | QL (90 caps every 365 days), MO |
| ***esomeprazole magnesium pack 10mg*** | Tier 1 | QL (90 packets every 365 days), MO; Covered for age less than 1 year only |
| ***lansoprazole cpdr 15mg, 30mg*** | Tier 1 | QL (90 caps every 365 days), MO |
| NEXIUM PACK 2.5mg, 5mg ***(esomeprazole magnesium)*** | 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 tbec 20mg, 40mg*** | Tier 1 | QL (90 tabs every 365 days), MO |
| ***rabeprazole sodium tbec 20mg*** | Tier 1 | QL (90 tabs every 365 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***RECTAL, CORTICOSTEROIDS*** | | |
| ***hydrocortisone (rectal) crea 1%, 2.5%*** | Tier 1 | |
| ***proctozone-hc crea 2.5%*** (Proctozone-hc) | Tier 1 | |
| **GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS** | | |
| ***BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE*** | | |
| ***alfuzosin hcl tb24 10mg*** | Tier 1 | MO |
| CARDURA XL TB24 4mg, 8mg ***(doxazosin mesylate (bph))*** | Tier 3 | ST, MO; PA** |
| ***doxazosin mesylate tabs 1mg, 2mg, 4mg, 8mg*** | Tier 1 | MO |
| ***dutasteride caps .5mg*** | Tier 1 | MO |
| ***dutasteride-tamsulosin hcl cap 0.5-0.4 mg*** | Tier 1 | MO |
| ***finasteride tabs 5mg*** | Tier 1 | MO |
| ***silodosin caps 4mg, 8mg*** | Tier 1 | MO |
| ***tadalafil tabs 2.5mg, 5mg*** | Tier 1 | PA, QL (30 tabs every 30 days), MO |
| ***tamsulosin hcl caps .4mg*** | Tier 1 | MO |
| ***terazosin hcl caps 1mg, 2mg, 5mg, 10mg*** | Tier 1 | MO |
| ***CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL*** | | |
| ENCARE SUPP 100mg ***(nonoxynol-9)*** | PV | |
| OPTIONS GYNOL II VAGINAL GEL 3% ***(nonoxynol-9)*** | PV | |
| PHEXXI GEL ***(lactic acid-citric acid-potassium bitartrate)*** | PV | |
| TODAY SPONGE MISC 1000mg ***(nonoxynol-9)*** | PV | |
| VCF VAGINAL CONTRACEPTIVE FILM 28%; GEL 4% ***(nonoxynol-9)*** | PV | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***MISCELLANEOUS*** | | |
| ***bethanechol chloride tabs 5mg, 10mg, 25mg, 50mg*** | Tier 1 | |
| ELMIRON CAPS 100mg ***(pentosan polysulfate sodium)*** | Tier 3 | |
| ***potassium citrate (alkalinizer) tbcr 15meq, 540mg, 1080mg*** | Tier 1 | |
| ***URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE*** | | |
| ***darifenacin hydrobromide tb24 7.5mg, 15mg*** | Tier 1 | MO |
| ***fesoterodine fumarate tb24 4mg, 8mg*** | Tier 1 | MO |
| ***oxybutynin chloride soln 5mg/5ml; tabs 5mg; tb24 5mg, 10mg, 15mg*** | Tier 1 | MO |
| ***solifenacin succinate tabs 5mg, 10mg*** | Tier 1 | MO |
| ***tolterodine tartrate cp24 2mg, 4mg; tabs 1mg, 2mg*** | Tier 1 | MO |
| ***trospium chloride cp24 60mg; tabs 20mg*** | Tier 1 | MO |
| ***VAGINAL ANTI-INFECTIVES*** | | |
| CLEOCIN SUPP 100mg ***(clindamycin phosphate vaginal)*** | Tier 2 | |
| ***clindamycin phosphate vaginal crea 2%*** | Tier 1 | |
| GYNAZOLE-1 CREA 2% ***(butoconazole nitrate (one dose))*** | Tier 3 | |
| ***metronidazole vaginal gel .75%*** | Tier 1 | |
| ***miconazole 3 supp 200mg*** (Miconazole 3) | Tier 1 | |
| ***terconazole vaginal crea .4%, .8%; supp 80mg*** | Tier 1 | |
| **HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS** | | |
| ***ANTICOAGULANTS - BLOOD THINNERS*** | | |
| ***dabigatran etexilate mesylate caps 75mg, 110mg, 150mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ELIQUIS TABS 2.5mg, 5mg ***(apixaban)*** | Tier 2 | MO |
| ELIQUIS STARTER PACK TBPK 5mg ***(apixaban)*** | Tier 2 | |
| ***enoxaparin sodium soln 300mg/3ml; sosy 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml*** | MB | |
| ***fondaparinux sodium soln 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml*** | MB | |
| FRAGMIN SOLN 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 ***(dalteparin sodium)*** | MB | |
| ***heparin sodium (porcine) soln 1000unit/ml, 5000unit/0.5ml, 5000unit/ml, 10000unit/ml, 20000unit/ml*** | MB | |
| ***jantoven tabs 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg*** (Jantoven) | Tier 1 | MO |
| PRADAXA CAPS 75mg ***(dabigatran etexilate mesylate)*** | 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 ***(rivaroxaban)*** | Tier 2 | MO |
| XARELTO STAR TAB 15/20MG ***(rivaroxaban)*** | 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 ***(darbepoetin alfa)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| FYLNETRA SOSY 6mg/0.6ml ***(pegfilgrastim-pbbk)*** | MB | |
| MIRCERA SOSY 30mcg/0.3ml, 50mcg/0.3ml, 75mcg/0.3ml, 100mcg/0.3ml, 120mcg/0.3ml, 150mcg/0.3ml, 200mcg/0.3ml ***(methoxy polyethylene glycol-epoetin beta)*** | MB | |
| NIVESTYM SOLN 300mcg/ml, 480mcg/1.6ml; SOSY 300mcg/0.5ml, 480mcg/0.8ml ***(filgrastim-aafi)*** | MB | |
| NYVEPRIA SOSY 6mg/0.6ml ***(pegfilgrastim-apgf)*** | MB | |
| RETACRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml ***(epoetin alfa-epbx)*** | MB | |
| ***HEMOPHILIA A AGENTS*** | | |
| HEMLIBRA SOLN 12mg/0.4ml, 30mg/ml, 60mg/0.4ml, 105mg/0.7ml, 150mg/ml, 300mg/2ml ***(emicizumab-kxwh)*** | MB | |
| ***MISCELLANEOUS*** | | |
| ***anagrelide hcl caps .5mg, 1mg*** | Tier 1 | MO |
| ***cilostazol tabs 50mg, 100mg*** | Tier 1 | MO |
| DROXIA CAPS 200mg, 300mg, 400mg ***(hydroxyurea (sickle cell disease))*** | Tier 2 | MO; OAC |
| ***pentoxifylline tbcr 400mg*** | Tier 1 | MO |
| ***tranexamic acid soln 1000mg/10ml*** | MB | |
| ***tranexamic acid tabs 650mg*** | Tier 1 | |
| ***PLATELET AGGREGATION INHIBITORS*** | | |
| ***aspirin-dipyridamole cap er 12hr 25-200 mg*** | Tier 1 | MO |
| ***clopidogrel bisulfate tabs 75mg*** | Tier 1 | MO |
| ***clopidogrel bisulfate tabs 300mg*** | Tier 1 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***dipyridamole tabs 25mg, 50mg, 75mg*** | Tier 1 | PA, MO; High Risk Medications require PA for members age 70 and older |
| ***prasugrel hcl tabs 5mg, 10mg*** | Tier 1 | MO |
| ***THROMBOCYTOPENIA AGENTS*** | | |
| DOPTELET TAB 20MG (10 TABLETS) TABS 20mg ***(avatrombopag maleate)*** | Tier 4 | SP, PA, QL (1 carton every 5 days) |
| DOPTELET TAB 20MG (15 TABLETS) TABS 20mg ***(avatrombopag maleate)*** | Tier 4 | SP, PA, QL (1 carton every 5 days) |
| DOPTELET TAB 20MG (30 TABLETS) TABS 20mg ***(avatrombopag maleate)*** | Tier 4 | SP, PA, QL (2 cartons every 30 days) |
| **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 ***(tocilizumab)*** | MB | |
| SIMPONI ARIA SOLN 50mg/4ml ***(golimumab)*** | MB | |
| SKYRIZI SOLN 600mg/10ml ***(risankizumab-rzaa (crohn's))*** | MB | |
| ***AUTOIMMUNE AGENTS (SELF-ADMINISTERED)*** | | |
| ACTEMRA SOSY 162mg/0.9ml ***(tocilizumab)*** | MB | |
| ADALIMUMAB-ADAZ SOAJ 40mg/0.4ml; SOSY 40mg/0.4ml | MB | |
| COSENTYX SOSY 75mg/0.5ml, 150mg/ml ***(secukinumab)*** | MB | |
| COSENTYX SENSOREADY PEN SOAJ 150mg/ml ***(secukinumab)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| COSENTYX UNOREADY SOAJ 300mg/2ml ***(secukinumab)*** | MB | |
| ENBREL SOLN 25mg/0.5ml; SOSY 25mg/0.5ml, 50mg/ml ***(etanercept)*** | MB | |
| ENBREL MINI SOCT 50mg/ml ***(etanercept)*** | MB | |
| ENBREL SURECLICK SOAJ 50mg/ml ***(etanercept)*** | MB | |
| HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml, 40mg/0.4ml, 40mg/0.8ml ***(adalimumab)*** | MB | |
| HUMIRA PEDIA INJ CROHNS ***(adalimumab)*** | MB | |
| HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml ***(adalimumab)*** | MB | |
| HUMIRA PEN AJKT 40mg/0.4ml, 40mg/0.8ml, 80mg/0.8ml ***(adalimumab)*** | MB | |
| HUMIRA PEN KIT PS/UV ***(adalimumab)*** | MB | |
| HYRIMOZ SOAJ 40mg/0.4ml, 40mg/0.8ml, 80mg/0.8ml; SOSY 10mg/0.1ml, 20mg/0.2ml, 40mg/0.4ml, 40mg/0.8ml ***(adalimumab-adaz)*** | MB | |
| HYRIMOZ CROHN'S DISEASE A SOAJ 80mg/0.8ml ***(adalimumab-adaz)*** | MB | |
| HYRIMOZ PEDIATRIC CROHNS SOSY 80mg/0.8ml ***(adalimumab-adaz)*** | MB | |
| HYRIMOZ SENSOREADY PENS SOAJ 80mg/0.8ml ***(adalimumab-adaz)*** | MB | |
| HYRIMOZ-PED INJ CROHNS ***(adalimumab-adaz)*** | MB | |
| HYRIMOZ-PLAQ INJ PSOR/UVE ***(adalimumab-adaz)*** | MB | |
| KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml; SOSY 150mg/1.14ml, 200mg/1.14ml ***(sarilumab)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| OTEZLA TABS 20mg, 30mg ***(apremilast)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis |
| OTEZLA TAB 10/20 ***(apremilast)*** | Tier 4 | SP, PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis |
| OTEZLA TAB 10/20/30 ***(apremilast)*** | Tier 4 | SP, PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis |
| RINVOQ TB24 15mg ***(upadacitinib)*** | 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 ***(upadacitinib)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); Preferred agent for Atopic Dermatitis, Crohn's Disease and Ulcerative Colitis. |
| RINVOQ TB24 45mg ***(upadacitinib)*** | Tier 4 | SP, PA, QL (One time induction dose for CD/UC diagnosis only); Preferred agent for Crohn's Disease and Ulcerative Colitis. |
| RINVOQ LQ SOLN 1mg/ml ***(upadacitinib)*** | Tier 4 | SP, PA, QL (360 mL every 30 days); Preferred agent for Psoriatic Arthritis |
| SIMPONI SOAJ 50mg/0.5ml, 100mg/ml; SOSY 50mg/0.5ml, 100mg/ml ***(golimumab)*** | MB | |
| SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml ***(risankizumab-rzaa (crohn's))*** | MB | |
| SKYRIZI SOSY 150mg/ml ***(risankizumab-rzaa)*** | MB | |
| SKYRIZI PEN SOAJ 150mg/ml ***(risankizumab-rzaa)*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| STELARA SOLN 45mg/0.5ml; SOSY 45mg/0.5ml, 90mg/ml ***(ustekinumab)*** | MB | |
| TALTZ SOAJ 80mg/ml; SOSY 20mg/0.25ml, 40mg/0.5ml, 80mg/ml ***(ixekizumab)*** | MB | |
| TREMFYA SOAJ 100mg/ml; SOSY 100mg/ml ***(guselkumab)*** | MB | |
| XELJANZ SOLN 1mg/ml ***(tofacitinib citrate)*** | Tier 4 | SP, PA, QL (240 mL every 24 days) |
| XELJANZ TABS 5mg ***(tofacitinib citrate)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); Preferred agent for Rheumatoid Arthritis and Ulcerative Colitis. |
| XELJANZ TABS 10mg ***(tofacitinib citrate)*** | Tier 4 | SP, PA, QL (60 tabs every 30 days); Preferred agent for Ulcerative Colitis. |
| XELJANZ XR TB24 11mg ***(tofacitinib citrate)*** | Tier 4 | SP, PA, QL (30 tabs every 30 days); Preferred agent for Rheumatoid Arthritis and Ulcerative Colitis. |
| XELJANZ XR TB24 22mg ***(tofacitinib citrate)*** | 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 tabs 200mg*** | Tier 1 | MO |
| ***leflunomide tabs 10mg, 20mg*** | Tier 1 | MO |
| ***methotrexate sodium tabs 2.5mg*** | Tier 1 | OAC |
| ***HEREDITARY ANGIOEDEMA*** | | |
| HAEGARDA SOLR 2000unit, 3000unit ***(c1 esterase inhibitor (human))*** | MB | |
| ***icatibant acetate sosy 30mg/3ml*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***IMMUNOGLOBULIN*** | | |
| CUTAQUIG SOLN 1gm/6ml, 1.65gm/10ml, 2gm/12ml, 3.3gm/20ml, 4gm/24ml, 8gm/48ml ***(immune globulin (human)-hipp)*** | MB | |
| ***IMMUNOMODULATORS*** | | |
| ACTIMMUNE SOLN 100mcg/0.5ml ***(interferon gamma-1b)*** | MB | |
| ARCALYST SOLR 220mg ***(rilonacept)*** | MB | |
| ***IMMUNOSUPPRESSANTS*** | | |
| ASTAGRAF XL CP24 .5mg, 1mg, 5mg ***(tacrolimus)*** | Tier 3 | SP |
| ***azathioprine tabs 50mg, 75mg, 100mg*** | Tier 1 | MO |
| CELLCEPT CAPS 250mg; SUSR 200mg/ml; TABS 500mg ***(mycophenolate mofetil)*** | Tier 3 | SP |
| CELLCEPT INTRAVENOUS SOLR 500mg ***(mycophenolate mofetil hcl)*** | MB | |
| ***cyclosporine caps 25mg, 100mg*** | Tier 1 | SP |
| ***cyclosporine soln 50mg/ml*** | MB | |
| ***cyclosporine modified (for microemulsion) caps 25mg, 50mg, 100mg; soln 100mg/ml*** | Tier 1 | SP |
| ENVARSUS XR TB24 .75mg, 1mg, 4mg ***(tacrolimus)*** | Tier 3 | SP |
| ***everolimus (immunosuppressant) tabs .25mg, .5mg, .75mg, 1mg*** | Tier 1 | SP |
| ***gengraf caps 25mg, 100mg; soln 100mg/ml*** (Gengraf) | Tier 1 | SP |
| ***mycophenolate mofetil caps 250mg; susr 200mg/ml; tabs 500mg*** | Tier 1 | SP |
| ***mycophenolate mofetil hcl solr 500mg*** | MB | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***mycophenolate sodium tbec 180mg, 360mg*** | Tier 1 | SP |
| MYFORTIC TBEC 180mg, 360mg ***(mycophenolate sodium)*** | Tier 3 | SP |
| NEORAL CAPS 25mg, 100mg; SOLN 100mg/ml ***(cyclosporine modified (for microemulsion))*** | Tier 3 | SP |
| NULOJIX SOLR 250mg ***(belatacept)*** | MB | |
| PROGRAF CAPS .5mg, 1mg, 5mg; PACK .2mg, 1mg ***(tacrolimus)*** | Tier 3 | SP |
| PROGRAF SOLN 5mg/ml ***(tacrolimus)*** | MB | |
| RAPAMUNE SOLN 1mg/ml; TABS .5mg, 1mg, 2mg ***(sirolimus)*** | Tier 3 | SP |
| SANDIMMUNE CAPS 25mg, 100mg; SOLN 100mg/ml ***(cyclosporine)*** | Tier 3 | SP |
| SANDIMMUNE SOLN 50mg/ml ***(cyclosporine)*** | MB | |
| ***sirolimus soln 1mg/ml; tabs .5mg, 1mg, 2mg*** | Tier 1 | SP |
| ***tacrolimus caps .5mg, 1mg, 5mg*** | Tier 1 | SP |
| ZORTRESS TABS .25mg, .5mg, .75mg, 1mg ***(everolimus (immunosuppressant))*** | Tier 3 | SP |
| ***MISCELLANEOUS*** | | |
| BEYFORTUS SOSY 50mg/0.5ml, 100mg/ml ***(nirsevimab-alip)*** | MB | |
| **NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS** | | |
| ***ELECTROLYTES*** | | |
| ***effer-k tbef 25meq*** (Effer-k) | Tier 1 | MO |
| ***fluoritab soln .125mg/drop*** (Fluoritab) | PV | MO; $0 applies for ages 5 and under, otherwise not covered |
| ***klor-con 8 tbcr 8meq*** (Klor-con 8) | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***klor-con 10 tbcr 10meq*** (Klor-con 10) | Tier 1 | MO |
| ***klor-con m15 tbcr 15meq*** (Klor-con M15) | Tier 1 | MO |
| ***magnesium sulfate soln 2gm/50ml, 50%*** | MB | |
| ***magnesium sulfate in dextrose 5% iv soln 1 gm/100ml*** | MB | |
| ***monoject sodium chloride soln .9%*** (Monoject Sodium Chloride) | MB | |
| ***nafrinse drops soln .125mg/drop*** (Nafrinse Drops) | PV | MO; $0 applies for ages 5 and under, otherwise not covered |
| ***potassium chloride cpcr 8meq, 10meq; soln 10%, 20%; tbcr 8meq, 10meq, 15meq, 20meq*** | Tier 1 | MO |
| ***potassium chloride microencapsulated crystals er tbcr 10meq, 20meq*** | Tier 1 | MO |
| ***sodium chloride soln 2.5meq/ml*** | MB | |
| ***sodium fluoride chew 1mg; tabs 1mg*** | Tier 1 | MO |
| ***sodium fluoride chew .25mg, .5mg; soln .5mg/ml; tabs .5mg*** | PV | MO; $0 applies for ages 5 and under, otherwise not covered |
| ***IV REPLACEMENT SOLUTIONS*** | | |
| ***potassium chloride soln 2meq/ml*** | MB | |
| ***sodium chloride soln .45%, .9%, 3%, 5%*** | MB | |
| ***PRENATAL VITAMINS*** | | |
| ***elite-ob*** (Elite-ob) | Tier 1 | |
| ***inatal gt*** (Inatal Gt) | Tier 1 | |
| ***pnv-dha*** (Pnv-dha) | Tier 1 | |
| ***pnv-select*** (Pnv-select) | Tier 1 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***prenatal 19*** (Prenatal 19) | Tier 1 | |
| ***trinate*** (Trinate) | Tier 1 | |
| ***VITAMINS*** | | |
| ***calcitriol caps .25mcg, .5mcg; soln 1mcg/ml*** | Tier 1 | MO |
| ***cyanocobalamin soln 1000mcg/ml*** | MB | |
| ***doxercalciferol caps .5mcg, 1mcg, 2.5mcg*** | Tier 1 | MO |
| ***ergocalciferol 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 caps 1mcg, 2mcg, 4mcg*** | Tier 1 | MO |
| ***phytonadione tabs 5mg*** | Tier 1 | |
| **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 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***neomycin-polymyxin-dexamethasone ophth oint 0.1%*** | Tier 1 | |
| ***neomycin-polymyxin-dexamethasone ophth susp 0.1%*** | 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% ***(tobramycin-dexamethasone)*** | Tier 2 | |
| TOBRADEX ST SUS 0.3-0.05 ***(tobramycin-dexamethasone)*** | Tier 2 | |
| ***tobramycin-dexamethasone ophth susp 0.3-0.1%*** | Tier 1 | |
| ***ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS*** | | |
| AZASITE SOLN 1% ***(azithromycin (ophth))*** | Tier 2 | |
| ***bacitracin (ophthalmic) oint 500unit/gm*** | Tier 1 | |
| ***bacitracin-polymyxin b ophth oint*** | Tier 1 | |
| BESIVANCE SUSP .6% ***(besifloxacin hcl)*** | Tier 3 | |
| ***ciprofloxacin hcl (ophth) soln .3%*** | Tier 1 | |
| ***erythromycin (ophth) oint 5mg/gm*** | Tier 1 | |
| ***gatifloxacin (ophth) soln .5%*** | Tier 1 | |
| ***gentamicin sulfate (ophth) soln .3%*** | Tier 1 | |
| ***moxifloxacin hcl (ophth) soln .5%*** | Tier 1 | |
| NATACYN SUSP 5% ***(natamycin)*** | Tier 2 | |
| ***neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml*** | Tier 1 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ofloxacin (ophth) soln .3%*** | Tier 1 | |
| ***polycin*** (Polycin) | 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% ***(ganciclovir ophthalmic)*** | Tier 3 | |
| ***ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION*** | | |
| ACUVAIL SOLN .45% ***(ketorolac tromethamine (ophth))*** | Tier 2 | |
| ***bromfenac sodium (ophth) soln .09%*** | Tier 1 | |
| ***dexamethasone sodium phosphate (ophth) soln .1%*** | Tier 1 | |
| ***diclofenac sodium (ophth) soln .1%*** | Tier 1 | |
| ***difluprednate emul .05%*** | Tier 1 | |
| ***flurbiprofen sodium soln .03%*** | Tier 1 | |
| ILEVRO SUSP .3% ***(nepafenac)*** | Tier 2 | |
| ***ketorolac tromethamine (ophth) soln .4%, .5%*** | Tier 1 | |
| ***loteprednol etabonate susp .5%*** | Tier 1 | |
| NEVANAC SUSP .1% ***(nepafenac)*** | Tier 2 | |
| ***prednisolone acetate (ophth) susp 1%*** | Tier 1 | |
| PREDNISOLONE SODIUM PHOSP SOLN 1% | Tier 2 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ANTIALLERGICS - DRUGS TO TREAT ALLERGIES*** | | |
| ALOCRIL SOLN 2% ***(nedocromil sodium (ophth))*** | Tier 3 | |
| ALOMIDE SOLN .1% ***(lodoxamide tromethamine)*** | Tier 3 | |
| ***azelastine hcl (ophth) soln .05%*** | Tier 1 | |
| ***bepotastine besilate 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% ***(cetirizine hcl (ophth))*** | Tier 3 | |
| ***ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA*** | | |
| ***apraclonidine hcl soln .5%*** | Tier 1 | |
| ***betaxolol hcl (ophth) soln .5%*** | Tier 1 | MO |
| BETIMOL SOLN .25%, .5% ***(timolol)*** | Tier 3 | MO |
| BETOPTIC-S SUSP .25% ***(betaxolol hcl (ophth))*** | Tier 2 | MO |
| ***brimonidine tartrate soln .1%, .15%, .2%*** | Tier 1 | MO |
| ***brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%*** | Tier 1 | MO |
| ***brinzolamide 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%*** | Tier 1 | MO |
| IOPIDINE SOLN 1% ***(apraclonidine hcl)*** | Tier 3 | |
| ***latanoprost soln .005%*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***levobunolol hcl soln .5%*** | Tier 1 | MO |
| LUMIGAN SOLN .01% ***(bimatoprost)*** | Tier 2 | ST, MO; PA** |
| PHOSPHOLINE IODIDE SOLR .125% ***(echothiophate iodide)*** | Tier 3 | MO |
| ***pilocarpine hcl soln 1%*** | Tier 1 | MO |
| SIMBRINZA SUS 1-0.2% ***(brinzolamide-brimonidine tartrate)*** | Tier 2 | MO |
| ***tafluprost soln .015mg/ml*** | Tier 1 | MO |
| ***timolol maleate (ophth) solg .25%, .5%; soln .25%, .5%*** | Tier 1 | MO |
| ***travoprost soln .004%*** | Tier 1 | MO |
| ***DRY EYE DISEASE*** | | |
| RESTASIS EMUL .05% ***(cyclosporine (ophth))*** | Tier 1 | MO |
| RESTASIS MULTIDOSE EMUL .05% ***(cyclosporine (ophth))*** | Tier 2 | MO; Multi-dose vial remains on preferred brand tier |
| ***MISCELLANEOUS*** | | |
| ***atropine sulfate (ophthalmic) soln 1%*** | Tier 1 | MO |
| CYSTARAN SOLN .44% ***(cysteamine hcl)*** | Tier 4 | PA, QL (4 bottles every 28 days) |
| ***phenylephrine hcl (mydriatic) soln 2.5%, 10%*** | Tier 1 | |
| ***tropicamide soln .5%, 1%*** | Tier 1 | MO |
| **PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.** | | |
| ***HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS*** | | |
| ADDYI TABS 100mg ***(flibanserin)*** | Tier 3 | PA, MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| **RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS** | | |
| ***ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS*** | | |
| PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg ***(alpha1-proteinase inhibitor (human))*** | MB | |
| ***ANAPHYLAXIS TREATMENT AGENTS*** | | |
| ***epinephrine (anaphylaxis) soaj .15mg/0.3ml, .3mg/0.3ml*** | 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 ***(epinephrine (anaphylaxis))*** | Tier 2 | QL (4 auto-injectors every 30 days) |
| EPIPEN-JR 2-PAK SOAJ .15mg/0.3ml ***(epinephrine (anaphylaxis))*** | Tier 2 | QL (4 auto-injectors every 30 days) |
| ***ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD*** | | |
| BEVESPI AER 9-4.8MCG ***(glycopyrrolate-formoterol fumarate)*** | 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 |
| STIOLTO AER 2.5-2.5 ***(tiotropium bromide-olodaterol hcl)*** | Tier 2 | QL (1 package every 30 days), MO |
| ***ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS*** | | |
| TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)*** | Tier 2 | QL (1 package every 30 days), MO |
| TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)*** | 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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SPIRIVA RESPIMAT AERS 1.25mcg/act, 2.5mcg/act ***(tiotropium bromide monohydrate)*** | Tier 2 | QL (1 package every 30 days), MO |
| ***tiotropium bromide monohydrate caps 18mcg*** | Tier 1 | QL (1 package every 30 days), MO |
| ***ANTIHISTAMINE COMBINATIONS*** | | |
| ***azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act*** | 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 tabs 5mg; 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 caps 25mg, 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) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD*** | | |
| ***albuterol sulfate aers 108mcg/act*** | Tier 1 | QL (2 inhalers every 30 days), MO |
| ***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 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 ***(olodaterol hcl)*** | 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*** | Tier 1 | QL (30 mL every day); Subject to initial 7-day limit |
| ***hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg*** | Tier 1 | QL (6 tabs every day); Subject to initial 7-day limit |
| ***hydromet*** (Hydromet) | Tier 1 | QL (30 mL every day); Subject to initial 7-day limit |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***promethazine vc*** (Promethazine Vc) | Tier 1 | |
| ***promethazine vc/codeine*** (Promethazine Vc/codeine) | Tier 1 | QL (30 mL every day); Subject to initial 7-day limit |
| ***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 | |
| ***pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml*** | Tier 1 | |
| TUZISTRA XR SUS ***(codeine polistirex-chlorpheniramine polistirex)*** | Tier 3 | QL (20 mL every day); Subject to initial 7-day limit |
| ***CYSTIC FIBROSIS*** | | |
| CAYSTON SOLR 75mg ***(aztreonam lysine)*** | Tier 4 | SP, PA, QL (84 vials every 28 days) |
| KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg ***(ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| KALYDECO TABS 150mg ***(ivacaftor)*** | Tier 4 | SP, PA, QL (56 tabs every 28 days); carton consists of 56 tablets |
| ORKAMBI GRA 75-94MG ***(lumacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| ORKAMBI GRA 100-125 ***(lumacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| ORKAMBI GRA 150-188 ***(lumacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| ORKAMBI TAB 100-125 ***(lumacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (112 tabs every 28 days) |
| ORKAMBI TAB 200-125 ***(lumacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (112 tabs every 28 days) |
| SYMDEKO TAB 50-75MG ***(tezacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 tabs every 28 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| SYMDEKO TAB 100-150 ***(tezacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 tabs every 28 days) |
| ***tobramycin nebu 300mg/4ml*** | Tier 4 | SP, PA, QL (224 mL every 28 days) |
| ***tobramycin nebu 300mg/5ml*** | Tier 4 | SP, PA, QL (280 mL every 28 days) |
| TRIKAFTA PAK 59.5MG ***(elexacaftor-tezacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| TRIKAFTA PAK 75MG ***(elexacaftor-tezacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (56 packets every 28 days) |
| TRIKAFTA TAB ***(elexacaftor-tezacaftor-ivacaftor)*** | Tier 4 | SP, PA, QL (84 tabs every 28 days) |
| ***LEUKOTRIENE MODIFIERS*** | | |
| ***zileuton tb12 600mg*** | Tier 2 | MO |
| ***LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES*** | | |
| ***montelukast sodium chew 4mg, 5mg; pack 4mg; tabs 10mg*** | Tier 1 | MO |
| ***zafirlukast 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 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) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***fluticasone propionate (nasal) susp 50mcg/act*** | Tier 1 | QL (1 container every 30 days) |
| ***PULMONARY FIBROSIS AGENTS*** | | |
| ***pirfenidone caps 267mg*** | Tier 4 | SP, PA, QL (270 caps every 30 days) |
| ***pirfenidone tabs 267mg*** | Tier 4 | SP, PA, QL (270 tabs every 30 days) |
| ***pirfenidone tabs 801mg*** | Tier 4 | SP, PA, QL (90 tabs every 30 days) |
| ***RESPIRATORY THERAPY SUPPLIES*** | | |
| ADULT RESPIRATORY MASK ***(spacer/aerosol-holding chambers)*** | Tier 2 | |
| HOLD CHAMBER MIS MEDIUM ***(spacer/aerosol-holding chambers)*** | Tier 2 | |
| PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)*** | Tier 2 | |
| PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)*** | Tier 2 | |
| ***SEVERE ASTHMA AGENTS*** | | |
| DUPIXENT SOSY 100mg/0.67ml ***(dupilumab)*** | MB | |
| FASENRA SOSY 10mg/0.5ml, 30mg/ml ***(benralizumab)*** | MB | |
| FASENRA PEN SOAJ 30mg/ml ***(benralizumab)*** | MB | |
| XOLAIR SOAJ 75mg/0.5ml, 150mg/ml, 300mg/2ml; SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml, 300mg/2ml ***(omalizumab)*** | MB | |
| ***STEROID INHALANTS - DRUGS TO TREAT ASTHMA*** | | |
| ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act ***(fluticasone furoate (inhalation))*** | Tier 2 | QL (1 package every 30 days), MO |
| ***budesonide (inhalation) susp 1mg/2ml*** | Tier 1 | QL (1 box every 30 days), MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***budesonide (inhalation) susp .5mg/2ml*** | Tier 1 | QL (2 boxes every 30 days), MO |
| ***budesonide (inhalation) susp .25mg/2ml*** | Tier 1 | QL (3 boxes every 30 days), MO |
| QVAR REDIHALER AERB 40mcg/act, 80mcg/act ***(beclomethasone dipropionate hfa)*** | Tier 2 | QL (2 packages every 30 days), MO |
| ***STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD*** | | |
| AIRSUPRA AER 90-80MCG ***(albuterol-budesonide)*** | Tier 2 | QL (3 packages every 30 days) |
| BREO ELLIPTA INH 50-25MCG ***(fluticasone furoate-vilanterol)*** | Tier 2 | QL (1 package every 30 days), MO |
| BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)*** | Tier 2 | QL (1 package every 30 days), MO |
| BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)*** | Tier 2 | QL (1 package every 30 days), MO |
| ***budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act*** | Tier 1 | QL (3 packages every 30 days), MO |
| ***budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act*** | Tier 1 | QL (3 packages every 30 days), MO |
| ***fluticasone-salmeterol aer powder ba 100-50 mcg/act*** | Tier 1 | QL (1 package every 30 days), MO |
| ***fluticasone-salmeterol aer powder ba 250-50 mcg/act*** | Tier 1 | QL (1 package every 30 days), MO |
| ***fluticasone-salmeterol aer powder ba 500-50 mcg/act*** | Tier 1 | QL (1 package every 30 days), MO |
| ***XANTHINES - DRUGS TO TREAT COPD*** | | |
| ***aminophylline soln 25mg/ml*** | MB | |
| ***theophylline elix 80mg/15ml; soln 80mg/15ml; tb12 300mg, 450mg; tb24 400mg, 600mg*** | Tier 1 | MO |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| **TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS** | | |
| ***DERMATOLOGY, ACNE*** | | |
| ***adapalene crea .1%; gel .1%, .3%*** | Tier 1 | PA, QL (45g every 28 days); PA applies for members age 35 and older |
| ***adapalene-benzoyl peroxide gel 0.1-2.5%*** | Tier 1 | |
| ***adapalene-benzoyl peroxide gel 0.3-2.5%*** | Tier 1 | |
| ***benzoyl peroxide-erythromycin gel 5-3%*** | 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) lotn 1%; 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%*** | Tier 1 | QL (50g every 30 days) |
| ***ery pads 2%*** (Ery) | Tier 1 | |
| ***erythromycin (acne aid) gel 2%*** | Tier 1 | QL (60g every 30 days) |
| ***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) lotn 10%*** | Tier 1 | |
| ***tretinoin crea .025%, .05%, .1%; gel .01%, .025%, .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 |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***DERMATOLOGY, ACTINIC KERATOSIS*** | | |
| ***fluorouracil (topical) crea 5%; soln 2%, 5%*** | Tier 1 | |
| ***imiquimod crea 5%*** | Tier 1 | |
| ***DERMATOLOGY, ANTIBIOTICS*** | | |
| ***gentamicin sulfate (topical) crea .1%; oint .1%*** | Tier 1 | |
| ***mupirocin oint 2%*** | Tier 1 | QL (30g every 30 days) |
| ***silver sulfadiazine crea 1%*** | Tier 1 | |
| ***ssd crea 1%*** (Ssd) | Tier 1 | |
| SULFAMYLON CREA 85mg/gm ***(mafenide acetate)*** | 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% ***(sertaconazole nitrate)*** | Tier 3 | QL (60g every 30 days) |
| JUBLIA SOLN 10% ***(efinaconazole)*** | Tier 3 | PA, QL (4 mL every 28 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***ketoconazole (topical) crea 2%*** | Tier 1 | QL (120g every 30 days) |
| MENTAX CREA 1% ***(butenafine hcl)*** | Tier 3 | QL (60g every 30 days) |
| ***naftifine hcl crea 1%, 2%*** | Tier 1 | QL (60g every 30 days) |
| ***nyamyc powd 100000unit/gm*** (Nyamyc) | Tier 1 | QL (120g 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) |
| ***nystop powd 100000unit/gm*** (Nystop) | Tier 1 | QL (120g every 30 days) |
| ***oxiconazole nitrate 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) crea 5%*** | Tier 2 | |
| ***DERMATOLOGY, ANTIPSORIATICS*** | | |
| ***acitretin caps 10mg, 17.5mg, 25mg*** | Tier 1 | |
| ***calcipotriene soln .005%*** | Tier 1 | ST, QL (60 mL every 30 days); PA** |
| ***calcipotriene-betamethasone dipropionate oint 0.005-0.064%*** | Tier 2 | ST, QL (60g every 30 days); PA** |
| ***calcitriol (topical) oint 3mcg/gm*** | Tier 2 | ST, QL (100g every 30 days); PA** |
| ***methoxsalen rapid caps 10mg*** | Tier 1 | |
| ***tazarotene crea .05%, .1%; gel .05%, .1%*** | Tier 1 | PA |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| TAZORAC CREA .05% ***(tazarotene)*** | Tier 2 | PA |
| ***DERMATOLOGY, ANTISEBORRHEICS*** | | |
| ***ketoconazole (topical) sham 2%*** | Tier 1 | QL (120 mL every 30 days) |
| ***selenium sulfide lotn 2.5%*** | Tier 1 | |
| ***DERMATOLOGY, ATOPIC DERMATITIS*** | | |
| DUPIXENT SOAJ 200mg/1.14ml, 300mg/2ml; SOSY 200mg/1.14ml, 300mg/2ml ***(dupilumab)*** | MB | |
| EUCRISA OINT 2% ***(crisaborole)*** | Tier 2 | ST, QL (60g every 30 days); PA** |
| ***tacrolimus (topical) oint .03%, .1%*** | Tier 2 | ST; PA** |
| ***DERMATOLOGY, CORTICOSTEROIDS*** | | |
| ***ala-cort crea 1%*** (Ala-cort) | Tier 1 | QL (120g every 30 days) |
| ***alclometasone dipropionate crea .05%; oint .05%*** | Tier 1 | QL (120g every 30 days) |
| ***amcinonide lotn .1%*** | Tier 1 | QL (120 mL every 30 days) |
| ***amcinonide oint .1%*** | Tier 1 | QL (120g 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%; oint .05%*** | Tier 1 | QL (120g every 30 days) |
| ***betamethasone dipropionate augmented lotn .05%*** | Tier 1 | QL (120 mL 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) |
| ***clobetasol propionate crea .05%; foam .05%; gel .05%; oint .05%*** | Tier 1 | QL (120g every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***clobetasol propionate liqd .05%; lotn .05%; sham .05%; soln .05%*** | Tier 1 | QL (120 mL every 30 days) |
| ***clobetasol propionate emo crea .05%*** (Clobetasol Propionate Emo) | Tier 1 | QL (120g every 30 days) |
| ***clocortolone pivalate crea .1%*** | Tier 2 | QL (120g every 30 days) |
| ***desonide crea .05%; oint .05%*** | Tier 1 | QL (120g every 30 days) |
| ***desonide lotn .05%*** | Tier 1 | QL (120 mL every 30 days) |
| ***desoximetasone crea .05%, .25%; gel .05%; oint .25%*** | Tier 1 | QL (120g every 30 days) |
| ***diflorasone diacetate crea .05%; oint .05%*** | Tier 2 | QL (120g every 30 days) |
| ***fluocinolone acetonide crea .01%, .025%; oint .025%*** | Tier 1 | QL (120g every 30 days) |
| ***fluocinolone acetonide oil .01%; soln .01%*** | Tier 1 | QL (120 mL every 30 days) |
| ***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) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***mometasone furoate soln .1%*** | Tier 1 | QL (120 mL 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 ptch 5%*** | Tier 1 | PA, QL (90 patches every 30 days) |
| ***lidocaine hcl 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) gel 1%*** | Tier 4 | SP, PA |
| ***diclofenac sodium (topical) gel 1%*** | Tier 1 | QL (300g every 30 days) |
| ***lactic acid (ammonium lactate) crea 12%; lotn 12%*** | Tier 1 | |
| ***nitroglycerin (intra-anal) oint .4%*** | Tier 1 | |
| ***penciclovir crea 1%*** | Tier 1 | |
| ***podofilox gel .5%; soln .5%*** | Tier 1 | |
| ***DERMATOLOGY, ROSACEA*** | | |
| ***azelaic acid gel 15%*** | Tier 1 | |
| ***brimonidine tartrate (topical) gel .33%*** | Tier 1 | PA |
| FINACEA FOAM 15% ***(azelaic acid)*** | Tier 2 | |
| ***metronidazole (topical) crea .75%; gel .75%, 1%*** | Tier 1 | QL (60g every 30 days) |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***metronidazole (topical) lotn .75%*** | Tier 1 | QL (60 mL every 30 days) |
| ***DERMATOLOGY, SCABICIDES AND PEDICULICIDES*** | | |
| ***crotan lotn 10%*** (Crotan) | Tier 1 | |
| ***malathion lotn .5%*** | Tier 1 | |
| ***permethrin crea 5%*** | Tier 1 | |
| ***spinosad susp .9%*** | Tier 1 | |
| ***DERMATOLOGY, WOUND CARE AGENTS*** | | |
| REGRANEX GEL .01% ***(becaplermin)*** | Tier 3 | PA, QL (30g every 30 days) |
| ***MOUTH/THROAT/DENTAL AGENTS*** | | |
| ***cevimeline hcl 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 | |
| ***oralone dental paste pste .1%*** (Oralone Dental Paste) | Tier 1 | |
| ORAVIG TABS 50mg ***(miconazole (mouth-throat))*** | Tier 3 | QL (14 tabs every 30 days) |
| ***pilocarpine hcl (oral) 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 ***(neomycin-colistin-hc-thonzonium)*** | Tier 3 | |

| PRESCRIPTION DRUG NAME | DRUG TIER | COVERAGE REQUIREMENTS AND LIMITS |
|---|---|---|
| ***fluocinolone acetonide (otic) 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 | |

# Index

## *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*** | 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*** | GIP AND GLP-1 AGONIST 676-D |
| ***Drug Names*** | MOUNJARO |
| ***Step Therapy Criteria*** | Coverage will be provided if the member has filled a prescription for at least a 30 day supply of metformin when the date of a metformin fill is AT LEAST 10 days prior to the claim for a GLP-1 receptor agonist or a GIP-GLP-1 receptor agonist within the past 180 days |

| | |
|---|---|
| ***Step Therapy Group*** | GLP-1 AGONIST 676-D |
| ***Drug Names*** | LIRAGLUTIDE, OZEMPIC, TRULICITY, VICTOZA |
| ***Step Therapy Criteria*** | Coverage will be provided if the member has filled a prescription for at least a 30 day supply of metformin when the date of a metformin fill is AT LEAST 10 days prior to the claim for a GLP-1 receptor agonist or a GIP-GLP-1 receptor agonist within the past 180 days |

| | |
|---|---|
| ***Step Therapy Group*** | GLP-1 AGONIST/LONG ACTING INSULIN COMBO 676-D |
| ***Drug Names*** | SOLIQUA 100/33, XULTOPHY 100/3.6 |
| ***Step Therapy Criteria*** | Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days |

| | |
|---|---|
| ***Step Therapy Group*** | LYRICA 656-D |
| ***Drug Names*** | PREGABALIN |
| ***Step Therapy Criteria*** | Coverage will be provided if the member has filled a prescription for regular release generic gabapentin (at least a 30 day supply within the past 120 days) |

| | |
|---|---|
| ***Step Therapy Group*** | OPIOID ER 2219-M |
| ***Drug Names*** | BELBUCA, BUPRENORPHINE, FENTANYL, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, METHADONE HYDROCHLORIDE, 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 HYDROCHLORIDE |
| ***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, valproic acid, metoprolol, propranolol, timolol, atenolol, nadolol, candesartan, amitriptyline, or venlafaxine within the past 730 days.<br><br>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*** | RANEXA 658-D |
| ***Drug Names*** | RANOLAZINE ER |
| ***Step Therapy Criteria*** | Coverage will be provided if the member has filled a prescription for any two of the following: beta blocker, 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 at least a 30 day supply of at least one generic alpha-1 adrenergic blocker drug or at least one generic 5-alpha reductase inhibitor drug, or at least one generic alpha-1 adrenergic blocker/5-alpha reductase inhibitor combination drug 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<br><br>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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