SHARP Health Plan

2025 Formulary PPO

List of covered prescription drugs

This drug list applies to all PPO products

April 2025

List of covered prescription drugs for Employer-sponsored plans from Sharp Health Plan

An electronic version of this Prescription Drug List is available on the Sharp Health Plan website, by visiting sharphealthplan.com/search-drug-list. You can find specific cost sharing information in your plan's coverage documents by logging in to your Sharp Connect account on our website by visiting sharphealthplan.com/login. This document is subject to change and all previous versions are no longer in effect. Last updated 04/01/2025.

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INTRODUCTION

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. 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. 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 Physician to treat phenylketonuria (PKU), provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office.
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.

"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 your 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 Medispan® classification system for therapeutic category and class. Medispan® 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, 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 100 mg) 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
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.
1	Tier 1	Preferred Generic Drugs. These drugs are subject to your Tier 1 Copayment.
2	Tier 2	Preferred Brand-Name Drugs and inhaler spacers. These drugs and inhaler spacers are subject to your Tier 2 Copayment.
3	Tier 3	Non-preferred drugs (may include Brand Name or Generic Drugs). These drugs are subject to your Tier 3 Copayment.
4	Tier 4	Specialty Drugs

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 an alternative drug. In these instances, your doctor may request a Step Therapy Exception by following the Prior Authorization process as described above. 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 we fail to notify your provider of our coverage determination within 72 hours for non-urgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills. If your provider does not receive a coverage determination or request for additional or clinically relevant material information within 72 hours for standard requests or 24 hours for expedited requests, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

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 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 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. The enrollee may be required to try an interchangeable product before providing coverage for the equivalent branded prescription drug. Nothing in this section will prohibit or supersede a step therapy exception request.

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 required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.

2. 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 treatment failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.

3. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.

4. 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.

5. Vitamins (other than pediatric or prenatal vitamins listed in this Formulary).

6. 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.)

7. Herbal, nutritional and dietary supplements.

8. Drugs prescribed solely for the purpose of shortening the duration of the common cold.

9. 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.

10. 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.

11. Travel and/or required work-related immunizations.

12. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.

13. Drugs obtained outside of the United States, unless they are furnished in connection with Urgent Care Services or Emergency Services.

14. 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.

15. 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.

16. Replacement of lost, stolen, or destroyed medications.

17. Compounded medications, unless determined to be Medically Necessary and Prior Authorization is obtained.

18. Brand-Name Drugs when a generic equivalent is available.

19. 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 class becomes 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 the Plan 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 Diabetes Treatment.

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. When an interchangeable biological product is available, the pharmacy may be required to fill your Prescription with the interchangeable biological product unless prior Authorization is obtained and the reference product, or existing FDA-approved biologic, is determined to be Medically Necessary.

NONDISCRIMINATION NOTICE

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

Sharp Health Plan:

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

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

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

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

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

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

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

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

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

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

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

LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STEP THERAPY CRITERIA

Step Therapy Group	HPGST ANTIPSYCHOTICS 478-D
Drug Names	VRAYLAR
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of aripiprazole, clozapine, olanzapine, paliperidone ext-rel, risperidone, quetiapine, quetiapine ext-rel, or ziprasidone within the past 365 days
Step Therapy Group	HPGST SSRI 409-D
Drug Names	TRINTELLIX
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription of a generic SSRI product (at least a 30 day supply within the past 365 days)
Step Therapy Group	HPGST TRIPTANS 410-D
Drug Names	ONZETRA XSAIL, ZEMBRACE SYMTOUCH
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription of a generic triptan (almotriptan, eletriptan, frovatriptan, sumatriptan, naratriptan, rizatriptan, rizatriptan ODT, zolmitriptan, Sumatriptan-Naproxen Sodium) at least a 30 day supply within the past 180 days
Step Therapy Group	OPIOID ER 2219-M
Drug Names	BELBUCA, BUPRENORPHINE, FENTANYL, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HYDROCHLORI, METHADONE HYDROCHLORIDE, MORPHINE SULFATE ER, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER
Step Therapy Criteria	Coverage will be provided if the member has filled a cumulative 7-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 COMBO PRODUCTS 1358-E
Drug Names	ACETAMINOPHEN/CAFFEINE/DI, ACETAMINOPHEN/CODEINE, ACETAMINOPHEN/CODEINE PHO, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, TRAMADOL HYDROCHLORIDE/AC, TREZIX
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 7-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AMPHETAMINES		
amphetamine sulfate tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine sulfate tab 10 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 5 mg	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 10 mg	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 15 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 20 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 7.5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 10 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 12.5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 15 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 20 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 30 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 5 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 10 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dextroamphetamine sulfate cap er 24hr 15 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate oral solution 5 mg/5ml	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Oral Solution 5 mg/5ml) PROCENTRA	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 2.5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 2.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 7.5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 7.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 10 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 10 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dextroamphetamine sulfate tab 15 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 15 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 20 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 20 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 30 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 30 mg) ZENZEDI	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 10 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 20 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 30 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 40 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 50 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lisdexamfetamine dimesylate cap 60 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate cap 70 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 10 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 20 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 30 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 40 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 50 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 60 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methamphetamine hcl tab 5 mg	1	PA, QL (450 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
ANOREXIANTS NON-AMPHETAMINE		
benzphetamine hcl tab 50 mg	1	PA
diethylpropion hcl tab 25 mg	1	PA
diethylpropion hcl tab er 24hr 75 mg	1	PA
phendimetrazine tartrate tab 35 mg	1	PA
phentermine hcl cap 15 mg	1	PA
phentermine hcl cap 30 mg	1	PA
phentermine hcl cap 37.5 mg	1	PA
phentermine hcl tab 37.5 mg	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
QSYMIA CAP 3.75-23 ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 7.5-46MG ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 11.25-69 ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 15-92MG ***(phentermine hcl-topiramate)***	2	PA
ANTI-OBESITY AGENTS		
orlistat cap 120 mg	1	PA
SAXENDA INJ 18MG/3ML ***(liraglutide (weight management))***	2	PA, MO
WEGOVY INJ 0.5MG ***(semaglutide (weight management))***	2	PA
WEGOVY INJ 0.25MG ***(semaglutide (weight management))***	2	PA
WEGOVY INJ 1.7MG ***(semaglutide (weight management))***	2	PA, MO
WEGOVY INJ 1MG ***(semaglutide (weight management))***	2	PA
WEGOVY INJ 2.4MG ***(semaglutide (weight management))***	2	PA, MO
ZEPBOUND INJ 2.5/0.5 ***(tirzepatide (weight management))***	2	PA
ZEPBOUND INJ 5/0.5ML ***(tirzepatide (weight management))***	2	PA, MO
ZEPBOUND INJ 7.5/0.5 ***(tirzepatide (weight management))***	2	PA, MO
ZEPBOUND INJ 10/0.5ML ***(tirzepatide (weight management))***	2	PA, MO
ZEPBOUND INJ 12.5/0.5 ***(tirzepatide (weight management))***	2	PA, MO
ZEPBOUND INJ 15/0.5ML ***(tirzepatide (weight management))***	2	PA, MO
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER		
atomoxetine hcl cap 10 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 18 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
atomoxetine hcl cap 25 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 40 mg (base equiv)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 60 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 80 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 100 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
clonidine hcl tab er 12hr 0.1 mg	1	MO
guanfacine hcl tab er 24hr 1 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 2 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 3 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 4 mg (base equiv)	1	MO
QELBREE CAP 100MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
QELBREE CAP 150MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
QELBREE CAP 200MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG ***(solriamfetol hcl)***	2	PA, MO
SUNOSI TAB 150MG ***(solriamfetol hcl)***	2	PA, MO
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG ***(pitolisant hcl)***	4	SP, PA, QL (2 tabs every 1 day)
WAKIX TAB 17.8MG ***(pitolisant hcl)***	4	SP, PA, QL (2 tabs every 1 day)
STIMULANTS - MISC.		
armodafinil tab 50 mg	1	PA, MO
armodafinil tab 150 mg	1	PA, MO
armodafinil tab 200 mg	1	PA, MO
armodafinil tab 250 mg	1	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
AZSTARYS CAP 26.1-5.2 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 39.2-7.8 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 52.3-10. ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 5 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 10 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 15 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 20 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 25 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 30 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 35 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 40 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dexmethylphenidate hcl tab 2.5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl tab 10 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 10 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 20 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 15 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 20 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 20 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 30 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cap er 24hr 30 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 50 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 60 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 60 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 30 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 40 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 50 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 60 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 2.5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl chew tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 5 mg/5ml	1	PA, QL (5400 mL every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 10 mg/5ml	1	PA, QL (2700 mL every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 10 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl tab er 24hr 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 72 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 10 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 15 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 20 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 30 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
modafinil tab 100 mg	1	PA, MO
modafinil tab 200 mg	1	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES		
ALLERGENIC EXTRACTS		
GRASTEK SUB 2800BAU ***(timothy grass pollen allergen extract)***	2	PA, MO
ORALAIR SUB 300 IR ***(grass mixed pollens allergen extract)***	4	SP, PA
RAGWITEK SUB ***(short ragweed pollen allergen extract)***	2	PA, MO
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
neomycin sulfate tab 500 mg	1	
tobramycin nebu soln 300 mg/4ml	4	SP, PA, QL (8 mL every 1 day)
tobramycin nebu soln 300 mg/5ml	4	SP, PA, QL (10 mL every 1 day)
ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMU-ADAZ INJ 20/0.2ML	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
ADALIMU-ADAZ INJ 40/0.4ML	4	SP, PA, QL (4 pens every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
ADALIMU-ADAZ INJ 80/0.8ML	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
ADALIMU-FKJP KIT 20/0.4ML	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ADALIMU-FKJP KIT 40/0.8ML	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 10/0.1ML ***(adalimumab-adaz)***	4	SP, PA, QL (2 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 20/0.2ML ***(adalimumab-adaz)***	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 40/0.4ML ***(adalimumab-adaz)***	4	SP, PA, QL (4 pens every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 40/0.4ML ***(adalimumab-adaz)***	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 40/0.8ML ***(adalimumab-adaz)***	4	SP, PA, QL (4 pens every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HYRIMOZ INJ 40/0.8ML ***(adalimumab-adaz)***	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ INJ 80/0.8ML ***(adalimumab-adaz)***	4	SP, PA, QL (2 pens every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ SENS INJ 80/0.8ML ***(adalimumab-adaz)***	4	SP, PA, QL (2 pens every 28 days); Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ-CROH INJ UC SP ***(adalimumab-adaz)***	4	SP, PA, QL (3 pens every 28 days); Loading Dose; Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ-PED INJ CROHNS ***(adalimumab-adaz)***	4	SP, PA, QL (2 syringes every 28 days); Loading Dose; Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
HYRIMOZ-PED INJ CROHNS ***(adalimumab-adaz)***	4	SP, PA, QL (3 syringes every 28 days); Loading Dose; Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HYRIMOZ-PLAQ INJ PSOR/UVE ***(adalimumab-adaz)***	4	SP, PA, QL (3 pens every 28 days); Loading Dose; Preferred for Ankylosing Spondylitis, Crohn's Disease, Hidradenitis Suppurativa, Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
ANTIRHEUMATIC - ENZYME INHIBITORS		
RINVOQ LQ SOL 1MG/ML ***(upadacitinib)***	4	SP, PA, QL (12 mL every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 15MG ER ***(upadacitinib)***	4	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 30MG ER ***(upadacitinib)***	4	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 45MG ER ***(upadacitinib)***	4	SP, PA, QL (56 tabs every 56 days); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ SOL 1MG/ML ***(tofacitinib citrate)***	4	SP, PA, QL (10 mL every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ TAB 5MG ***(tofacitinib citrate)***	4	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XELJANZ TAB 10MG ***(tofacitinib citrate)***	4	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ XR TAB 11MG ***(tofacitinib citrate)***	4	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ XR TAB 22MG ***(tofacitinib citrate)***	4	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
ANTIRHEUMATIC ANTIMETABOLITES		
RASUVO INJ 7.5MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 10MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 12.5MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 15MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 17.5MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 20MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 22.5MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 25MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
RASUVO INJ 30MG ***(methotrexate (antirheumatic))***	4	SP, PA, QL (4 pens every 28 days)
INTERLEUKIN-6 RECEPTOR INHIBITORS		
KEVZARA INJ 150/1.14 ***(sarilumab)***	4	SP, PA, QL (2 syringes every 4 weeks); Preferred for Rheumatoid Arthritis
KEVZARA INJ 200/1.14 ***(sarilumab)***	4	SP, PA, QL (2 syringes every 4 weeks); Preferred for Rheumatoid Arthritis
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap 50 mg	1	MO
celecoxib cap 100 mg	1	MO
celecoxib cap 200 mg	1	MO
celecoxib cap 400 mg	1	MO
diclofenac potassium tab 50 mg	1	MO
diclofenac sodium tab delayed release 25 mg	1	MO
diclofenac sodium tab delayed release 50 mg	1	MO
diclofenac sodium tab delayed release 75 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diclofenac sodium tab er 24hr 100 mg	1	MO
diclofenac w/ misoprostol tab delayed release 50-0.2 mg	1	MO
diclofenac w/ misoprostol tab delayed release 75-0.2 mg	1	MO
etodolac cap 200 mg	1	MO
etodolac cap 300 mg	1	MO
etodolac tab 400 mg	1	MO
etodolac tab 500 mg	1	MO
etodolac tab er 24hr 400 mg	1	MO
etodolac tab er 24hr 500 mg	1	MO
etodolac tab er 24hr 600 mg	1	MO
flurbiprofen tab 50 mg	1	MO
flurbiprofen tab 100 mg	1	MO
ibuprofen tab 400 mg	1	MO
(Ibuprofen Tab 400 mg) IBU	1	MO
ibuprofen tab 600 mg	1	MO
(Ibuprofen Tab 600 mg) IBU	1	MO
ibuprofen tab 800 mg	1	MO
(Ibuprofen Tab 800 mg) IBU	1	MO
ibuprofen-famotidine tab 800-26.6 mg	1	PA, MO
indomethacin cap 25 mg	1	MO
indomethacin cap 50 mg	1	MO
indomethacin cap er 75 mg	1	MO
indomethacin suppos 50 mg	1	MO
indomethacin susp 25 mg/5ml	1	MO
ketorolac tromethamine tab 10 mg	1	
meclofenamate sodium cap 50 mg	1	MO
meclofenamate sodium cap 100 mg	1	MO
mefenamic acid cap 250 mg	1	MO
meloxicam susp 7.5 mg/5ml	1	MO
meloxicam tab 7.5 mg	1	MO
meloxicam tab 15 mg	1	MO
nabumetone tab 500 mg	1	MO
nabumetone tab 750 mg	1	MO
naproxen sodium tab 275 mg	1	MO
naproxen sodium tab 550 mg	1	MO
naproxen tab 250 mg	1	MO
naproxen tab 375 mg	1	MO
naproxen tab 500 mg	1	MO
naproxen tab ec 375 mg	1	MO
(Naproxen Tab Ec 375 mg) EC-NAPROXEN	1	MO
naproxen tab ec 500 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Naproxen Tab Ec 500 mg) EC-NAPROXEN	1	MO
oxaprozin cap 300 mg	1	MO
oxaprozin tab 600 mg	1	MO
piroxicam cap 10 mg	1	MO
piroxicam cap 20 mg	1	MO
sulindac tab 150 mg	1	MO
sulindac tab 200 mg	1	MO
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20 ***(apremilast)***	4	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 10/20/30 ***(apremilast)***	4	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 20MG ***(apremilast)***	4	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 30MG ***(apremilast)***	4	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab 10 mg	1	MO
leflunomide tab 20 mg	1	MO
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25/0.5ML ***(etanercept)***	4	SP, PA, QL (8 syringes every 28 days); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis
ENBREL INJ 25MG ***(etanercept)***	4	SP, PA, QL (8 vials every 28 days); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis
ENBREL INJ 50MG/ML ***(etanercept)***	4	SP, PA, QL (4 syringes every 28 days); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis
ENBREL MINI INJ 50MG/ML ***(etanercept)***	4	SP, PA, QL (4 cartridges every 28 days); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis
ENBREL SRCLK INJ 50MG/ML ***(etanercept)***	4	SP, PA, QL (4 pens every 28 days); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER		
ANALGESIC COMBINATIONS		
butalbital-acetaminophen tab 50-325 mg	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs every 25 days)
butalbital-acetaminophen-caffeine tab 50-325-40 mg	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg) BAC	1	QL (48 tabs every 25 days)
butalbital-aspirin-caffeine cap 50-325-40 mg	1	QL (48 caps every 25 days)
SALICYLATES		
(Aspirin Chew Tab 81 mg) ASPIRIN CHILDRENS	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
aspirin tab delayed release 81 mg	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tab 500 mg	1	MO
salsalate tab 750 mg	1	MO
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN		
OPIOID AGONISTS		
codeine sulfate tab 30 mg	1	PA, QL (42 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
fentanyl td patch 72hr 12 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 25 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 37.5 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 50 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 62.5 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 75 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 87.5 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 100 mcg/hr	1	PA; High Strength Requires PA
hydrocodone bitartrate cap er 12hr 10 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 15 mg	1	ST, QL (60 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone bitartrate cap er 12hr 20 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 30 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 40 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 50 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 20 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 30 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 40 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 60 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 80 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 100 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 120 mg	1	PA; High Strength Requires PA
hydromorphone hcl liqd 1 mg/ml	1	PA, QL (600 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 2 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 4 mg	1	PA, QL (150 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 8 mg	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab er 24hr 8 mg	1	ST, QL (120 tabs every 25 days); PA**
hydromorphone hcl tab er 24hr 12 mg	1	ST, QL (120 tabs every 25 days); PA**
hydromorphone hcl tab er 24hr 16 mg	1	ST, QL (120 tabs every 25 days); PA**
hydromorphone hcl tab er 24hr 32 mg	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
meperidine hcl oral soln 50 mg/5ml	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
meperidine hcl tab 50 mg	1	PA, QL (18 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
methadone hcl conc 10 mg/ml	1	QL (30 mL every 25 days); Indicated for opioid addiction
(Methadone Hcl Conc 10 mg/ml) METHADONE HYDROCHLORIDE I	1	PA, QL (30 mL every 25 days); Indicated for opioid addiction
methadone hcl soln 5 mg/5ml	1	ST, QL (450 ml every 25 days); PA**
methadone hcl soln 10 mg/5ml	1	ST, QL (300 mL every 25 days); PA**
methadone hcl tab 5 mg	1	ST, QL (90 tabs every 25 days); PA**
methadone hcl tab 10 mg	1	ST, QL (60 tabs every 25 days); PA**
methadone hcl tab for oral susp 40 mg	1	QL (9 tabs every 25 days); Indicated for opioid addiction
(Methadone Hcl Tab For Oral Susp 40 mg) METHADOSE	1	QL (9 tabs every 25 days); Indicated for opioid addiction
morphine sulfate beads cap er 24hr 30 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 45 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 60 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 75 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 90 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 120 mg	1	PA; High Strength Requires PA
morphine sulfate cap er 24hr 10 mg	1	ST, QL (60 caps every 25 days); PA**
morphine sulfate cap er 24hr 20 mg	1	ST, QL (60 caps every 25 days); PA**
morphine sulfate cap er 24hr 30 mg	1	ST, QL (60 caps every 25 days); PA**
morphine sulfate cap er 24hr 50 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate cap er 24hr 60 mg	1	ST, QL (30 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
morphine sulfate cap er 24hr 80 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate cap er 24hr 100 mg	1	PA; High Strength Requires PA
morphine sulfate oral soln 10 mg/5ml	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate oral soln 20 mg/5ml	1	PA, QL (675 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	1	PA, QL (135 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate tab 15 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate tab 30 mg	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate tab er 15 mg	1	ST, QL (90 tabs every 25 days); PA**
morphine sulfate tab er 30 mg	1	ST, QL (90 tabs every 25 days); PA**
morphine sulfate tab er 60 mg	1	PA; High Strength Requires PA
morphine sulfate tab er 100 mg	1	PA; High Strength Requires PA
morphine sulfate tab er 200 mg	1	PA; High Strength Requires PA
oxycodone hcl cap 5 mg	1	PA, QL (180 caps every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl conc 100 mg/5ml (20 mg/ml)	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl soln 5 mg/5ml	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 5 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone hcl tab 10 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 15 mg	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 20 mg	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 30 mg	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tab 5 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tab 10 mg	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
tramadol hcl oral soln 5 mg/ml	1	PA, QL (1800 mL every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
tramadol hcl tab 50 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
tramadol hcl tab er 24hr 100 mg	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12
tramadol hcl tab er 24hr 200 mg	1	PA; High Strength Requires PA; Not available under age 12
tramadol hcl tab er 24hr 300 mg	1	PA; High Strength Requires PA; Not available under age 12
tramadol hcl tab er 24hr biphasic release 100 mg	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12
tramadol hcl tab er 24hr biphasic release 200 mg	1	PA; High Strength Requires PA; Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tramadol hcl tab er 24hr biphasic release 300 mg	1	PA; High Strength Requires PA; Not available under age 12
OPIOID COMBINATIONS		
acetaminophen w/ codeine soln 120-12 mg/5ml	1	ST, QL (2700 mL every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
acetaminophen w/ codeine tab 300-15 mg	1	ST, QL (400 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
acetaminophen w/ codeine tab 300-30 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
acetaminophen w/ codeine tab 300-60 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
(Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg) TREZIX	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg	1	QL (48 caps every 25 days); Not available under age 12
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg	1	QL (48 caps every 25 days); Not available under age 12
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg	1	QL (48 caps every 25 days); Not available under age 12
(Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg) ASCOMP/CODEINE	1	QL (48 caps every 25 days); Not available under age 12
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-acetaminophen soln 10-325 mg/15ml	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 2.5-325 mg	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 5-300 mg	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 5-325 mg	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 7.5-300 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 7.5-325 mg	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 10-300 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 10-325 mg	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 7.5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 10-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone w/ acetaminophen tab 2.5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 2.5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 7.5-325 mg	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 7.5-325 mg) ENDOCET	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 10-325 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 10-325 mg) ENDOCET	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
tramadol-acetaminophen tab 37.5-325 mg	1	ST, QL (40 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG ***(buprenorphine hcl)***	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 150MCG ***(buprenorphine hcl)***	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 300MCG ***(buprenorphine hcl)***	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 450MCG ***(buprenorphine hcl)***	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 600MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
BELBUCA MIS 750MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
BELBUCA MIS 900MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
buprenorphine hcl sl tab 2 mg (base equiv)	1	
buprenorphine hcl sl tab 8 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	
buprenorphine td patch weekly 5 mcg/hr	1	ST, QL (4 patches every month); PA**
buprenorphine td patch weekly 7.5 mcg/hr	1	ST, QL (4 patches every month); PA**
buprenorphine td patch weekly 10 mcg/hr	1	ST, QL (4 patches every month); PA**
buprenorphine td patch weekly 15 mcg/hr	1	PA; High Strength Requires PA
buprenorphine td patch weekly 20 mcg/hr	1	PA; High Strength Requires PA
butorphanol tartrate nasal soln 10 mg/ml	1	
pentazocine w/ naloxone hcl tab 50-0.5 mg	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
ZUBSOLV SUB 0.7-0.18 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES		
ANDROGENS		
danazol cap 50 mg	1	
danazol cap 100 mg	1	
danazol cap 200 mg	1	
methyltestosterone cap 10 mg	1	PA, MO
(Methyltestosterone Oral Tab 10 mg) METHITEST	1	PA, MO
NATESTO GEL 5.5MG ***(testosterone)***	2	PA, MO
testosterone td gel 10mg/act (2%)	1	PA, MO
testosterone td gel 12.5 mg/act (1%)	1	PA, MO
testosterone td gel 20.25 mg/1.25gm (1.62%)	1	PA, MO
testosterone td gel 20.25 mg/act (1.62%)	1	PA, MO
testosterone td gel 25 mg/2.5gm (1%)	1	PA, MO
testosterone td gel 40.5 mg/2.5gm (1.62%)	1	PA, MO
testosterone td gel 50 mg/5gm (1%)	1	PA, MO
testosterone td soln 30 mg/act	1	PA, MO
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS		
INTRARECTAL STEROIDS		
budesonide rectal foam 2 mg/act	1	
CORTIFOAM AER 90MG ***(hydrocortisone acetate (intrarectal))***	2	
hydrocortisone enema 100 mg/60ml	1	
RECTAL COMBINATIONS		
hydrocortisone acetate w/ pramoxine perianal cream 1-1%	1	
PROCTOFOAM AER HC 1% ***(hydrocortisone acetate w/ pramoxine)***	2	
RECTAL STEROIDS		
(Hydrocortisone Acetate Suppos 25 mg) ANUCORT-HC	1	
hydrocortisone perianal cream 2.5%	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTO-MED HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOSOL HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOZONE-HC	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VASODILATING AGENTS		
nitroglycerin oint 0.4%	1	
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
albendazole tab 200 mg	1	
EMVERM CHW 100MG ***(mebendazole)***	2	
ivermectin tab 3 mg	1	
praziquantel tab 600 mg	1	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
IMPAVIDO CAP 50MG ***(miltefosine)***	3	
metronidazole cap 375 mg	1	
metronidazole tab 250 mg	1	
metronidazole tab 500 mg	1	
pentamidine isethionate for nebulization soln 300 mg	1	
tinidazole tab 250 mg	1	
tinidazole tab 500 mg	1	
trimethoprim tab 100 mg	1	
XIFAXAN TAB 550MG ***(rifaximin)***	2	MO
ANTI-INFECTIVE MISC. - COMBINATIONS		
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
(Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml) SULFATRIM PEDIATRIC	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
ANTIPROTOZOAL AGENTS		
atovaquone susp 750 mg/5ml	1	
nitazoxanide tab 500 mg	1	
GLYCOPEPTIDES		
vancomycin hcl cap 125 mg (base equivalent)	1	
vancomycin hcl cap 250 mg (base equivalent)	1	
vancomycin hcl for oral soln 25 mg/ml (base equivalent)	1	
vancomycin hcl for oral soln 50 mg/ml (base equivalent)	1	
LEPROSTATICS		
dapsone tab 25 mg	1	MO
dapsone tab 100 mg	1	MO
LINCOSAMIDES		
clindamycin hcl cap 75 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clindamycin hcl cap 150 mg	1	
clindamycin hcl cap 300 mg	1	
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	1	
MONOBACTAMS		
CAYSTON INH 75MG ***(aztreonam lysine)***	4	SP, PA
OXAZOLIDINONES		
linezolid for susp 100 mg/5ml	1	
linezolid tab 600 mg	1	
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS		
fosfomycin tromethamine powd pack 3 gm (base equivalent)	1	
methenamine hippurate tab 1 gm	1	
methenamine mandelate tab 0.5 gm	1	
nitrofurantoin macrocrystalline cap 25 mg	1	
nitrofurantoin macrocrystalline cap 50 mg	1	
nitrofurantoin macrocrystalline cap 100 mg	1	
nitrofurantoin monohydrate macrocrystalline cap 100 mg	1	
nitrofurantoin susp 25 mg/5ml	1	
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS		
ANTIANGINALS-OTHER		
ranolazine tab er 12hr 500 mg	1	MO
ranolazine tab er 12hr 1000 mg	1	MO
NITRATES		
isosorbide dinitrate tab 5 mg	1	MO
isosorbide dinitrate tab 10 mg	1	MO
isosorbide dinitrate tab 20 mg	1	MO
isosorbide dinitrate tab 30 mg	1	MO
isosorbide mononitrate tab er 24hr 30 mg	1	MO
isosorbide mononitrate tab er 24hr 60 mg	1	MO
isosorbide mononitrate tab er 24hr 120 mg	1	MO
nitroglycerin sl tab 0.3 mg	1	MO
nitroglycerin sl tab 0.4 mg	1	MO
nitroglycerin sl tab 0.6 mg	1	MO
nitroglycerin td patch 24hr 0.1 mg/hr	1	MO
nitroglycerin td patch 24hr 0.2 mg/hr	1	MO
nitroglycerin td patch 24hr 0.4 mg/hr	1	MO
nitroglycerin td patch 24hr 0.6 mg/hr	1	MO
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY		
ANTIANXIETY AGENTS - MISC.		
buspirone hcl tab 5 mg	1	
buspirone hcl tab 7.5 mg	1	
buspirone hcl tab 10 mg	1	
buspirone hcl tab 15 mg	1	
buspirone hcl tab 30 mg	1	
hydroxyzine hcl syrup 10 mg/5ml	1	
hydroxyzine hcl tab 10 mg	1	
hydroxyzine hcl tab 25 mg	1	
hydroxyzine hcl tab 50 mg	1	
hydroxyzine pamoate cap 25 mg	1	
hydroxyzine pamoate cap 50 mg	1	
hydroxyzine pamoate cap 100 mg	1	
meprobamate tab 200 mg	1	
meprobamate tab 400 mg	1	
BENZODIAZEPINES		
alprazolam orally disintegrating tab 0.5 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 0.25 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 1 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 2 mg	1	QL (150 tabs every 25 days)
alprazolam tab 0.5 mg	1	QL (150 tabs every 25 days)
alprazolam tab 0.25 mg	1	QL (150 tabs every 25 days)
alprazolam tab 1 mg	1	QL (150 tabs every 25 days)
alprazolam tab 2 mg	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 0.5 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 0.5 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 1 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 1 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 2 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 2 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 3 mg	1	QL (90 tabs every 25 days)
(Alprazolam Tab Er 24hr 3 mg) ALPRAZOLAM XR	1	QL (90 tabs every 25 days)
chlordiazepoxide hcl cap 5 mg	1	QL (360 caps every 25 days)
chlordiazepoxide hcl cap 10 mg	1	QL (360 caps every 25 days)
chlordiazepoxide hcl cap 25 mg	1	QL (360 caps every 25 days)
clorazepate dipotassium tab 3.75 mg	1	QL (180 tabs every 25 days)
clorazepate dipotassium tab 7.5 mg	1	QL (180 tabs every 25 days)
clorazepate dipotassium tab 15 mg	1	QL (180 tabs every 25 days)
diazepam conc 5 mg/ml	1	QL (240 mL every 25 days)
(Diazepam Conc 5 mg/ml) DIAZEPAM INTENSOL	1	QL (240 mL every 25 days)
diazepam oral soln 1 mg/ml	1	QL (1200 mL every 25 days)
diazepam tab 2 mg	1	QL (120 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diazepam tab 5 mg	1	QL (120 tabs every 25 days)
diazepam tab 10 mg	1	QL (120 tabs every 25 days)
lorazepam conc 2 mg/ml	1	QL (150 mL every 25 days)
lorazepam tab 0.5 mg	1	QL (150 tabs every 25 days)
lorazepam tab 1 mg	1	QL (150 tabs every 25 days)
lorazepam tab 2 mg	1	QL (150 tabs every 25 days)
oxazepam cap 10 mg	1	QL (120 caps every 25 days)
oxazepam cap 15 mg	1	QL (120 caps every 25 days)
oxazepam cap 30 mg	1	QL (120 caps every 25 days)
ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide phosphate cap 100 mg	1	MO
disopyramide phosphate cap 150 mg	1	MO
quinidine gluconate tab er 324 mg	1	MO
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap 150 mg	1	MO
mexiletine hcl cap 200 mg	1	MO
mexiletine hcl cap 250 mg	1	MO
ANTIARRHYTHMICS TYPE I-C		
flecainide acetate tab 50 mg	1	MO
flecainide acetate tab 100 mg	1	MO
flecainide acetate tab 150 mg	1	MO
propafenone hcl cap er 12hr 225 mg	1	MO
propafenone hcl cap er 12hr 325 mg	1	MO
propafenone hcl cap er 12hr 425 mg	1	MO
propafenone hcl tab 150 mg	1	MO
propafenone hcl tab 225 mg	1	MO
propafenone hcl tab 300 mg	1	MO
ANTIARRHYTHMICS TYPE III		
amiodarone hcl tab 100 mg	1	MO
(Amiodarone Hcl Tab 100 mg) PACERONE	1	MO
amiodarone hcl tab 200 mg	1	MO
(Amiodarone Hcl Tab 200 mg) PACERONE	1	MO
amiodarone hcl tab 400 mg	1	MO
(Amiodarone Hcl Tab 400 mg) PACERONE	1	MO
dofetilide cap 125 mcg (0.125 mg)	4	SP, PA
dofetilide cap 250 mcg (0.25 mg)	4	SP, PA
dofetilide cap 500 mcg (0.5 mg)	4	SP, PA
MULTAQ TAB 400MG ***(dronedarone hcl)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
ANTI-INFLAMMATORY AGENTS		
cromolyn sodium soln nebu 20 mg/2ml	1	QL (720 mL every 75 days), MO
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
FASENRA INJ 10MG/0.5 ***(benralizumab)***	4	SP, PA, QL (1 syringe every 56 days)
FASENRA INJ 30MG/ML ***(benralizumab)***	4	SP, PA, QL (1 syringe every 28 days)
FASENRA PEN INJ 30MG/ML ***(benralizumab)***	4	SP, PA, QL (1 pen every 28 days)
NUCALA INJ 40MG/0.4 ***(mepolizumab)***	4	SP, PA, QL (1 syringe every 28 days)
NUCALA INJ 100MG/ML ***(mepolizumab)***	4	SP, PA, QL (3 syringes every 28 days)
XOLAIR INJ 75/0.5 ***(omalizumab)***	4	SP, PA, QL (2 syringes every 28 days)
XOLAIR INJ 150MG/ML ***(omalizumab)***	4	SP, PA, QL (8 syringes every 28 days)
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium bromide inhal soln 0.02%	1	QL (938 mL every 75 days), MO
SPIRIVA AER 1.25MCG ***(tiotropium bromide monohydrate)***	2	QL (3 inhalers every 75 days), MO
SPIRIVA CAP HANDIHLR ***(tiotropium bromide monohydrate)***	2	QL (90 caps every 75 days), MO
SPIRIVA SPR 2.5MCG ***(tiotropium bromide monohydrate)***	2	QL (3 inhalers every 75 days), MO
YUPELRI SOL ***(revefenacin)***	2	QL (270 mL every 75 days), MO
LEUKOTRIENE MODULATORS		
montelukast sodium chew tab 4 mg (base equiv)	1	MO
montelukast sodium chew tab 5 mg (base equiv)	1	MO
montelukast sodium oral granules packet 4 mg (base equiv)	1	MO
montelukast sodium tab 10 mg (base equiv)	1	MO
zafirlukast tab 10 mg	1	MO
zafirlukast tab 20 mg	1	MO
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
roflumilast tab 250 mcg	1	MO
roflumilast tab 500 mcg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STEROID INHALANTS		
ASMANEX HFA AER 50MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 100 MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 200 MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
budesonide inhalation susp 0.5 mg/2ml	1	QL (360 mL every 75 days), MO
budesonide inhalation susp 0.25 mg/2ml	1	QL (540 mL every 75 days), MO
budesonide inhalation susp 1 mg/2ml	1	QL (180 mL every 75 days), MO
fluticasone propionate hfa inhal aer 110 mcg/act	3	QL (6 inhalers every 75 days), MO
fluticasone propionate hfa inhal aer 220 mcg/act	3	QL (6 inhalers every 75 days), MO
fluticasone propionate hfa inhal aero 44 mcg/act	3	QL (6 inhalers every 75 days), MO
PULMICORT INH 90MCG ***(budesonide (inhalation))***	2	QL (9 inhalers every 75 days), MO
PULMICORT INH 180MCG ***(budesonide (inhalation))***	2	QL (6 inhalers every 75 days), MO
SYMPATHOMIMETICS		
AIRSUPRA AER 90-80MCG ***(albuterol-budesonide)***	2	QL (9 inhalers every 75 days)
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	1	QL (6 inhalers every 75 days), MO
albuterol sulfate soln nebu 0.5% (5 mg/ml)	1	QL (180 mL every 75 days), MO
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)	1	QL (1125 mL every 75 days), MO
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)	1	QL (1125 mL every 75 days), MO
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)	1	QL (1125 mL every 75 days), MO
albuterol sulfate syrup 2 mg/5ml	1	MO
albuterol sulfate tab 2 mg	1	MO
albuterol sulfate tab 4 mg	1	MO
ANORO ELLIPT AER 62.5-25 ***(umeclidinium-vilanterol)***	2	QL (180 blisters every 75 days), MO
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	1	QL (360 mL every 75 days), MO
BREO ELLIPTA INH 50-25MCG ***(fluticasone furoate-vilanterol)***	2	QL (3 inhalers every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)***	2	QL (180 blisters every 75 days), MO
BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)***	2	QL (180 blisters every 75 days), MO
BREZTRI AERO AER SPHERE ***(budesonide-glycopyrrolate-formoterol fumarate)***	2	QL (3 inhalers every 75 days), MO
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act	1	QL (9 inhalers every 75 days), MO
(Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act	1	QL (9 inhalers every 75 days), MO
(Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
fluticasone-salmeterol aer powder ba 100-50 mcg/act	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
fluticasone-salmeterol aer powder ba 250-50 mcg/act	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
fluticasone-salmeterol aer powder ba 500-50 mcg/act	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
formoterol fumarate soln nebu 20 mcg/2ml	1	QL (360 mL every 75 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	QL (1620 mL every 75 days), MO
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)	1	QL (270 mL every 75 days), MO
levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)	1	QL (6 inhalers every 75 days), MO
SEREVENT DIS AER 50MCG ***(salmeterol xinafoate)***	2	QL (180 inhalations every 75 days), MO
STIOLTO AER 2.5-2.5 ***(tiotropium bromide-olodaterol hcl)***	2	QL (3 inhalers every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STRIVERDI AER 2.5MCG ***(olodaterol hcl)***	2	QL (3 inhalers every 75 days), MO
terbutaline sulfate tab 2.5 mg	1	MO
terbutaline sulfate tab 5 mg	1	MO
TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 inhalers every 75 days), MO
TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 inhalers every 75 days), MO
XANTHINES		
theophylline elixir 80 mg/15ml	1	MO
(Theophylline Elixir 80 mg/15ml) ELIXOPHYLLIN	1	MO
theophylline soln 80 mg/15ml	1	MO
theophylline tab er 12hr 300 mg	1	MO
theophylline tab er 12hr 450 mg	1	MO
theophylline tab er 24hr 400 mg	1	MO
theophylline tab er 24hr 600 mg	1	MO
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS		
COUMARIN ANTICOAGULANTS		
warfarin sodium tab 1 mg	1	MO
(Warfarin Sodium Tab 1 mg) JANTOVEN	1	MO
warfarin sodium tab 2 mg	1	MO
(Warfarin Sodium Tab 2 mg) JANTOVEN	1	MO
warfarin sodium tab 2.5 mg	1	MO
(Warfarin Sodium Tab 2.5 mg) JANTOVEN	1	MO
warfarin sodium tab 3 mg	1	MO
(Warfarin Sodium Tab 3 mg) JANTOVEN	1	MO
warfarin sodium tab 4 mg	1	MO
(Warfarin Sodium Tab 4 mg) JANTOVEN	1	MO
warfarin sodium tab 5 mg	1	MO
(Warfarin Sodium Tab 5 mg) JANTOVEN	1	MO
warfarin sodium tab 6 mg	1	MO
(Warfarin Sodium Tab 6 mg) JANTOVEN	1	MO
warfarin sodium tab 7.5 mg	1	MO
(Warfarin Sodium Tab 7.5 mg) JANTOVEN	1	MO
warfarin sodium tab 10 mg	1	MO
(Warfarin Sodium Tab 10 mg) JANTOVEN	1	MO
DIRECT FACTOR XA INHIBITORS		
ELIQUIS ST P TAB 5MG ***(apixaban)***	2	
ELIQUIS TAB 2.5MG ***(apixaban)***	2	MO
ELIQUIS TAB 5MG ***(apixaban)***	2	MO
XARELTO STAR TAB 15/20MG ***(rivaroxaban)***	2	
XARELTO SUS 1MG/ML ***(rivaroxaban)***	2	MO
XARELTO TAB 2.5MG ***(rivaroxaban)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XARELTO TAB 10MG ***(rivaroxaban)***	2	MO
XARELTO TAB 15MG ***(rivaroxaban)***	2	MO
XARELTO TAB 20MG ***(rivaroxaban)***	2	MO
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin sodium inj soln pref syr 30 mg/0.3ml	1	
enoxaparin sodium inj soln pref syr 40 mg/0.4ml	1	
enoxaparin sodium inj soln pref syr 60 mg/0.6ml	1	
enoxaparin sodium inj soln pref syr 80 mg/0.8ml	1	
enoxaparin sodium inj soln pref syr 100 mg/ml	1	
enoxaparin sodium inj soln pref syr 120 mg/0.8ml	1	
enoxaparin sodium inj soln pref syr 150 mg/ml	1	
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap 75 mg (etexilate base eq)	1	MO
dabigatran etexilate mesylate cap 110 mg (etexilate base eq)	1	MO
dabigatran etexilate mesylate cap 150 mg (etexilate base eq)	1	MO
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA SUS 0.5MG/ML ***(perampanel)***	2	MO
FYCOMPA TAB 2MG ***(perampanel)***	2	MO
FYCOMPA TAB 4MG ***(perampanel)***	2	MO
FYCOMPA TAB 6MG ***(perampanel)***	2	MO
FYCOMPA TAB 8MG ***(perampanel)***	2	MO
FYCOMPA TAB 10MG ***(perampanel)***	2	MO
FYCOMPA TAB 12MG ***(perampanel)***	2	MO
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam suspension 2.5 mg/ml	1	MO
clobazam tab 10 mg	1	MO
clobazam tab 20 mg	1	MO
clonazepam orally disintegrating tab 0.5 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 0.25 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 0.125 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 1 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 2 mg	1	QL (300 tabs every 25 days)
clonazepam tab 0.5 mg	1	QL (300 tabs every 25 days)
clonazepam tab 1 mg	1	QL (300 tabs every 25 days)
clonazepam tab 2 mg	1	QL (300 tabs every 25 days)
diazepam rectal gel delivery system 2.5 mg	1	
diazepam rectal gel delivery system 10 mg	1	
diazepam rectal gel delivery system 20 mg	1	
NAYZILAM SPR 5MG ***(midazolam (anticonvulsant))***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VALTOCO SPR 5MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 10MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 15MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 20MG ***(diazepam (anticonvulsant))***	2	
ANTICONVULSANTS - MISC.		
APTIOM TAB 200MG ***(eslicarbazepine acetate)***	2	MO
APTIOM TAB 400MG ***(eslicarbazepine acetate)***	2	MO
APTIOM TAB 600MG ***(eslicarbazepine acetate)***	2	MO
APTIOM TAB 800MG ***(eslicarbazepine acetate)***	2	MO
BRIVIACT SOL 10MG/ML ***(brivaracetam)***	2	MO
BRIVIACT TAB 10MG ***(brivaracetam)***	2	MO
BRIVIACT TAB 25MG ***(brivaracetam)***	2	MO
BRIVIACT TAB 50MG ***(brivaracetam)***	2	MO
BRIVIACT TAB 75MG ***(brivaracetam)***	2	MO
BRIVIACT TAB 100MG ***(brivaracetam)***	2	MO
carbamazepine cap er 12hr 100 mg	1	MO
carbamazepine cap er 12hr 200 mg	1	MO
carbamazepine cap er 12hr 300 mg	1	MO
carbamazepine chew tab 100 mg	1	MO
carbamazepine chew tab 200 mg	1	MO
carbamazepine susp 100 mg/5ml	1	MO
carbamazepine tab 200 mg	1	MO
(Carbamazepine Tab 200 mg) EPITOL	1	MO
carbamazepine tab er 12hr 100 mg	1	MO
carbamazepine tab er 12hr 200 mg	1	MO
carbamazepine tab er 12hr 400 mg	1	MO
gabapentin cap 100 mg	1	MO
gabapentin cap 300 mg	1	MO
gabapentin cap 400 mg	1	MO
gabapentin oral soln 250 mg/5ml	1	MO
gabapentin tab 600 mg	1	MO
gabapentin tab 800 mg	1	MO
lacosamide oral solution 10 mg/ml	1	MO
lacosamide tab 50 mg	1	MO
lacosamide tab 100 mg	1	MO
lacosamide tab 150 mg	1	MO
lacosamide tab 200 mg	1	MO
lamotrigine orally disintegrating tab 25 mg	1	MO
lamotrigine orally disintegrating tab 50 mg	1	MO
lamotrigine orally disintegrating tab 100 mg	1	MO
lamotrigine orally disintegrating tab 200 mg	1	MO
lamotrigine tab 25 mg	1	MO
(Lamotrigine Tab 25 mg) SUBVENITE	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	1	
(Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit) SUBVENITE STARTER KIT/ORA	1	
lamotrigine tab 35 x 25 mg starter kit	1	
(Lamotrigine Tab 35 X 25 mg Starter Kit) SUBVENITE STARTER KIT/BLU	1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	1	
(Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit) SUBVENITE STARTER KIT/GRE	1	
lamotrigine tab 100 mg	1	MO
(Lamotrigine Tab 100 mg) SUBVENITE	1	MO
lamotrigine tab 150 mg	1	MO
(Lamotrigine Tab 150 mg) SUBVENITE	1	MO
lamotrigine tab 200 mg	1	MO
(Lamotrigine Tab 200 mg) SUBVENITE	1	MO
lamotrigine tab chewable dispersible 5 mg	1	MO
lamotrigine tab chewable dispersible 25 mg	1	MO
lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit	1	
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit	1	
lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit	1	
lamotrigine tab er 24hr 25 mg	1	MO
lamotrigine tab er 24hr 50 mg	1	MO
lamotrigine tab er 24hr 100 mg	1	MO
lamotrigine tab er 24hr 200 mg	1	MO
lamotrigine tab er 24hr 250 mg	1	MO
lamotrigine tab er 24hr 300 mg	1	MO
levetiracetam oral soln 100 mg/ml	1	MO
levetiracetam tab 250 mg	1	MO
levetiracetam tab 500 mg	1	MO
(Levetiracetam Tab 500 mg) ROWEEPRA	1	MO
levetiracetam tab 750 mg	1	MO
levetiracetam tab 1000 mg	1	MO
levetiracetam tab er 24hr 500 mg	1	MO
levetiracetam tab er 24hr 750 mg	1	MO
oxcarbazepine susp 300 mg/5ml (60 mg/ml)	1	MO
oxcarbazepine tab 150 mg	1	MO
oxcarbazepine tab 300 mg	1	MO
oxcarbazepine tab 600 mg	1	MO
oxcarbazepine tab er 24hr 150 mg	1	MO
oxcarbazepine tab er 24hr 300 mg	1	MO
oxcarbazepine tab er 24hr 600 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OXTELLAR XR TAB 150MG ***(oxcarbazepine)***	2	MO
OXTELLAR XR TAB 300MG ***(oxcarbazepine)***	2	MO
OXTELLAR XR TAB 600MG ***(oxcarbazepine)***	2	MO
pregabalin cap 25 mg	1	MO
pregabalin cap 50 mg	1	MO
pregabalin cap 75 mg	1	MO
pregabalin cap 100 mg	1	MO
pregabalin cap 150 mg	1	MO
pregabalin cap 200 mg	1	MO
pregabalin cap 225 mg	1	MO
pregabalin cap 300 mg	1	MO
pregabalin soln 20 mg/ml	1	MO
primidone tab 50 mg	1	MO
primidone tab 250 mg	1	MO
rufinamide susp 40 mg/ml	1	MO
rufinamide tab 200 mg	1	MO
rufinamide tab 400 mg	1	MO
topiramate cap er 24hr 25 mg	1	MO
topiramate cap er 24hr 50 mg	1	MO
topiramate cap er 24hr 100 mg	1	MO
topiramate cap er 24hr 200 mg	1	MO
topiramate sprinkle cap 15 mg	1	MO
topiramate sprinkle cap 25 mg	1	MO
topiramate sprinkle cap 50 mg	1	MO
topiramate tab 25 mg	1	MO
topiramate tab 50 mg	1	MO
topiramate tab 100 mg	1	MO
topiramate tab 200 mg	1	MO
zonisamide cap 25 mg	1	MO
zonisamide cap 50 mg	1	MO
zonisamide cap 100 mg	1	MO
CARBAMATES		
felbamate susp 600 mg/5ml	1	MO
felbamate tab 400 mg	1	MO
felbamate tab 600 mg	1	MO
XCOPRI PAK 12.5-25 ***(cenobamate)***	2	PA
XCOPRI PAK 50-100MG ***(cenobamate)***	2	PA
XCOPRI PAK 100-150 ***(cenobamate)***	2	PA, MO
XCOPRI PAK 150-200 ***(cenobamate)***	2	PA
XCOPRI PAK 150-200 ***(cenobamate)***	2	PA, MO
XCOPRI TAB 25MG ***(cenobamate)***	2	PA, MO
XCOPRI TAB 50MG ***(cenobamate)***	2	PA, MO
XCOPRI TAB 100MG ***(cenobamate)***	2	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XCOPRI TAB 150MG ***(cenobamate)***	2	PA, MO
XCOPRI TAB 200MG ***(cenobamate)***	2	PA, MO
GABA MODULATORS		
tiagabine hcl tab 2 mg	1	MO
tiagabine hcl tab 4 mg	1	MO
tiagabine hcl tab 12 mg	1	MO
tiagabine hcl tab 16 mg	1	MO
vigabatrin powd pack 500 mg	4	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGADRONE	4	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGPODER	4	SP, PA, QL (6 packets every 1 day)
vigabatrin tab 500 mg	4	SP, PA, QL (6 tabs every 1 day)
HYDANTOINS		
phenytoin chew tab 50 mg	1	MO
phenytoin sodium extended cap 100 mg	1	MO
phenytoin sodium extended cap 200 mg	1	MO
phenytoin sodium extended cap 300 mg	1	MO
phenytoin susp 125 mg/5ml	1	MO
SUCCINIMIDES		
ethosuximide cap 250 mg	1	MO
ethosuximide soln 250 mg/5ml	1	MO
methsuximide cap 300 mg	1	MO
VALPROIC ACID		
divalproex sodium cap delayed release sprinkle 125 mg	1	MO
divalproex sodium tab delayed release 125 mg	1	MO
divalproex sodium tab delayed release 250 mg	1	MO
divalproex sodium tab delayed release 500 mg	1	MO
divalproex sodium tab er 24 hr 250 mg	1	MO
divalproex sodium tab er 24 hr 500 mg	1	MO
valproate sodium oral soln 250 mg/5ml (base equiv)	1	MO
valproic acid cap 250 mg	1	MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine orally disintegrating tab 15 mg	1	MO
mirtazapine orally disintegrating tab 30 mg	1	MO
mirtazapine orally disintegrating tab 45 mg	1	MO
mirtazapine tab 7.5 mg	1	MO
mirtazapine tab 15 mg	1	MO
mirtazapine tab 30 mg	1	MO
mirtazapine tab 45 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDEPRESSANTS - MISC.		
bupropion hcl tab 75 mg	1	MO
bupropion hcl tab 100 mg	1	MO
bupropion hcl tab er 12hr 100 mg	1	MO
bupropion hcl tab er 12hr 150 mg	1	MO
bupropion hcl tab er 12hr 200 mg	1	MO
bupropion hcl tab er 24hr 150 mg	1	MO
bupropion hcl tab er 24hr 300 mg	1	MO
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID		
ZURZUVAE CAP 20MG ***(zuranolone)***	4	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 25MG ***(zuranolone)***	4	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 30MG ***(zuranolone)***	4	SP, PA, QL (1 cap every 1 day)
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
phenelzine sulfate tab 15 mg	1	MO
tranylcypromine sulfate tab 10 mg	1	MO
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram hydrobromide oral soln 10 mg/5ml	1	MO
citalopram hydrobromide tab 10 mg (base equiv)	1	MO
citalopram hydrobromide tab 20 mg (base equiv)	1	MO
citalopram hydrobromide tab 40 mg (base equiv)	1	MO
escitalopram oxalate soln 5 mg/5ml (base equiv)	1	MO
escitalopram oxalate tab 5 mg (base equiv)	1	MO
escitalopram oxalate tab 10 mg (base equiv)	1	MO
escitalopram oxalate tab 20 mg (base equiv)	1	MO
fluoxetine hcl cap 10 mg	1	MO
fluoxetine hcl cap 20 mg	1	MO
fluoxetine hcl cap 40 mg	1	MO
fluoxetine hcl cap delayed release 90 mg	1	MO
fluoxetine hcl solution 20 mg/5ml	1	MO
fluoxetine hcl tab 10 mg	1	MO
fluoxetine hcl tab 20 mg	1	MO
fluvoxamine maleate cap er 24hr 100 mg	1	MO
fluvoxamine maleate cap er 24hr 150 mg	1	MO
fluvoxamine maleate tab 25 mg	1	MO
fluvoxamine maleate tab 50 mg	1	MO
fluvoxamine maleate tab 100 mg	1	MO
paroxetine hcl oral susp 10 mg/5ml (base equiv)	1	MO
paroxetine hcl tab 10 mg	1	MO
paroxetine hcl tab 20 mg	1	MO
paroxetine hcl tab 30 mg	1	MO
paroxetine hcl tab 40 mg	1	MO
paroxetine hcl tab er 24hr 12.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
paroxetine hcl tab er 24hr 25 mg	1	MO
paroxetine hcl tab er 24hr 37.5 mg	1	MO
sertraline hcl oral concentrate for solution 20 mg/ml	1	MO
sertraline hcl tab 25 mg	1	MO
sertraline hcl tab 50 mg	1	MO
sertraline hcl tab 100 mg	1	MO
SEROTONIN MODULATORS		
nefazodone hcl tab 50 mg	1	MO
nefazodone hcl tab 100 mg	1	MO
nefazodone hcl tab 150 mg	1	MO
nefazodone hcl tab 200 mg	1	MO
nefazodone hcl tab 250 mg	1	MO
trazodone hcl tab 50 mg	1	MO
trazodone hcl tab 100 mg	1	MO
trazodone hcl tab 150 mg	1	MO
trazodone hcl tab 300 mg	1	MO
TRINTELLIX TAB 5MG ***(vortioxetine hbr)***	2	ST, MO; PA**
TRINTELLIX TAB 10MG ***(vortioxetine hbr)***	2	ST, MO; PA**
TRINTELLIX TAB 20MG ***(vortioxetine hbr)***	2	ST, MO; PA**
vilazodone hcl tab 10 mg	1	MO
vilazodone hcl tab 20 mg	1	MO
vilazodone hcl tab 40 mg	1	MO
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
desvenlafaxine succinate tab er 24hr 25 mg (base equiv)	1	MO
desvenlafaxine succinate tab er 24hr 50 mg (base equiv)	1	MO
desvenlafaxine succinate tab er 24hr 100 mg (base equiv)	1	MO
duloxetine hcl enteric coated pellets cap 20 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 40 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 60 mg (base eq)	1	MO
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)	1	MO
venlafaxine hcl cap er 24hr 75 mg (base equivalent)	1	MO
venlafaxine hcl cap er 24hr 150 mg (base equivalent)	1	MO
venlafaxine hcl tab 25 mg (base equivalent)	1	MO
venlafaxine hcl tab 37.5 mg (base equivalent)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
venlafaxine hcl tab 50 mg (base equivalent)	1	MO
venlafaxine hcl tab 75 mg (base equivalent)	1	MO
venlafaxine hcl tab 100 mg (base equivalent)	1	MO
venlafaxine hcl tab er 24hr 225 mg (base equivalent)	1	MO
TRICYCLIC AGENTS		
amitriptyline hcl tab 10 mg	1	MO
amitriptyline hcl tab 25 mg	1	MO
amitriptyline hcl tab 50 mg	1	MO
amitriptyline hcl tab 75 mg	1	MO
amitriptyline hcl tab 100 mg	1	MO
amitriptyline hcl tab 150 mg	1	MO
amoxapine tab 25 mg	1	MO
amoxapine tab 50 mg	1	MO
amoxapine tab 100 mg	1	MO
amoxapine tab 150 mg	1	MO
clomipramine hcl cap 25 mg	1	MO
clomipramine hcl cap 50 mg	1	MO
clomipramine hcl cap 75 mg	1	MO
desipramine hcl tab 10 mg	1	MO
desipramine hcl tab 25 mg	1	MO
desipramine hcl tab 50 mg	1	MO
desipramine hcl tab 75 mg	1	MO
desipramine hcl tab 100 mg	1	MO
desipramine hcl tab 150 mg	1	MO
doxepin hcl cap 10 mg	1	MO
doxepin hcl cap 25 mg	1	MO
doxepin hcl cap 50 mg	1	MO
doxepin hcl cap 75 mg	1	MO
doxepin hcl cap 100 mg	1	MO
doxepin hcl cap 150 mg	1	MO
doxepin hcl conc 10 mg/ml	1	MO
imipramine hcl tab 10 mg	1	MO
imipramine hcl tab 25 mg	1	MO
imipramine hcl tab 50 mg	1	MO
imipramine pamoate cap 75 mg	1	MO
imipramine pamoate cap 100 mg	1	MO
imipramine pamoate cap 125 mg	1	MO
imipramine pamoate cap 150 mg	1	MO
nortriptyline hcl cap 10 mg	1	MO
nortriptyline hcl cap 25 mg	1	MO
nortriptyline hcl cap 50 mg	1	MO
nortriptyline hcl cap 75 mg	1	MO
nortriptyline hcl soln 10 mg/5ml	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
protriptyline hcl tab 5 mg	1	MO
protriptyline hcl tab 10 mg	1	MO
trimipramine maleate cap 25 mg	1	MO
trimipramine maleate cap 50 mg	1	MO
trimipramine maleate cap 100 mg	1	MO
ANTIDIABETICS - DRUGS TO TREAT DIABETES		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab 25 mg	1	MO
acarbose tab 50 mg	1	MO
acarbose tab 100 mg	1	MO
miglitol tab 25 mg	1	MO
miglitol tab 50 mg	1	MO
miglitol tab 100 mg	1	MO
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN 60 INJ 1000MCG ***(pramlintide acetate)***	2	MO
SYMLNPEN 120 INJ 1000MCG ***(pramlintide acetate)***	2	MO
ANTIDIABETIC COMBINATIONS		
glipizide-metformin hcl tab 2.5-250 mg	1	MO
glipizide-metformin hcl tab 2.5-500 mg	1	MO
glipizide-metformin hcl tab 5-500 mg	1	MO
glyburide-metformin tab 1.25-250 mg	1	MO
glyburide-metformin tab 2.5-500 mg	1	MO
glyburide-metformin tab 5-500 mg	1	MO
GLYXAMBI TAB 10-5 MG ***(empagliflozin-linagliptin)***	2	MO
GLYXAMBI TAB 25-5 MG ***(empagliflozin-linagliptin)***	2	MO
pioglitazone hcl-glimepiride tab 30-2 mg	1	MO
pioglitazone hcl-glimepiride tab 30-4 mg	1	MO
pioglitazone hcl-metformin hcl tab 15-500 mg	1	MO
pioglitazone hcl-metformin hcl tab 15-850 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 5-500 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 5-1000 mg	1	MO
SOLIQUA INJ 100/33 ***(insulin glargine-lixisenatide)***	2	PA, MO
SYNJARDY TAB ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 5-500MG ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 12.5-500 ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SYNJARDY XR TAB 10-1000 ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB 25-1000 ***(empagliflozin-metformin hcl)***	2	MO
TRIJARDY XR TAB ***(empagliflozin-linagliptin-metformin)***	2	MO
XIGDUO XR TAB 2.5-1000 ***(dapagliflozin propanediol-metformin hcl)***	2	MO
XIGDUO XR TAB 5-500MG ***(dapagliflozin propanediol-metformin hcl)***	2	MO
XIGDUO XR TAB 5-1000MG ***(dapagliflozin propanediol-metformin hcl)***	2	MO
XIGDUO XR TAB 10-500MG ***(dapagliflozin propanediol-metformin hcl)***	2	MO
XIGDUO XR TAB 10-1000 ***(dapagliflozin propanediol-metformin hcl)***	2	MO
XULTOPHY INJ 100/3.6 ***(insulin degludec-liraglutide)***	2	PA, MO
ZITUVIMET TAB 50-500MG ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET TAB 50-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 50-500MG ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 50-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 100-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
BIGUANIDES		
metformin hcl oral soln 500 mg/5ml	1	MO
metformin hcl tab 500 mg	1	MO
metformin hcl tab 850 mg	1	MO
metformin hcl tab 1000 mg	1	MO
metformin hcl tab er 24hr 500 mg	1	MO
metformin hcl tab er 24hr 750 mg	1	MO
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE ***(glucagon)***	2	
BAQSIMI TWO POW 3MG/DOSE ***(glucagon)***	2	
diazoxide susp 50 mg/ml	1	MO
glucagon (rdna) for inj kit 1 mg	1	
GVOKE HYPO 1 INJ 0.5/.1ML ***(glucagon)***	2	
GVOKE HYPO 1 INJ 1MG/.2ML ***(glucagon)***	2	
GVOKE HYPO 2 INJ 0.5/.1ML ***(glucagon)***	2	
GVOKE HYPO 2 INJ 1MG/.2ML ***(glucagon)***	2	
GVOKE KIT SOL 1MG/0.2M ***(glucagon)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GVOKE PFS INJ ***(glucagon)***	2	
mifepristone tab 300 mg	4	SP, PA, QL (4 tabs every 1 day)
ZEGALOGUE INJ 0.6/0.6 ***(dasiglucagon hcl)***	2	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
saxagliptin hcl tab 2.5 mg (base equiv)	1	MO
saxagliptin hcl tab 5 mg (base equiv)	1	MO
ZITUVIO TAB 25MG ***(sitagliptin)***	2	MO
ZITUVIO TAB 50MG ***(sitagliptin)***	2	MO
ZITUVIO TAB 100MG ***(sitagliptin)***	2	MO
INCRETIN MIMETIC AGENTS		
liraglutide soln pen-injector 18 mg/3ml (6 mg/ml)	1	PA, MO
MOUNJARO INJ 2.5/0.5 ***(tirzepatide)***	2	PA
MOUNJARO INJ 5MG/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 7.5/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 10MG/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 12.5/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 15MG/0.5 ***(tirzepatide)***	2	PA, MO
OZEMPIC INJ 2MG/3ML ***(semaglutide)***	2	PA, MO
OZEMPIC INJ 4MG/3ML ***(semaglutide)***	2	PA, MO
OZEMPIC INJ 8MG/3ML ***(semaglutide)***	2	PA, MO
RYBELSUS TAB 3MG ***(semaglutide)***	2	PA, MO
RYBELSUS TAB 7MG ***(semaglutide)***	2	PA, MO
RYBELSUS TAB 14MG ***(semaglutide)***	2	PA, MO
TRULICITY INJ 0.75/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 1.5/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 3/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 4.5/0.5 ***(dulaglutide)***	2	PA, MO
INSULIN		
FIASP FLEX INJ TOUCH ***(insulin aspart (with niacinamide))***	2	MO
FIASP INJ 100/ML ***(insulin aspart (with niacinamide))***	2	MO
FIASP PENFIL INJ U-100 ***(insulin aspart (with niacinamide))***	2	MO
GLARGIN YFGN INJ 100U/ML	2	MO
GLARGIN YFGN SOL 100U/ML	2	MO
HUMULIN R INJ U-500 ***(insulin regular (human))***	2	MO
LANTUS INJ 100/ML ***(insulin glargine)***	2	MO
LANTUS SOLOS INJ 100/ML ***(insulin glargine)***	2	MO
NOVOLIN INJ 70/30 ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NOVOLIN N INJ 100 UNIT ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN N INJ U-100 ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN R INJ 100 UNIT ***(insulin regular (human))***	2	MO; RELION not covered
NOVOLIN R INJ U-100 ***(insulin regular (human))***	2	MO; RELION not covered
NOVOLOG INJ 100/ML ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG INJ FLEXPEN ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG INJ PENFILL ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG MIX INJ 70/30 ***(insulin aspart protamine & aspart (human))***	2	MO; RELION not covered
NOVOLOG MIX INJ FLEXPEN ***(insulin aspart protamine & aspart (human))***	2	MO; RELION not covered
TOUJEO MAX INJ 300/ML ***(insulin glargine)***	2	MO
TOUJEO SOLO INJ 300/ML ***(insulin glargine)***	2	MO
TRESIBA FLEX INJ 100UNIT ***(insulin degludec)***	2	MO
TRESIBA FLEX INJ 200UNIT ***(insulin degludec)***	2	MO
TRESIBA INJ 100UNIT ***(insulin degludec)***	2	MO
INSULIN SENSITIZING AGENTS		
pioglitazone hcl tab 15 mg (base equiv)	1	MO
pioglitazone hcl tab 30 mg (base equiv)	1	MO
pioglitazone hcl tab 45 mg (base equiv)	1	MO
MEGLITINIDE ANALOGUES		
nateglinide tab 60 mg	1	MO
nateglinide tab 120 mg	1	MO
repaglinide tab 0.5 mg	1	MO
repaglinide tab 1 mg	1	MO
repaglinide tab 2 mg	1	MO
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB 5MG ***(dapagliflozin propanediol)***	2	MO
FARXIGA TAB 10MG ***(dapagliflozin propanediol)***	2	MO
JARDIANCE TAB 10MG ***(empagliflozin)***	2	MO
JARDIANCE TAB 25MG ***(empagliflozin)***	2	MO
SULFONYLUREAS		
glimepiride tab 1 mg	1	MO
glimepiride tab 2 mg	1	MO
glimepiride tab 4 mg	1	MO
glipizide tab 5 mg	1	MO
glipizide tab 10 mg	1	MO
glipizide tab er 24hr 2.5 mg	1	MO
glipizide tab er 24hr 5 mg	1	MO
glipizide tab er 24hr 10 mg	1	MO
glyburide micronized tab 1.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
glyburide micronized tab 3 mg	1	MO
glyburide micronized tab 6 mg	1	MO
glyburide tab 1.25 mg	1	MO
glyburide tab 2.5 mg	1	MO
glyburide tab 5 mg	1	MO
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA		
ANTIPERISTALTIC AGENTS		
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
ANTIDOTES - CHELATING AGENTS		
deferasirox granules packet 90 mg	4	SP, PA
deferasirox granules packet 180 mg	4	SP, PA
deferasirox granules packet 360 mg	4	SP, PA
deferasirox tab 90 mg	4	SP, PA
deferasirox tab 180 mg	4	SP, PA
deferasirox tab 360 mg	4	SP, PA
deferasirox tab for oral susp 125 mg	4	SP, PA
deferasirox tab for oral susp 250 mg	4	SP, PA
deferasirox tab for oral susp 500 mg	4	SP, PA
deferiprone tab 500 mg	4	SP, PA
deferiprone tab 1000 mg	4	SP, PA
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
VISTOGARD PAK 10GM ***(uridine triacetate (emergency treatment))***	4	SP, QL (20 packets every 5 days)
OPIOID ANTAGONISTS		
naloxone hcl nasal spray 4 mg/0.1ml	1	QL (4 sprays every 25 days)
naltrexone hcl tab 50 mg	1	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron hcl tab 1 mg	1	QL (12 tabs every 21 days)
ondansetron hcl oral soln 4 mg/5ml	1	QL (200 mL every 21 days)
ondansetron hcl tab 4 mg	1	QL (18 tabs every 21 days)
ondansetron hcl tab 8 mg	1	QL (18 tabs every 21 days)
ondansetron hcl tab 24 mg	1	QL (2 tabs every 21 days)
ondansetron orally disintegrating tab 4 mg	1	QL (18 tabs every 21 days)
ondansetron orally disintegrating tab 8 mg	1	QL (18 tabs every 21 days)
SANCUSO DIS 3.1MG ***(granisetron)***	2	QL (2 patches every 21 days)
ANTIEMETICS - ANTICHOLINERGIC		
meclizine hcl tab 50 mg	1	
scopolamine td patch 72hr 1 mg/3days	1	
trimethobenzamide hcl cap 300 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIEMETICS - MISCELLANEOUS		
doxylamine-pyridoxine tab delayed release 10-10 mg	1	
dronabinol cap 2.5 mg	1	QL (60 caps every 25 days)
dronabinol cap 5 mg	1	QL (60 caps every 25 days)
dronabinol cap 10 mg	1	QL (60 caps every 25 days)
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant capsule 40 mg	1	QL (3 caps every 180 days)
aprepitant capsule 80 mg	1	QL (4 caps every 21 days)
aprepitant capsule 125 mg	1	QL (2 caps every 21 days)
aprepitant capsule therapy pack 80 & 125 mg	1	QL (6 caps every 21 days)
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
flucytosine cap 250 mg	1	
griseofulvin microsize susp 125 mg/5ml	1	
griseofulvin microsize tab 500 mg	1	
griseofulvin ultramicrosize tab 125 mg	1	
griseofulvin ultramicrosize tab 165 mg	1	
griseofulvin ultramicrosize tab 250 mg	1	
nystatin tab 500000 unit	1	
terbinafine hcl tab 250 mg	1	PA
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole for susp 10 mg/ml	1	
fluconazole for susp 40 mg/ml	1	
fluconazole tab 50 mg	1	
fluconazole tab 100 mg	1	
fluconazole tab 150 mg	1	
fluconazole tab 200 mg	1	
itraconazole cap 100 mg	1	PA
itraconazole oral soln 10 mg/ml	1	PA
ketoconazole tab 200 mg	1	
posaconazole susp 40 mg/ml	1	MO
voriconazole for susp 40 mg/ml	1	
voriconazole tab 50 mg	1	
voriconazole tab 200 mg	1	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
ANTIHISTAMINES - ETHANOLAMINES		
carbinoxamine maleate extended release susp 4 mg/5ml	1	
carbinoxamine maleate soln 4 mg/5ml	1	
carbinoxamine maleate tab 4 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)	1	
clemastine fumarate tab 2.68 mg	1	
ANTIHISTAMINES - NON-SEDATING		
desloratadine tab 5 mg	1	
desloratadine tab orally disintegrating 2.5 mg	1	
desloratadine tab orally disintegrating 5 mg	1	
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine hcl oral soln 6.25 mg/5ml	1	
promethazine hcl suppos 12.5 mg	1	
(Promethazine Hcl Suppos 12.5 mg) PROMETHEGAN	1	
promethazine hcl suppos 25 mg	1	
(Promethazine Hcl Suppos 25 mg) PROMETHEGAN	1	
(Promethazine Hcl Suppos 50 mg) PROMETHEGAN	1	
promethazine hcl tab 12.5 mg	1	
promethazine hcl tab 25 mg	1	
promethazine hcl tab 50 mg	1	
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine hcl syrup 2 mg/5ml	1	
cyproheptadine hcl tab 4 mg	1	
ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG ***(bempedoic acid)***	2	MO
ANTIHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg	1	MO
ezetimibe-simvastatin tab 10-20 mg	1	MO
ezetimibe-simvastatin tab 10-40 mg	1	MO
ezetimibe-simvastatin tab 10-80 mg	1	MO
NEXLIZET TAB 180/10MG ***(bempedoic acid-ezetimibe)***	2	MO
ANTIHYPERLIPIDEMICS - MISC.		
icosapent ethyl cap 0.5 gm	1	MO
icosapent ethyl cap 1 gm	1	MO
omega-3-acid ethyl esters cap 1 gm	1	MO
BILE ACID SEQUESTRANTS		
cholestyramine light powder 4 gm/dose	1	MO
(Cholestyramine Light Powder 4 gm/dose) PREVALITE	1	MO
cholestyramine light powder packets 4 gm	1	MO
(Cholestyramine Light Powder Packets 4 gm) PREVALITE	1	MO
cholestyramine powder 4 gm/dose	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
cholestyramine powder packets 4 gm	1	MO
colesevelam hcl packet for susp 3.75 gm	1	MO
colesevelam hcl tab 625 mg	1	MO
colestipol hcl granule packets 5 gm	1	MO
colestipol hcl granules 5 gm	1	MO
colestipol hcl tab 1 gm	1	MO
FIBRIC ACID DERIVATIVES		
choline fenofibrate cap dr 45 mg (fenofibric acid equiv)	1	MO
choline fenofibrate cap dr 135 mg (fenofibric acid equiv)	1	MO
fenofibrate cap 150 mg	1	MO
fenofibrate micronized cap 43 mg	1	MO
fenofibrate micronized cap 67 mg	1	MO
fenofibrate micronized cap 134 mg	1	MO
fenofibrate micronized cap 200 mg	1	MO
fenofibrate tab 48 mg	1	MO
fenofibrate tab 54 mg	1	MO
fenofibrate tab 145 mg	1	MO
fenofibrate tab 160 mg	1	MO
fenofibric acid tab 35 mg	1	MO
fenofibric acid tab 105 mg	1	MO
gemfibrozil tab 600 mg	1	MO
HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium tab 10 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
atorvastatin calcium tab 20 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
atorvastatin calcium tab 40 mg (base equivalent)	1	MO
atorvastatin calcium tab 80 mg (base equivalent)	1	MO
fluvastatin sodium cap 20 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
fluvastatin sodium cap 40 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
fluvastatin sodium tab er 24 hr 80 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
lovastatin tab 10 mg	1	MO; $0 copay for members age 40 through 75
lovastatin tab 20 mg	1	MO; $0 copay for members age 40 through 75
lovastatin tab 40 mg	1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tab 1 mg	1	MO; $0 copay for members age 40 through 75

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
pitavastatin calcium tab 2 mg	1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tab 4 mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tab 10 mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tab 20 mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tab 40 mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tab 80 mg	1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tab 5 mg	1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tab 10 mg	1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tab 20 mg	1	MO
rosuvastatin calcium tab 40 mg	1	MO
simvastatin tab 5 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 10 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 20 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 40 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 80 mg	1	MO
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab 10 mg	1	MO
NICOTINIC ACID DERIVATIVES		
niacin tab er 500 mg (antihyperlipidemic)	1	MO
niacin tab er 750 mg (antihyperlipidemic)	1	MO
niacin tab er 1000 mg (antihyperlipidemic)	1	MO
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ACE INHIBITORS		
benazepril hcl tab 5 mg	1	MO
benazepril hcl tab 10 mg	1	MO
benazepril hcl tab 20 mg	1	MO
benazepril hcl tab 40 mg	1	MO
captopril tab 12.5 mg	1	MO
captopril tab 25 mg	1	MO
captopril tab 50 mg	1	MO
captopril tab 100 mg	1	MO
enalapril maleate oral soln 1 mg/ml	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
enalapril maleate tab 2.5 mg	1	MO
enalapril maleate tab 5 mg	1	MO
enalapril maleate tab 10 mg	1	MO
enalapril maleate tab 20 mg	1	MO
fosinopril sodium tab 10 mg	1	MO
fosinopril sodium tab 20 mg	1	MO
fosinopril sodium tab 40 mg	1	MO
lisinopril tab 2.5 mg	1	MO
lisinopril tab 5 mg	1	MO
lisinopril tab 10 mg	1	MO
lisinopril tab 20 mg	1	MO
lisinopril tab 30 mg	1	MO
lisinopril tab 40 mg	1	MO
moexipril hcl tab 7.5 mg	1	MO
moexipril hcl tab 15 mg	1	MO
perindopril erbumine tab 2 mg	1	MO
perindopril erbumine tab 4 mg	1	MO
perindopril erbumine tab 8 mg	1	MO
quinapril hcl tab 5 mg	1	MO
quinapril hcl tab 10 mg	1	MO
quinapril hcl tab 20 mg	1	MO
quinapril hcl tab 40 mg	1	MO
ramipril cap 1.25 mg	1	MO
ramipril cap 2.5 mg	1	MO
ramipril cap 5 mg	1	MO
ramipril cap 10 mg	1	MO
trandolapril tab 1 mg	1	MO
trandolapril tab 2 mg	1	MO
trandolapril tab 4 mg	1	MO
AGENTS FOR PHEOCHROMOCYTOMA		
metyrosine cap 250 mg	4	SP, PA, QL (16 caps every 1 day)
phenoxybenzamine hcl cap 10 mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil tab 4 mg	1	MO
candesartan cilexetil tab 8 mg	1	MO
candesartan cilexetil tab 16 mg	1	MO
candesartan cilexetil tab 32 mg	1	MO
irbesartan tab 75 mg	1	MO
irbesartan tab 150 mg	1	MO
irbesartan tab 300 mg	1	MO
losartan potassium tab 25 mg	1	MO
losartan potassium tab 50 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
losartan potassium tab 100 mg	1	MO
olmesartan medoxomil tab 5 mg	1	MO
olmesartan medoxomil tab 20 mg	1	MO
olmesartan medoxomil tab 40 mg	1	MO
telmisartan tab 20 mg	1	MO
telmisartan tab 40 mg	1	MO
telmisartan tab 80 mg	1	MO
valsartan oral soln 4 mg/ml	1	MO
valsartan tab 40 mg	1	MO
valsartan tab 80 mg	1	MO
valsartan tab 160 mg	1	MO
valsartan tab 320 mg	1	MO
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine hcl tab 0.1 mg	1	MO
clonidine hcl tab 0.2 mg	1	MO
clonidine hcl tab 0.3 mg	1	MO
clonidine tab er 24hr 0.17 mg	1	MO
clonidine td patch weekly 0.1 mg/24hr	1	MO
clonidine td patch weekly 0.2 mg/24hr	1	MO
clonidine td patch weekly 0.3 mg/24hr	1	MO
doxazosin mesylate tab 1 mg	1	MO
doxazosin mesylate tab 2 mg	1	MO
doxazosin mesylate tab 4 mg	1	MO
doxazosin mesylate tab 8 mg	1	MO
guanfacine hcl tab 1 mg	1	MO
guanfacine hcl tab 2 mg	1	MO
methyldopa tab 250 mg	1	MO
methyldopa tab 500 mg	1	MO
prazosin hcl cap 1 mg	1	MO
prazosin hcl cap 2 mg	1	MO
prazosin hcl cap 5 mg	1	MO
terazosin hcl cap 1 mg (base equivalent)	1	MO
terazosin hcl cap 2 mg (base equivalent)	1	MO
terazosin hcl cap 5 mg (base equivalent)	1	MO
terazosin hcl cap 10 mg (base equivalent)	1	MO
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-40 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-40 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	1	MO
amlodipine besylate-valsartan tab 5-160 mg	1	MO
amlodipine besylate-valsartan tab 5-320 mg	1	MO
amlodipine besylate-valsartan tab 10-160 mg	1	MO
amlodipine besylate-valsartan tab 10-320 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	1	MO
atenolol & chlorthalidone tab 50-25 mg	1	MO
atenolol & chlorthalidone tab 100-25 mg	1	MO
benazepril & hydrochlorothiazide tab 5-6.25 mg	1	MO
benazepril & hydrochlorothiazide tab 10-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	1	MO
captopril & hydrochlorothiazide tab 25-15 mg	1	MO
captopril & hydrochlorothiazide tab 25-25 mg	1	MO
captopril & hydrochlorothiazide tab 50-15 mg	1	MO
captopril & hydrochlorothiazide tab 50-25 mg	1	MO
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	1	MO
irbesartan-hydrochlorothiazide tab 150-12.5 mg	1	MO
irbesartan-hydrochlorothiazide tab 300-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-25 mg	1	MO
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 50-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-50 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	1	MO
quinapril-hydrochlorothiazide tab 10-12.5 mg	1	MO
telmisartan-amlodipine tab 40-5 mg	1	MO
telmisartan-amlodipine tab 40-10 mg	1	MO
telmisartan-amlodipine tab 80-5 mg	1	MO
telmisartan-amlodipine tab 80-10 mg	1	MO
telmisartan-hydrochlorothiazide tab 40-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
trandolapril-verapamil hcl tab er 1-240 mg	1	MO
trandolapril-verapamil hcl tab er 2-180 mg	1	MO
trandolapril-verapamil hcl tab er 2-240 mg	1	MO
trandolapril-verapamil hcl tab er 4-240 mg	1	MO
valsartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-25 mg	1	MO
valsartan-hydrochlorothiazide tab 320-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 320-25 mg	1	MO
DIRECT RENIN INHIBITORS		
aliskiren fumarate tab 150 mg (base equivalent)	1	MO
aliskiren fumarate tab 300 mg (base equivalent)	1	MO
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab 25 mg	1	MO
eplerenone tab 50 mg	1	MO
VASODILATORS		
hydralazine hcl tab 10 mg	1	MO
hydralazine hcl tab 25 mg	1	MO
hydralazine hcl tab 50 mg	1	MO
hydralazine hcl tab 100 mg	1	MO
minoxidil tab 2.5 mg	1	MO
minoxidil tab 10 mg	1	MO
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
ANTIMALARIAL COMBINATIONS		
atovaquone-proguanil hcl tab 62.5-25 mg	1	
atovaquone-proguanil hcl tab 250-100 mg	1	
COARTEM TAB 20-120MG ***(artemether-lumefantrine)***	3	
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
chloroquine phosphate tab 250 mg	1	MO
chloroquine phosphate tab 500 mg	1	MO
hydroxychloroquine sulfate tab 200 mg	1	MO
mefloquine hcl tab 250 mg	1	MO
primaquine phosphate tab 26.3 mg (15 mg base)	1	
pyrimethamine tab 25 mg	1	
quinine sulfate cap 324 mg	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
GUANIDINE TAB 125MG	3	PA
pyridostigmine bromide oral soln 60 mg/5ml	1	
pyridostigmine bromide tab 60 mg	1	
pyridostigmine bromide tab er 180 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
ANTI TB COMBINATIONS		
RIFATER TAB ***(isoniazid-rifampin w/ pyrazinamide)***	3	
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
cycloserine cap 250 mg	1	
ethambutol hcl tab 100 mg	1	
ethambutol hcl tab 400 mg	1	
isoniazid syrup 50 mg/5ml	1	MO
isoniazid tab 100 mg	1	MO
isoniazid tab 300 mg	1	MO
PASER GRA 4GM ***(aminosalicylic acid)***	3	
pyrazinamide tab 500 mg	1	
rifabutin cap 150 mg	1	
rifampin cap 150 mg	1	
rifampin cap 300 mg	1	
SIRTURO TAB 20MG ***(bedaquiline fumarate)***	3	
SIRTURO TAB 100MG ***(bedaquiline fumarate)***	3	
TRECATOR TAB 250MG ***(ethionamide)***	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
cyclophosphamide cap 25 mg	1	OAC
cyclophosphamide cap 50 mg	1	OAC
GLEOSTINE CAP 10MG ***(lomustine)***	4	SP; OAC
GLEOSTINE CAP 40MG ***(lomustine)***	4	SP; OAC
GLEOSTINE CAP 100MG ***(lomustine)***	4	SP; OAC
temozolomide cap 5 mg	4	SP, PA; OAC
temozolomide cap 20 mg	4	SP, PA; OAC
temozolomide cap 100 mg	4	SP, PA; OAC
temozolomide cap 140 mg	4	SP, PA; OAC
temozolomide cap 180 mg	4	SP, PA; OAC
temozolomide cap 250 mg	4	SP, PA; OAC
ANTIMETABOLITES		
capecitabine tab 150 mg	4	SP, PA; OAC
capecitabine tab 500 mg	4	SP, PA; OAC
mercaptopurine tab 50 mg	1	OAC
methotrexate sodium tab 2.5 mg (base equiv)	1	OAC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG ***(axitinib)***	4	SP, PA, QL (8 tabs every 1 day); OAC
INLYTA TAB 5MG ***(axitinib)***	4	SP, PA, QL (4 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LENVIMA CAP 4MG ***(lenvatinib mesylate)***	4	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 8 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 10 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 12MG ***(lenvatinib mesylate)***	4	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 14 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 18 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 20 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 24 MG ***(lenvatinib mesylate)***	4	SP, PA, QL (3 caps every 1 day); OAC
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib hcl tab 25 mg (base equivalent)	4	SP, PA, QL (2 tabs every 1 day); OAC
erlotinib hcl tab 100 mg (base equivalent)	4	SP, PA, QL (1 tab every 1 day); OAC
erlotinib hcl tab 150 mg (base equivalent)	4	SP, PA, QL (1 tab every 1 day); OAC
gefitinib tab 250 mg	4	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 40MG ***(osimertinib mesylate)***	4	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 80MG ***(osimertinib mesylate)***	4	SP, PA, QL (1 tab every 1 day); OAC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG ***(vismodegib)***	4	SP, PA, QL (1 cap every 1 day); OAC
ODOMZO CAP 200MG ***(sonidegib phosphate)***	4	SP, PA, QL (1 cap every 1 day); OAC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
abiraterone acetate tab 250 mg	4	SP, PA, QL (4 tabs every 1 day); OAC
abiraterone acetate tab 500 mg	4	SP, PA, QL (2 tabs every 1 day); OAC
anastrozole tab 1 mg	PV	MO; OAC, $0 copay ages 35 and older for the primary prevention of breast cancer
bicalutamide tab 50 mg	1	OAC
ELIGARD INJ 7.5MG ***(leuprolide acetate)***	4	SP, PA
ELIGARD INJ 22.5MG ***(leuprolide acetate (3 month))***	4	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ELIGARD INJ 30MG ***(leuprolide acetate (4 month))***	4	SP, PA
ELIGARD INJ 45MG ***(leuprolide acetate (6 month))***	4	SP, PA
ERLEADA TAB 60MG ***(apalutamide)***	4	SP, PA, QL (4 tabs every 1 day); OAC
ERLEADA TAB 240MG ***(apalutamide)***	4	SP, PA, QL (1 tab every 1 day); OAC
exemestane tab 25 mg	PV	MO; OAC, $0 copay ages 35 and older for the primary prevention of breast cancer
letrozole tab 2.5 mg	1	MO; OAC
megestrol acetate susp 40 mg/ml	1	OAC
megestrol acetate tab 20 mg	1	OAC
megestrol acetate tab 40 mg	1	OAC
nilutamide tab 150 mg	1	OAC
NUBEQA TAB 300MG ***(darolutamide)***	4	SP, PA, QL (4 tabs every 1 day); OAC
tamoxifen citrate tab 10 mg (base equivalent)	1	MO; OAC, $0 copay ages 35 and older for the primary prevention of breast cancer
tamoxifen citrate tab 20 mg (base equivalent)	1	MO; OAC, $0 copay ages 35 and older for the primary prevention of breast cancer
toremifene citrate tab 60 mg (base equivalent)	1	MO; OAC
XTANDI CAP 40MG ***(enzalutamide)***	4	SP, PA, QL (4 caps every 1 day); OAC
XTANDI TAB 40MG ***(enzalutamide)***	4	SP, PA, QL (4 tabs every 1 day); OAC
XTANDI TAB 80MG ***(enzalutamide)***	4	SP, PA, QL (2 tabs every 1 day); OAC
YONSA TAB 125MG ***(abiraterone acetate micronized)***	4	SP, PA, QL (4 tabs every 1 day); OAC
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG ***(pomalidomide)***	4	SP, PA; OAC
POMALYST CAP 2MG ***(pomalidomide)***	4	SP, PA; OAC
POMALYST CAP 3MG ***(pomalidomide)***	4	SP, PA; OAC
POMALYST CAP 4MG ***(pomalidomide)***	4	SP, PA; OAC
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB 15-6.14 ***(trifluridine-tipiracil)***	4	SP, PA, QL (100 tabs every 28 days); OAC
LONSURF TAB 20-8.19 ***(trifluridine-tipiracil)***	4	SP, PA, QL (80 tabs every 28 days); OAC
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP 150MG ***(alectinib hcl)***	4	SP, PA, QL (8 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ALUNBRIG PAK ***(brigatinib)***	4	SP, PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 30MG ***(brigatinib)***	4	SP, PA, QL (4 tabs every 1 day); OAC
ALUNBRIG TAB 90MG ***(brigatinib)***	4	SP, PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 180MG ***(brigatinib)***	4	SP, PA, QL (1 tab every 1 day); OAC
AUGTYRO CAP 40MG ***(repotrectinib)***	4	SP, PA, QL (8 caps every 1 day); OAC
AUGTYRO CAP 160MG ***(repotrectinib)***	4	SP, PA, QL (2 caps every 1 day); OAC
BOSULIF CAP 50MG ***(bosutinib)***	4	SP, PA, QL (1 cap every 1 day); OAC
BOSULIF CAP 100MG ***(bosutinib)***	4	SP, PA, QL (10 caps every 1 day); OAC
BOSULIF TAB 100MG ***(bosutinib)***	4	SP, PA, QL (3 tabs every 1 day); OAC
BOSULIF TAB 400MG ***(bosutinib)***	4	SP, PA, QL (1 tab every 1 day); OAC
BOSULIF TAB 500MG ***(bosutinib)***	4	SP, PA, QL (1 tab every 1 day); OAC
BRAFTOVI CAP 75MG ***(encorafenib)***	4	SP, PA, QL (6 caps every 1 day); OAC
BRUKINSA CAP 80MG ***(zanubrutinib)***	4	SP, PA, QL (4 caps every 1 day); OAC
CABOMETYX TAB 20MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 40MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 60MG ***(cabozantinib s-malate)***	4	SP, PA, QL (1 tab every 1 day); OAC
CALQUENCE TAB 100MG ***(acalabrutinib maleate)***	4	SP, PA, QL (2 tabs every 1 day); OAC
COPIKTRA CAP 15MG ***(duvelisib)***	4	SP, PA, QL (2 caps every 1 day); OAC
COPIKTRA CAP 25MG ***(duvelisib)***	4	SP, PA, QL (2 caps every 1 day); OAC
dasatinib tab 20 mg	4	SP, PA, QL (3 tabs every 1 day); OAC
dasatinib tab 50 mg	4	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 70 mg	4	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dasatinib tab 80 mg	4	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 100 mg	4	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 140 mg	4	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 2.5 mg	4	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 2.5 mg) TORPENZ	4	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 5 mg	4	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 5 mg) TORPENZ	4	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 7.5 mg	4	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 7.5 mg) TORPENZ	4	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 10 mg	4	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 10 mg) TORPENZ	4	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab for oral susp 2 mg	4	SP, PA, QL (2 tabs every 1 day); OAC
everolimus tab for oral susp 3 mg	4	SP, PA, QL (3 tabs every 1 day); OAC
everolimus tab for oral susp 5 mg	4	SP, PA, QL (2 tabs every 1 day); OAC
GAVRETO CAP 100MG ***(pralsetinib)***	4	SP, PA, QL (4 caps every 1 day); OAC
IBRANCE CAP 75MG ***(palbociclib)***	4	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 100MG ***(palbociclib)***	4	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 125MG ***(palbociclib)***	4	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE TAB 75MG ***(palbociclib)***	4	SP, PA, QL (42 tabs every 28 days); OAC
IBRANCE TAB 100MG ***(palbociclib)***	4	SP, PA, QL (42 tabs every 28 days); OAC
IBRANCE TAB 125MG ***(palbociclib)***	4	SP, PA, QL (42 tabs every 28 days); OAC
imatinib mesylate tab 100 mg (base equivalent)	4	SP, PA, QL (4 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
imatinib mesylate tab 400 mg (base equivalent)	4	SP, PA, QL (2 tabs every 1 day); OAC
KISQALI TAB 200DOSE ***(ribociclib succinate)***	4	SP, PA, QL (42 tabs every 28 days); OAC
KISQALI TAB 400DOSE ***(ribociclib succinate)***	4	SP, PA, QL (84 tabs every 28 days); OAC
KISQALI TAB 600DOSE ***(ribociclib succinate)***	4	SP, PA, QL (126 tabs every 28 days); OAC
KOSELUGO CAP 10MG ***(selumetinib sulfate)***	4	SP, PA, QL (8 caps every 1 day); OAC
KOSELUGO CAP 25MG ***(selumetinib sulfate)***	4	SP, PA, QL (4 caps every 1 day); OAC
KRAZATI TAB 200MG ***(adagrasib)***	4	SP, PA, QL (6 tabs every 1 day); OAC
lapatinib ditosylate tab 250 mg (base equiv)	4	SP, PA, QL (6 tabs every 1 day); OAC
LUMAKRAS TAB 120MG ***(sotorasib)***	4	SP, PA, QL (8 tabs every 1 day); OAC
LUMAKRAS TAB 240MG ***(sotorasib)***	4	SP, PA, QL (4 tabs every 1 day); OAC
LUMAKRAS TAB 320MG ***(sotorasib)***	4	SP, PA, QL (3 tabs every 1 day); OAC
LYNPARZA TAB 100MG ***(olaparib)***	4	SP, PA, QL (4 tabs every 1 day); OAC
LYNPARZA TAB 150MG ***(olaparib)***	4	SP, PA, QL (4 tabs every 1 day); OAC
MEKINIST SOL 0.05/ML ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (38 mL every 1 day); OAC
MEKINIST TAB 0.5MG ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (3 tabs every 1 day); OAC
MEKINIST TAB 2MG ***(trametinib dimethyl sulfoxide)***	4	SP, PA, QL (1 tab every 1 day); OAC
MEKTOVI TAB 15MG ***(binimetinib)***	4	SP, PA, QL (6 tabs every 1 day); OAC
NINLARO CAP 2.3MG ***(ixazomib citrate)***	4	SP, PA, QL (6 caps every 28 days); OAC
NINLARO CAP 3MG ***(ixazomib citrate)***	4	SP, PA, QL (6 caps every 28 days); OAC
NINLARO CAP 4MG ***(ixazomib citrate)***	4	SP, PA, QL (6 caps every 28 days); OAC
pazopanib hcl tab 200 mg (base equiv)	4	SP, PA, QL (4 tabs every 1 day); OAC
PIQRAY 200MG TAB DOSE ***(alpelisib)***	4	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PIQRAY 250MG TAB DOSE ***(alpelisib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
PIQRAY 300MG TAB DOSE ***(alpelisib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 40MG ***(selpercatinib)***	4	SP, PA, QL (3 tabs every 1 day); OAC
RETEVMO TAB 80MG ***(selpercatinib)***	4	SP, PA, QL (4 tabs every 1 day); OAC
RETEVMO TAB 120MG ***(selpercatinib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 160MG ***(selpercatinib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
ROZLYTREK CAP 100MG ***(entrectinib)***	4	SP, PA, QL (1 cap every 1 day); OAC
ROZLYTREK CAP 200MG ***(entrectinib)***	4	SP, PA, QL (3 caps every 1 day); OAC
ROZLYTREK PAK 50MG ***(entrectinib)***	4	SP, PA, QL (12 packets every 1 day); OAC
RYDAPT CAP 25MG ***(midostaurin)***	4	SP, PA, QL (8 caps every 1 day); OAC
SCEMBLIX TAB 20MG ***(asciminib hcl)***	4	SP, PA, QL (2 tabs every 1 day); OAC
SCEMBLIX TAB 40MG ***(asciminib hcl)***	4	SP, PA, QL (10 tabs every 1 day); OAC
SCEMBLIX TAB 100MG ***(asciminib hcl)***	4	SP, PA, QL (4 tabs every 1 day); OAC
sorafenib tosylate tab 200 mg (base equivalent)	4	SP, PA, QL (4 tabs every 1 day); OAC
STIVARGA TAB 40MG ***(regorafenib)***	4	SP, PA, QL (3 tabs every 1 day); OAC
sunitinib malate cap 12.5 mg (base equivalent)	4	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 25 mg (base equivalent)	4	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 37.5 mg (base equivalent)	4	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 50 mg (base equivalent)	4	SP, PA, QL (1 cap every 1 day); OAC
TAFINLAR CAP 50MG ***(dabrafenib mesylate)***	4	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR CAP 75MG ***(dabrafenib mesylate)***	4	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR TAB 10MG ***(dabrafenib mesylate)***	4	SP, PA, QL (30 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TRUQAP PAK 160MG ***(capivasertib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP PAK 200MG ***(capivasertib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP TAB 200MG ***(capivasertib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
VITRAKVI CAP 25MG ***(larotrectinib sulfate)***	4	SP, PA, QL (6 caps every 1 day); OAC
VITRAKVI CAP 100MG ***(larotrectinib sulfate)***	4	SP, PA, QL (2 caps every 1 day); OAC
VITRAKVI SOL 20MG/ML ***(larotrectinib sulfate)***	4	SP, PA, QL (10 mL every 1 day); OAC
XOSPATA TAB 40MG ***(gilteritinib fumarate)***	4	SP, PA, QL (3 tabs every 1 day); OAC
ZEJULA TAB 100MG ***(niraparib tosylate)***	4	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 200MG ***(niraparib tosylate)***	4	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 300MG ***(niraparib tosylate)***	4	SP, PA, QL (1 tab every 1 day); OAC
ZYDELIG TAB 100MG ***(idelalisib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
ZYDELIG TAB 150MG ***(idelalisib)***	4	SP, PA, QL (2 tabs every 1 day); OAC
ZYKADIA TAB 150MG ***(ceritinib)***	4	SP, PA, QL (3 tabs every 1 day); OAC
ANTINEOPLASTICS MISC.		
BESREMI SOL 500MCG ***(ropeginterferon alfa-2b-njft)***	4	SP, PA, QL (2 syringes every 28 days)
bexarotene cap 75 mg	4	SP, PA; OAC
hydroxyurea cap 500 mg	1	OAC
tretinoin cap 10 mg	1	OAC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
leucovorin calcium tab 5 mg	1	OAC
leucovorin calcium tab 10 mg	1	OAC
leucovorin calcium tab 15 mg	1	OAC
leucovorin calcium tab 25 mg	1	OAC
mesna tab 400 mg	1	OAC
MITOTIC INHIBITORS		
etoposide cap 50 mg	1	OAC
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
ANTIPARKINSON ADJUNCTIVE THERAPY		
carbidopa tab 25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIPARKINSON ANTICHOLINERGICS		
benztropine mesylate tab 0.5 mg	1	MO
benztropine mesylate tab 1 mg	1	MO
benztropine mesylate tab 2 mg	1	MO
trihexyphenidyl hcl oral soln 0.4 mg/ml	1	MO
trihexyphenidyl hcl tab 2 mg	1	MO
trihexyphenidyl hcl tab 5 mg	1	MO
ANTIPARKINSON COMT INHIBITORS		
entacapone tab 200 mg	1	MO
tolcapone tab 100 mg	1	MO
ANTIPARKINSON DOPAMINERGICS		
amantadine hcl cap 100 mg	1	MO
amantadine hcl soln 50 mg/5ml	1	MO
amantadine hcl tab 100 mg	1	MO
bromocriptine mesylate cap 5 mg (base equivalent)	1	MO
bromocriptine mesylate tab 2.5 mg (base equivalent)	1	MO
carbidopa & levodopa orally disintegrating tab 10-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-250 mg	1	MO
carbidopa & levodopa tab 10-100 mg	1	MO
carbidopa & levodopa tab 25-100 mg	1	MO
carbidopa & levodopa tab 25-250 mg	1	MO
carbidopa & levodopa tab er 25-100 mg	1	MO
carbidopa & levodopa tab er 50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	MO
DHIVY TAB 25-100MG ***(carbidopa-levodopa)***	3	MO
INBRIJA CAP 42MG ***(levodopa)***	4	SP, PA, QL (10 caps every 1 day)
NEUPRO DIS 1MG/24HR ***(rotigotine)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NEUPRO DIS 2MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 3MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 4MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 6MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 8MG/24HR ***(rotigotine)***	2	MO
pramipexole dihydrochloride tab 0.5 mg	1	MO
pramipexole dihydrochloride tab 0.25 mg	1	MO
pramipexole dihydrochloride tab 0.75 mg	1	MO
pramipexole dihydrochloride tab 0.125 mg	1	MO
pramipexole dihydrochloride tab 1 mg	1	MO
pramipexole dihydrochloride tab 1.5 mg	1	MO
pramipexole dihydrochloride tab er 24hr 0.75 mg	1	MO
pramipexole dihydrochloride tab er 24hr 0.375 mg	1	MO
pramipexole dihydrochloride tab er 24hr 1.5 mg	1	MO
pramipexole dihydrochloride tab er 24hr 2.25 mg	1	MO
pramipexole dihydrochloride tab er 24hr 3 mg	1	MO
pramipexole dihydrochloride tab er 24hr 3.75 mg	1	MO
pramipexole dihydrochloride tab er 24hr 4.5 mg	1	MO
ropinirole hydrochloride tab 0.5 mg	1	MO
ropinirole hydrochloride tab 0.25 mg	1	MO
ropinirole hydrochloride tab 1 mg	1	MO
ropinirole hydrochloride tab 2 mg	1	MO
ropinirole hydrochloride tab 3 mg	1	MO
ropinirole hydrochloride tab 4 mg	1	MO
ropinirole hydrochloride tab 5 mg	1	MO
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	1	MO
RYTARY CAP 95MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 145MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 195MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 245MG ***(carbidopa-levodopa)***	2	MO
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
rasagiline mesylate tab 0.5 mg (base equiv)	1	MO
rasagiline mesylate tab 1 mg (base equiv)	1	MO
selegiline hcl cap 5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
selegiline hcl tab 5 mg	1	MO
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES		
ANTIMANIC AGENTS		
lithium carbonate cap 150 mg	1	MO
lithium carbonate cap 300 mg	1	MO
lithium carbonate cap 600 mg	1	MO
lithium carbonate tab 300 mg	1	MO
lithium carbonate tab er 300 mg	1	MO
lithium carbonate tab er 450 mg	1	MO
lithium oral solution 8 meq/5ml	1	MO
ANTIPSYCHOTICS - MISC.		
lurasidone hcl tab 20 mg	1	MO
lurasidone hcl tab 40 mg	1	MO
lurasidone hcl tab 60 mg	1	MO
lurasidone hcl tab 80 mg	1	MO
lurasidone hcl tab 120 mg	1	MO
VRAYLAR CAP 1.5MG ***(cariprazine hcl)***	2	ST, MO; PA**
VRAYLAR CAP 3MG ***(cariprazine hcl)***	2	ST, MO; PA**
VRAYLAR CAP 4.5MG ***(cariprazine hcl)***	2	ST, MO; PA**
VRAYLAR CAP 6MG ***(cariprazine hcl)***	2	ST, MO; PA**
ziprasidone hcl cap 20 mg	1	MO
ziprasidone hcl cap 40 mg	1	MO
ziprasidone hcl cap 60 mg	1	MO
ziprasidone hcl cap 80 mg	1	MO
BENZISOXAZOLES		
paliperidone tab er 24hr 1.5 mg	1	MO
paliperidone tab er 24hr 3 mg	1	MO
paliperidone tab er 24hr 6 mg	1	MO
paliperidone tab er 24hr 9 mg	1	MO
risperidone orally disintegrating tab 0.5 mg	1	MO
risperidone orally disintegrating tab 0.25 mg	1	MO
risperidone orally disintegrating tab 1 mg	1	MO
risperidone orally disintegrating tab 2 mg	1	MO
risperidone orally disintegrating tab 3 mg	1	MO
risperidone orally disintegrating tab 4 mg	1	MO
risperidone soln 1 mg/ml	1	MO
risperidone tab 0.5 mg	1	MO
risperidone tab 0.25 mg	1	MO
risperidone tab 1 mg	1	MO
risperidone tab 2 mg	1	MO
risperidone tab 3 mg	1	MO
risperidone tab 4 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BUTYROPHENONES		
haloperidol lactate oral conc 2 mg/ml	1	MO
haloperidol tab 0.5 mg	1	MO
haloperidol tab 1 mg	1	MO
haloperidol tab 2 mg	1	MO
haloperidol tab 5 mg	1	MO
haloperidol tab 10 mg	1	MO
haloperidol tab 20 mg	1	MO
DIBENZAPINES		
asenapine maleate sl tab 2.5 mg (base equiv)	1	MO
asenapine maleate sl tab 5 mg (base equiv)	1	MO
asenapine maleate sl tab 10 mg (base equiv)	1	MO
clozapine orally disintegrating tab 12.5 mg	1	
clozapine orally disintegrating tab 25 mg	1	
clozapine orally disintegrating tab 100 mg	1	
clozapine orally disintegrating tab 150 mg	1	
clozapine orally disintegrating tab 200 mg	1	
clozapine tab 25 mg	1	
clozapine tab 50 mg	1	
clozapine tab 100 mg	1	
clozapine tab 200 mg	1	
loxapine succinate cap 5 mg	1	MO
loxapine succinate cap 10 mg	1	MO
loxapine succinate cap 25 mg	1	MO
loxapine succinate cap 50 mg	1	MO
olanzapine orally disintegrating tab 5 mg	1	MO
olanzapine orally disintegrating tab 10 mg	1	MO
olanzapine orally disintegrating tab 15 mg	1	MO
olanzapine orally disintegrating tab 20 mg	1	MO
olanzapine tab 2.5 mg	1	MO
olanzapine tab 5 mg	1	MO
olanzapine tab 7.5 mg	1	MO
olanzapine tab 10 mg	1	MO
olanzapine tab 15 mg	1	MO
olanzapine tab 20 mg	1	MO
quetiapine fumarate tab 25 mg	1	MO
quetiapine fumarate tab 50 mg	1	MO
quetiapine fumarate tab 100 mg	1	MO
quetiapine fumarate tab 150 mg	1	MO
quetiapine fumarate tab 200 mg	1	MO
quetiapine fumarate tab 300 mg	1	MO
quetiapine fumarate tab 400 mg	1	MO
quetiapine fumarate tab er 24hr 50 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
quetiapine fumarate tab er 24hr 150 mg	1	MO
quetiapine fumarate tab er 24hr 200 mg	1	MO
quetiapine fumarate tab er 24hr 300 mg	1	MO
quetiapine fumarate tab er 24hr 400 mg	1	MO
DIHYDROINDOLONES		
molindone hcl tab 5 mg	1	MO
molindone hcl tab 10 mg	1	MO
molindone hcl tab 25 mg	1	MO
PHENOTHIAZINES		
chlorpromazine hcl tab 10 mg	1	MO
chlorpromazine hcl tab 25 mg	1	MO
chlorpromazine hcl tab 50 mg	1	MO
chlorpromazine hcl tab 100 mg	1	MO
chlorpromazine hcl tab 200 mg	1	MO
fluphenazine hcl elixir 2.5 mg/5ml	1	MO
fluphenazine hcl oral conc 5 mg/ml	1	MO
fluphenazine hcl tab 1 mg	1	MO
fluphenazine hcl tab 2.5 mg	1	MO
fluphenazine hcl tab 5 mg	1	MO
fluphenazine hcl tab 10 mg	1	MO
perphenazine tab 2 mg	1	MO
perphenazine tab 4 mg	1	MO
perphenazine tab 8 mg	1	MO
perphenazine tab 16 mg	1	MO
prochlorperazine maleate tab 5 mg (base equivalent)	1	MO
prochlorperazine maleate tab 10 mg (base equivalent)	1	MO
prochlorperazine suppos 25 mg	1	
(Prochlorperazine Suppos 25 mg) COMPRO	1	
thioridazine hcl tab 10 mg	1	MO
thioridazine hcl tab 25 mg	1	MO
thioridazine hcl tab 50 mg	1	MO
thioridazine hcl tab 100 mg	1	MO
trifluoperazine hcl tab 1 mg (base equivalent)	1	MO
trifluoperazine hcl tab 2 mg (base equivalent)	1	MO
trifluoperazine hcl tab 5 mg (base equivalent)	1	MO
trifluoperazine hcl tab 10 mg (base equivalent)	1	MO
QUINOLINONE DERIVATIVES		
aripiprazole oral solution 1 mg/ml	1	MO
aripiprazole orally disintegrating tab 10 mg	1	MO
aripiprazole orally disintegrating tab 15 mg	1	MO
aripiprazole tab 2 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
aripiprazole tab 5 mg	1	MO
aripiprazole tab 10 mg	1	MO
aripiprazole tab 15 mg	1	MO
aripiprazole tab 20 mg	1	MO
aripiprazole tab 30 mg	1	MO
THIOXANTHENES		
thiothixene cap 1 mg	1	MO
thiothixene cap 2 mg	1	MO
thiothixene cap 5 mg	1	MO
thiothixene cap 10 mg	1	MO
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIRETROVIRALS		
abacavir sulfate soln 20 mg/ml (base equiv)	4	SP, QL (30 mL every 1 day)
abacavir sulfate tab 300 mg (base equiv)	4	SP, QL (2 tabs every 1 day)
abacavir sulfate-lamivudine tab 600-300 mg	4	SP, QL (1 tab every 1 day)
APTIVUS CAP 250MG ***(tipranavir)***	4	SP
atazanavir sulfate cap 150 mg (base equiv)	4	SP, QL (1 cap every 1 day)
atazanavir sulfate cap 200 mg (base equiv)	4	SP, QL (2 caps every 1 day)
atazanavir sulfate cap 300 mg (base equiv)	4	SP, QL (1 cap every 1 day)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day); (30-120-15 mg)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day); (50-200-25 mg)
CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	4	SP, QL (1 tab every 1 day)
CRIXIVAN CAP 200MG ***(indinavir sulfate)***	4	SP, PA
CRIXIVAN CAP 400MG ***(indinavir sulfate)***	4	SP, PA
darunavir tab 600 mg	4	SP, QL (2 tabs every 1 day)
darunavir tab 800 mg	4	SP, QL (1 tab every 1 day)
DESCOVY TAB 120-15MG ***(emtricitabine-tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day)
DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day); $0 copay for PrEP
DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)***	4	SP, QL (1 tab every 1 day)
efavirenz tab 600 mg	4	SP, QL (1 tab every 1 day)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	4	SP, QL (1 tab every 1 day)
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	4	SP, QL (1 tab every 1 day)
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	4	SP, QL (1 tab every 1 day)
emtricitabine caps 200 mg	4	SP, QL (1 cap every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	4	SP, QL (1 tab every 1 day)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	4	SP, QL (1 tab every 1 day)
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	4	SP, QL (1 tab every 1 day)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	4	SP, QL (1 tab every 1 day); $0 copay for PrEP
etravirine tab 100 mg	4	SP, QL (4 tabs every 1 day)
etravirine tab 200 mg	4	SP, QL (2 tabs every 1 day)
fosamprenavir calcium tab 700 mg (base equiv)	4	SP, QL (4 tabs every 1 day)
GENVOYA TAB ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)***	4	SP, QL (1 tab every 1 day)
ISENTRESS CHW 25MG ***(raltegravir potassium)***	4	SP, QL (6 tabs every 1 day)
ISENTRESS CHW 100MG ***(raltegravir potassium)***	4	SP, QL (6 tabs every 1 day)
ISENTRESS HD TAB 600MG ***(raltegravir potassium)***	4	SP, QL (2 tabs every 1 day)
ISENTRESS POW 100MG ***(raltegravir potassium)***	4	SP, QL (2 packets every 1 day)
ISENTRESS TAB 400MG ***(raltegravir potassium)***	4	SP, QL (4 tabs every 1 day)
lamivudine tab 150 mg	4	SP, QL (2 tabs every 1 day)
lamivudine tab 300 mg	4	SP, QL (1 tab every 1 day)
lamivudine-zidovudine tab 150-300 mg	4	SP, QL (2 tabs every 1 day)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	4	SP, QL (16 mL every 1 day)
lopinavir-ritonavir tab 100-25 mg	4	SP, QL (10 tabs every 1 day)
lopinavir-ritonavir tab 200-50 mg	4	SP, QL (4 tabs every 1 day)
maraviroc tab 150 mg	4	SP, QL (2 tabs every 1 day)
maraviroc tab 300 mg	4	SP, QL (4 tabs every 1 day)
nevirapine susp 50 mg/5ml	4	SP, QL (40 mL every 1 day)
nevirapine tab 200 mg	4	SP, QL (2 tabs every 1 day)
nevirapine tab er 24hr 400 mg	4	SP, QL (1 tab every 1 day)
ODEFSEY TAB ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day)
PREZCOBIX TAB 800-150 ***(darunavir-cobicistat)***	4	SP, QL (1 tab every 1 day)
ritonavir tab 100 mg	4	SP, QL (12 tabs every 1 day)
SYMTUZA TAB ***(darunavir-cobicistat-emtricitabine-tenofovir alafenamide)***	4	SP, QL (1 tab every 1 day)
tenofovir disoproxil fumarate tab 300 mg	4	SP, QL (1 tab every 1 day)
TIVICAY PD TAB 5MG ***(dolutegravir sodium)***	4	SP, QL (12 tabs every 1 day)
TIVICAY TAB 50MG ***(dolutegravir sodium)***	4	SP, QL (2 tabs every 1 day)
TRIUMEQ PD TAB ***(abacavir-dolutegravir-lamivudine)***	4	SP, QL (6 tabs every 1 day)
TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)***	4	SP, QL (1 tab every 1 day)
VIRACEPT TAB 250MG ***(nelfinavir mesylate)***	4	SP, PA
VIRACEPT TAB 625MG ***(nelfinavir mesylate)***	4	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
zidovudine cap 100 mg	4	SP, QL (6 caps every 1 day)
zidovudine syrup 10 mg/ml	4	SP, QL (64 mL every 1 day)
zidovudine tab 300 mg	4	SP, QL (2 tabs every 1 day)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100 ***(nirmatrelvir-ritonavir)***	PV	QL (1 carton every 90 days)
PAXLOVID TAB 300-100 ***(nirmatrelvir-ritonavir)***	PV	QL (1 carton every 90 days)
CMV AGENTS		
valganciclovir hcl for soln 50 mg/ml (base equiv)	1	QL (1000 mL every 30 days), MO
valganciclovir hcl tab 450 mg (base equivalent)	1	QL (4 tabs every 1 day), MO
HEPATITIS AGENTS		
adefovir dipivoxil tab 10 mg	4	SP
entecavir tab 0.5 mg	4	SP, QL (1 tab every 1 day)
entecavir tab 1 mg	4	SP, QL (1 tab every 1 day)
EPCLUSA PAK 150-37.5 ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100 ***(sofosbuvir-velpatasvir)***	4	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
HARVONI TAB 90-400MG ***(ledipasvir-sofosbuvir)***	4	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
lamivudine tab 100 mg (hbv)	4	SP
MAVYRET PAK 50-20MG ***(glecaprevir-pibrentasvir)***	4	SP, PA
MAVYRET TAB 100-40MG ***(glecaprevir-pibrentasvir)***	4	SP, PA
ribavirin cap 200 mg	4	SP, PA
ribavirin tab 200 mg	4	SP, PA
SOVALDI PAK 150MG ***(sofosbuvir)***	4	SP, PA
SOVALDI PAK 200MG ***(sofosbuvir)***	4	SP, PA
SOVALDI TAB 200MG ***(sofosbuvir)***	4	SP, PA
SOVALDI TAB 400MG ***(sofosbuvir)***	4	SP, PA
VEMLIDY TAB 25MG ***(tenofovir alafenamide fumarate)***	4	SP, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VOSEVI TAB ***(sofosbuvir-velpatasvir-voxilaprevir)***	4	SP, PA, QL (1 tab every 1 day); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
ZEPATIER TAB 50-100MG ***(elbasvir-grazoprevir)***	4	SP, PA
HERPES AGENTS		
acyclovir cap 200 mg	1	
acyclovir susp 200 mg/5ml	1	
acyclovir tab 400 mg	1	
acyclovir tab 800 mg	1	
famciclovir tab 125 mg	1	
famciclovir tab 250 mg	1	
famciclovir tab 500 mg	1	
valacyclovir hcl tab 1 gm	1	
valacyclovir hcl tab 500 mg	1	
INFLUENZA AGENTS		
oseltamivir phosphate cap 30 mg (base equiv)	1	
oseltamivir phosphate cap 45 mg (base equiv)	1	
oseltamivir phosphate cap 75 mg (base equiv)	1	
oseltamivir phosphate for susp 6 mg/ml (base equiv)	1	
RELENZA MIS DISKHALE ***(zanamivir)***	2	
rimantadine hydrochloride tab 100 mg	1	
MISC. ANTIVIRALS		
LAGEVRIO CAP 200MG ***(molnupiravir)***	PV	QL (40 caps every 90 days)
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
ALPHA-BETA BLOCKERS		
carvedilol phosphate cap er 24hr 10 mg	1	MO
carvedilol phosphate cap er 24hr 20 mg	1	MO
carvedilol phosphate cap er 24hr 40 mg	1	MO
carvedilol phosphate cap er 24hr 80 mg	1	MO
carvedilol tab 3.125 mg	1	MO
carvedilol tab 6.25 mg	1	MO
carvedilol tab 12.5 mg	1	MO
carvedilol tab 25 mg	1	MO
labetalol hcl tab 100 mg	1	MO
labetalol hcl tab 200 mg	1	MO
labetalol hcl tab 300 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol hcl cap 200 mg	1	MO
acebutolol hcl cap 400 mg	1	MO
atenolol tab 25 mg	1	MO
atenolol tab 50 mg	1	MO
atenolol tab 100 mg	1	MO
betaxolol hcl tab 10 mg	1	MO
betaxolol hcl tab 20 mg	1	MO
bisoprolol fumarate tab 5 mg	1	MO
bisoprolol fumarate tab 10 mg	1	MO
metoprolol succinate tab er 24hr 25 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 50 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 100 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 200 mg (tartrate equiv)	1	MO
metoprolol tartrate tab 25 mg	1	MO
metoprolol tartrate tab 37.5 mg	1	MO
metoprolol tartrate tab 50 mg	1	MO
metoprolol tartrate tab 75 mg	1	MO
metoprolol tartrate tab 100 mg	1	MO
nebivolol hcl tab 2.5 mg (base equivalent)	1	MO
nebivolol hcl tab 5 mg (base equivalent)	1	MO
nebivolol hcl tab 10 mg (base equivalent)	1	MO
nebivolol hcl tab 20 mg (base equivalent)	1	MO
BETA BLOCKERS NON-SELECTIVE		
nadolol tab 20 mg	1	MO
nadolol tab 40 mg	1	MO
nadolol tab 80 mg	1	MO
pindolol tab 5 mg	1	MO
pindolol tab 10 mg	1	MO
propranolol hcl cap er 24hr 60 mg	1	MO
propranolol hcl cap er 24hr 80 mg	1	MO
propranolol hcl cap er 24hr 120 mg	1	MO
propranolol hcl cap er 24hr 160 mg	1	MO
propranolol hcl oral soln 20 mg/5ml	1	MO
propranolol hcl oral soln 40 mg/5ml	1	MO
propranolol hcl tab 10 mg	1	MO
propranolol hcl tab 20 mg	1	MO
propranolol hcl tab 40 mg	1	MO
propranolol hcl tab 60 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
propranolol hcl tab 80 mg	1	MO
sotalol hcl (afib/afl) tab 80 mg	1	MO
sotalol hcl (afib/afl) tab 120 mg	1	MO
sotalol hcl (afib/afl) tab 160 mg	1	MO
sotalol hcl tab 80 mg	1	MO
sotalol hcl tab 120 mg	1	MO
sotalol hcl tab 160 mg	1	MO
sotalol hcl tab 240 mg	1	MO
timolol maleate tab 5 mg	1	MO
timolol maleate tab 10 mg	1	MO
timolol maleate tab 20 mg	1	MO

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

amlodipine besylate tab 2.5 mg (base equivalent)	1	MO
amlodipine besylate tab 5 mg (base equivalent)	1	MO
amlodipine besylate tab 10 mg (base equivalent)	1	MO
diltiazem hcl cap er 12hr 60 mg	1	MO
diltiazem hcl cap er 12hr 90 mg	1	MO
diltiazem hcl cap er 12hr 120 mg	1	MO
diltiazem hcl cap er 24hr 120 mg	1	MO
(Diltiazem Hcl Cap Er 24hr 120 mg) DILT-XR	1	MO
diltiazem hcl cap er 24hr 180 mg	1	MO
(Diltiazem Hcl Cap Er 24hr 180 mg) DILT-XR	1	MO
diltiazem hcl cap er 24hr 240 mg	1	MO
(Diltiazem Hcl Cap Er 24hr 240 mg) DILT-XR	1	MO
diltiazem hcl coated beads cap er 24hr 120 mg	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg) CARTIA XT	1	MO
diltiazem hcl coated beads cap er 24hr 180 mg	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg) CARTIA XT	1	MO
diltiazem hcl coated beads cap er 24hr 240 mg	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg) CARTIA XT	1	MO
diltiazem hcl coated beads cap er 24hr 300 mg	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg) CARTIA XT	1	MO
diltiazem hcl coated beads cap er 24hr 360 mg	1	MO
diltiazem hcl extended release beads cap er 24hr 120 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg) TIADYLT ER	1	MO
diltiazem hcl extended release beads cap er 24hr 180 mg	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg) TIADYLT ER	1	MO
diltiazem hcl extended release beads cap er 24hr 240 mg	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg) TIADYLT ER	1	MO
diltiazem hcl extended release beads cap er 24hr 300 mg	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg) TIADYLT ER	1	MO
diltiazem hcl extended release beads cap er 24hr 360 mg	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg) TIADYLT ER	1	MO
diltiazem hcl extended release beads cap er 24hr 420 mg	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg) TIADYLT ER	1	MO
diltiazem hcl tab 30 mg	1	MO
diltiazem hcl tab 60 mg	1	MO
diltiazem hcl tab 90 mg	1	MO
diltiazem hcl tab 120 mg	1	MO
felodipine tab er 24hr 2.5 mg	1	MO
felodipine tab er 24hr 5 mg	1	MO
felodipine tab er 24hr 10 mg	1	MO
isradipine cap 2.5 mg	1	MO
isradipine cap 5 mg	1	MO
levamlodipine maleate tab 2.5 mg	1	MO
levamlodipine maleate tab 5 mg	1	MO
nicardipine hcl cap 20 mg	1	MO
nicardipine hcl cap 30 mg	1	MO
nifedipine cap 10 mg	1	MO
nifedipine cap 20 mg	1	MO
nifedipine tab er 24hr 30 mg	1	MO
nifedipine tab er 24hr 60 mg	1	MO
nifedipine tab er 24hr 90 mg	1	MO
nifedipine tab er 24hr osmotic release 30 mg	1	MO
nifedipine tab er 24hr osmotic release 60 mg	1	MO
nifedipine tab er 24hr osmotic release 90 mg	1	MO
nimodipine cap 30 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
nimodipine oral soln 60 mg/20ml (3 mg/ml)	1	
nisoldipine tab er 24hr 8.5 mg	1	MO
nisoldipine tab er 24hr 17 mg	1	MO
nisoldipine tab er 24hr 20 mg	1	MO
nisoldipine tab er 24hr 25.5 mg	1	MO
nisoldipine tab er 24hr 30 mg	1	MO
nisoldipine tab er 24hr 34 mg	1	MO
nisoldipine tab er 24hr 40 mg	1	MO
verapamil hcl cap er 24hr 100 mg	1	MO
verapamil hcl cap er 24hr 120 mg	1	MO
verapamil hcl cap er 24hr 180 mg	1	MO
verapamil hcl cap er 24hr 200 mg	1	MO
verapamil hcl cap er 24hr 240 mg	1	MO
verapamil hcl cap er 24hr 300 mg	1	MO
verapamil hcl cap er 24hr 360 mg	1	MO
verapamil hcl tab 40 mg	1	MO
verapamil hcl tab 80 mg	1	MO
verapamil hcl tab 120 mg	1	MO
verapamil hcl tab er 120 mg	1	MO
verapamil hcl tab er 180 mg	1	MO
verapamil hcl tab er 240 mg	1	MO
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS		
CARDIAC GLYCOSIDES		
digoxin oral soln 0.05 mg/ml	1	MO
digoxin tab 62.5 mcg (0.0625 mg)	1	MO
digoxin tab 125 mcg (0.125 mg)	1	MO
digoxin tab 250 mcg (0.25 mg)	1	MO
CARDIOVASCULAR		
ANTILIPEMICS, PCSK9 INHIBITORS		
REPATHA INJ 140MG/ML ***(evolocumab)***	4	SP, QL (3 syringes every 28 days)
REPATHA PUSH INJ 420/3.5 ***(evolocumab)***	4	SP, QL (1 cartridge every 28 days)
REPATHA SURE INJ 140MG/ML ***(evolocumab)***	4	SP, QL (3 pens every 28 days)
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine besylate-atorvastatin calcium tab 5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-80 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-80 mg	1	MO
ENTRESTO CAP 6-6MG ***(sacubitril-valsartan)***	2	PA, MO
ENTRESTO CAP 15-16MG ***(sacubitril-valsartan)***	2	PA, MO
ENTRESTO TAB 24-26MG ***(sacubitril-valsartan)***	2	PA, MO
ENTRESTO TAB 49-51MG ***(sacubitril-valsartan)***	2	PA, MO
ENTRESTO TAB 97-103MG ***(sacubitril-valsartan)***	2	PA, MO
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	1	MO
OPSYNVI TAB 10-20MG ***(macitentan-tadalafil)***	4	SP, PA, QL (1 tab every 1 day)
OPSYNVI TAB 10-40MG ***(macitentan-tadalafil)***	4	SP, PA, QL (1 tab every 1 day)
IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION		
sildenafil citrate tab 25 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
sildenafil citrate tab 50 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
sildenafil citrate tab 100 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
tadalafil tab 2.5 mg	1	PA, QL (1 tab every 1 day), MO; Only covered if member has supplemental benefit.
tadalafil tab 5 mg	1	PA, QL (1 tab every 1 day), MO; Only covered if member has supplemental benefit.
tadalafil tab 10 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tadalafil tab 20 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
vardenafil hcl orally disintegrating tab 10 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
vardenafil hcl tab 2.5 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
vardenafil hcl tab 5 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
vardenafil hcl tab 10 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
vardenafil hcl tab 20 mg	1	PA, QL (8 tabs every 21 days); Only covered if member has supplemental benefit.
PROSTAGLANDIN VASODILATORS		
ORENITRAM TAB 0.25MG ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB 0.125MG ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB 1MG ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB 2.5MG ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB 5MG ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB MONTH 1 ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB MONTH 2 ***(treprostinil diolamine)***	4	SP, PA
ORENITRAM TAB MONTH 3 ***(treprostinil diolamine)***	4	SP, PA
TYVASO DPI POW 16-32-48 ***(treprostinil)***	4	SP, PA, QL (9 cartridges every 1 day)
TYVASO DPI POW 16MCG ***(treprostinil)***	4	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 32MCG ***(treprostinil)***	4	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 48MCG ***(treprostinil)***	4	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 64MCG ***(treprostinil)***	4	SP, PA, QL (4 cartridges every 1 day)
TYVASO RF KT SOL 0.6MG/ML ***(treprostinil)***	4	SP, PA, QL (2.9 mL every 1 day)
TYVASO SOL 0.6MG/ML ***(treprostinil)***	4	SP, PA, QL (2.9 mL every 1 day)
TYVASO ST KT SOL 0.6MG/ML ***(treprostinil)***	4	SP, PA, QL (2.9 mL every 1 day)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab 5 mg	4	SP, PA, QL (1 tab every 1 day)
ambrisentan tab 10 mg	4	SP, PA, QL (1 tab every 1 day)
bosentan tab 62.5 mg	4	SP, PA, QL (2 tabs every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bosentan tab 125 mg	4	SP, PA, QL (2 tabs every 1 day)
OPSUMIT TAB 10MG ***(macitentan)***	4	SP, PA, QL (1 tab every 1 day)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil citrate for suspension 10 mg/ml	4	SP, PA, QL (224 mL every 30 days)
sildenafil citrate tab 20 mg	4	SP, PA, QL (12 tabs every 1 day)
tadalafil tab 20 mg (pah)	4	SP, PA, QL (2 tabs every 1 day)
(Tadalafil Tab 20 mg (Pah)) ALYQ	4	SP, PA, QL (2 tabs every 1 day)
TADLIQ SUS 20MG/5ML ***(tadalafil (pulmonary hypertension))***	4	SP, PA, QL (10 mL every 1 day)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI PACK TAB 200/800 ***(selexipag)***	4	SP, PA, QL (1 pack every 28 days)
UPTRAVI TAB 200MCG ***(selexipag)***	4	SP, PA, QL (5 tabs every 1 day)
UPTRAVI TAB 400MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 600MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 800MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1000MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1200MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1400MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1600MCG ***(selexipag)***	4	SP, PA, QL (2 tabs every 1 day)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG ***(riociguat)***	4	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1.5MG ***(riociguat)***	4	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1MG ***(riociguat)***	4	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2.5MG ***(riociguat)***	4	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2MG ***(riociguat)***	4	SP, PA, QL (3 tabs every 1 day)
SINUS NODE INHIBITORS		
ivabradine hcl tab 5 mg (base equiv)	1	MO
ivabradine hcl tab 7.5 mg (base equiv)	1	MO
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG ***(vericiguat)***	2	MO
VERQUVO TAB 5MG ***(vericiguat)***	2	MO
VERQUVO TAB 10MG ***(vericiguat)***	2	MO
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap 500 mg	1	
cefadroxil for susp 250 mg/5ml	1	
cefadroxil for susp 500 mg/5ml	1	
cefadroxil tab 1 gm	1	
cephalexin cap 250 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
cephalexin cap 500 mg	1	
cephalexin cap 750 mg	1	
cephalexin for susp 125 mg/5ml	1	
cephalexin for susp 250 mg/5ml	1	
cephalexin tab 250 mg	1	
cephalexin tab 500 mg	1	
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap 250 mg	1	
cefaclor cap 500 mg	1	
cefaclor for susp 250 mg/5ml	1	
cefprozil for susp 125 mg/5ml	1	
cefprozil for susp 250 mg/5ml	1	
cefprozil tab 250 mg	1	
cefprozil tab 500 mg	1	
cefuroxime axetil tab 250 mg	1	
cefuroxime axetil tab 500 mg	1	
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap 300 mg	1	
cefdinir for susp 125 mg/5ml	1	
cefdinir for susp 250 mg/5ml	1	
cefixime cap 400 mg	1	
cefixime for susp 100 mg/5ml	1	
cefixime for susp 200 mg/5ml	1	
cefpodoxime proxetil for susp 50 mg/5ml	1	
cefpodoxime proxetil for susp 100 mg/5ml	1	
cefpodoxime proxetil tab 100 mg	1	
cefpodoxime proxetil tab 200 mg	1	
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
COMBINATION CONTRACEPTIVES - ORAL		
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) AZURETTE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) KARIVA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) PIMTREA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) SIMLIYA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VIORELE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VOLNEA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) APRI	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CYRED EQ	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ENSKYCE	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ISIBLOOM	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) JULEBER	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KALLIGA	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) RECLIPSEN	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	PV	MO
drospirenone-ethinyl estradiol tab 3-0.02 mg	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) JASMIEL	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LO-ZUMANDIMINE	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LORYNA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) NIKKI	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) VESTURA	PV	MO
drospirenone-ethinyl estradiol tab 3-0.03 mg	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) OCELLA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZUMANDIMINE	PV	MO
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) KELNOR 1/35	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35	PV	MO
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) KELNOR 1/50	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) VALTYA 1/50	PV	MO
FALESSA KIT ***(levonorgestrel-ethinyl estradiol & folic acid)***	PV	MO
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg	PV	MO
(Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg) RIVELSA	PV	MO
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE LO	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) LOJAIMIESS	PV	MO
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) ASHLYNA	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) DAYSEE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) JAIMIESS	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) SIMPESSE	PV	MO
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) ICLEVIA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) INTROVALE	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) JOLESSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) SETLAKIN	PV	MO
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AFIRMELLE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AUBRA EQ	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AVIANE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) DELYLA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) FALMINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LESSINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LUTERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) SRONYX	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) VIENVA	PV	MO
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ALTAVERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) AYUNA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CHATEAL EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KURVELO	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) LEVORA 0.15/30-28	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) MARLISSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) PORTIA-28	PV	MO
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) ENPRESSE-28	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) TRIVORA-28	PV	MO
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) DOLISHALE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)	PV	MO
(Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) JOYEAUX	PV	MO
(Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) MINZOYA	PV	MO
LO LOESTRIN TAB 1-10-10 ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))***	PV	MO
NATAZIA TAB ***(estradiol valerate-dienogest)***	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BALZIVA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BRIELLYN	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) PHILITH	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) VYFEMLA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NECON 0.5/35-28	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NORTREL 0.5/35 (28)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) WERA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) ALYACEN 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) DASETTA 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NORTREL 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NYLIA 1/35	PV	MO
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) WYMZYA FE	PV	MO
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) KAITLIB FE	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) LAYOLIS FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) TILIA FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) TRI-LEGEST FE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) XARAH FE	PV	MO
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) AUROVELA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) JUNEL 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LARIN 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LOESTRIN 1/20-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) MICROGESTIN 1/20	PV	MO
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) AUROVELA 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) HAILEY 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) JUNEL 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LARIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LOESTRIN 1.5/30-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) MICROGESTIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) AUROVELA FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) BLISOVI FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) FEIRZA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) HAILEY FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) JUNEL FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LARIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LOESTRIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) MICROGESTIN FE 1/20	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) TARINA FE 1/20 EQ	PV	MO
norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) AUROVELA FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) BLISOVI FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) FEIRZA 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) HAILEY FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) JUNEL FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LARIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LOESTRIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) MICROGESTIN FE 1.5/30	PV	MO
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) CHARLOTTE 24 FE	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) FINZALA	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) MIBELAS 24 FE	PV	MO
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) GEMMILY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) MERZEE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) TAYSOFY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) AUROVELA 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) BLISOVI 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) HAILEY 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) JUNEL FE 24	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) LARIN 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) TARINA 24 FE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) ALYACEN 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) DASETTA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NORTREL 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NYLIA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) ARANELLE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) LEENA	PV	MO
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) ESTARYLLA	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MILI	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MONO-LINYAH	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) SPRINTEC 28	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) VYLIBRA	PV	MO
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-ESTARYLLA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MARZIA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-SPRINTEC	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-VYLIBRA LO	PV	MO
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-ESTARYLLA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-LINYAH	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-SPRINTEC	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-VYLIBRA	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) CRYSELLE-28	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) ELINEST	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) LOW-OGESTREL	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) TURQOZ	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg) OGESTREL	PV	MO
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) XULANE	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) ZAFEMY	PV	MO
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)***	PV	QL (1 ring every 300 days), MO; Quantity max 1 per fill; Quantity max 1 per 300 days
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ELURYNG	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ENILLORING	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) HALOETTE	PV	QL (13 rings every 300 days), MO
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG ***(ulipristal acetate)***	PV	
(Levonorgestrel Tab 1.5 mg) OPTION 2	PV	MO
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab 0.35 mg	PV	MO
(Norethindrone Tab 0.35 mg) CAMILA	PV	MO
(Norethindrone Tab 0.35 mg) DEBLITANE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Tab 0.35 mg) EMZAHH	PV	MO
(Norethindrone Tab 0.35 mg) ERRIN	PV	MO
(Norethindrone Tab 0.35 mg) HEATHER	PV	MO
(Norethindrone Tab 0.35 mg) INCASSIA	PV	MO
(Norethindrone Tab 0.35 mg) JENCYCLA	PV	MO
(Norethindrone Tab 0.35 mg) LYLEQ	PV	MO
(Norethindrone Tab 0.35 mg) LYZA	PV	MO
(Norethindrone Tab 0.35 mg) NORA-BE	PV	MO
(Norethindrone Tab 0.35 mg) NORLYROC	PV	MO
(Norethindrone Tab 0.35 mg) SHAROBEL	PV	MO
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
GLUCOCORTICOSTEROIDS		
budesonide delayed release particles cap 3 mg	1	
deflazacort susp 22.75 mg/ml	4	SP, PA, QL (54 mL every 30 days)
deflazacort tab 6 mg	4	SP, PA, QL (2 tabs every 1 day)
deflazacort tab 18 mg	4	SP, PA, QL (1 tab every 1 day)
deflazacort tab 30 mg	4	SP, PA, QL (1 tab every 1 day)
deflazacort tab 36 mg	4	SP, PA, QL (1 tab every 1 day)
dexamethasone elixir 0.5 mg/5ml	1	
dexamethasone soln 0.5 mg/5ml	1	
dexamethasone tab 0.5 mg	1	
dexamethasone tab 0.75 mg	1	
dexamethasone tab 1 mg	1	
dexamethasone tab 1.5 mg	1	
dexamethasone tab 2 mg	1	
dexamethasone tab 4 mg	1	
dexamethasone tab 6 mg	1	
dexamethasone tab therapy pack 1.5 mg (21)	1	
(Dexamethasone Tab Therapy Pack 1.5 mg (21)) HIDEX 6-DAY	1	
dexamethasone tab therapy pack 1.5 mg (35)	1	
dexamethasone tab therapy pack 1.5 mg (51)	1	
EMFLAZA SUS 22.75/ML ***(deflazacort)***	4	SP, PA
hydrocortisone tab 5 mg	1	
hydrocortisone tab 10 mg	1	
hydrocortisone tab 20 mg	1	
MEDROL TAB 2MG ***(methylprednisolone)***	3	
methylprednisolone tab 4 mg	1	
methylprednisolone tab 8 mg	1	
methylprednisolone tab 16 mg	1	
methylprednisolone tab 32 mg	1	
methylprednisolone tab therapy pack 4 mg (21)	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
prednisolone sod phos orally disintegr tab 10 mg (base eq)	1	
prednisolone sod phos orally disintegr tab 15 mg (base eq)	1	
prednisolone sod phos orally disintegr tab 30 mg (base eq)	1	
prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)	1	
prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)	1	
prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)	1	
prednisolone soln 15 mg/5ml	1	
prednisolone tab 5 mg	1	
prednisone oral soln 5 mg/5ml	1	
prednisone tab 1 mg	1	
prednisone tab 2.5 mg	1	
prednisone tab 5 mg	1	
prednisone tab 10 mg	1	
prednisone tab 20 mg	1	
prednisone tab 50 mg	1	
prednisone tab therapy pack 5 mg (21)	1	
prednisone tab therapy pack 5 mg (48)	1	
prednisone tab therapy pack 10 mg (21)	1	
prednisone tab therapy pack 10 mg (48)	1	
MINERALOCORTICOIDS		
fludrocortisone acetate tab 0.1 mg	1	MO
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS		
ANTITUSSIVES - DRUGS TO TREAT COUGH		
benzonatate cap 100 mg	1	
benzonatate cap 150 mg	1	
benzonatate cap 200 mg	1	
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	1	Not available under age 6
(Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 mg/5ml) HYDROMET	1	Not available under age 6
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	1	Not available under age 6
COUGH/COLD/ALLERGY COMBINATIONS		
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	1	Not available under age 12
promethazine & phenylephrine syrup 6.25-5 mg/5ml	1	
(Promethazine & Phenylephrine Syrup 6.25-5 mg/5ml) PROMETHAZINE VC	1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	1	Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
promethazine-dm syrup 6.25-15 mg/5ml	1	
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1	
EXPECTORANTS - DRUGS TO TREAT COUGH		
potassium iodide oral soln 1 gm/ml	1	
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS		
sodium chloride soln nebu 0.9%	1	
sodium chloride soln nebu 3%	1	
(Sodium Chloride Soln Nebu 3%) NEBUSAL	1	
sodium chloride soln nebu 7%	1	
(Sodium Chloride Soln Nebu 7%) PULMOSAL	1	
sodium chloride soln nebu 10%	1	
MUCOLYTICS - DRUGS TO TREAT COUGH		
acetylcysteine inhal soln 10%	1	
acetylcysteine inhal soln 20%	1	
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS		
ACNE PRODUCTS		
adapalene cream 0.1%	1	PA; PA Required for age greater than or equal to age 35
adapalene gel 0.1%	1	PA; PA Required for age greater than or equal to age 35
adapalene gel 0.3%	1	PA; PA Required for age greater than or equal to age 35
adapalene-benzoyl peroxide gel 0.1-2.5%	1	
adapalene-benzoyl peroxide gel 0.3-2.5%	1	
AKLIEF CRE 0.005% ***(trifarotene)***	2	PA
benzoyl peroxide foam 9.8%	1	
benzoyl peroxide-erythromycin gel 5-3%	1	
benzoyl peroxide-hydrocortisone lotion 5-0.5%	1	
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1	
(Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%) NEUAC	1	
clindamycin phosphate foam 1%	1	
(Clindamycin Phosphate Foam 1%) CLINDACIN	1	
clindamycin phosphate gel 1%	1	
clindamycin phosphate lotion 1%	1	
clindamycin phosphate soln 1%	1	
clindamycin phosphate swab 1%	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN ETZ PLEDGETS	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Clindamycin Phosphate Swab 1%) CLINDACIN-P	1	
clindamycin phosphate-benzoyl peroxide gel 1-5%	1	
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	1	
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%	1	
clindamycin phosphate-tretinoin gel 1.2-0.025%	1	PA; PA Required for age greater than or equal to age 35
dapsone gel 5%	1	
dapsone gel 7.5%	1	
EPIDUO FORTE GEL 0.3-2.5% ***(adapalene-benzoyl peroxide)***	2	
EPIDUO GEL 0.1-2.5% ***(adapalene-benzoyl peroxide)***	2	
erythromycin gel 2%	1	
(Erythromycin Pads 2%) ERY	1	
erythromycin soln 2%	1	
isotretinoin cap 10 mg	1	PA
(Isotretinoin Cap 10 mg) ACCUTANE	1	PA
(Isotretinoin Cap 10 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 10 mg) CLARAVIS	1	PA
(Isotretinoin Cap 10 mg) ZENATANE	1	PA
isotretinoin cap 20 mg	1	PA
(Isotretinoin Cap 20 mg) ACCUTANE	1	PA
(Isotretinoin Cap 20 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 20 mg) CLARAVIS	1	PA
(Isotretinoin Cap 20 mg) ZENATANE	1	PA
isotretinoin cap 30 mg	1	PA
(Isotretinoin Cap 30 mg) ACCUTANE	1	PA
(Isotretinoin Cap 30 mg) CLARAVIS	1	PA
(Isotretinoin Cap 30 mg) ZENATANE	1	PA
isotretinoin cap 40 mg	1	PA
(Isotretinoin Cap 40 mg) ACCUTANE	1	PA
(Isotretinoin Cap 40 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 40 mg) CLARAVIS	1	PA
(Isotretinoin Cap 40 mg) ZENATANE	1	PA
sulfacetamide sodium lotion 10% (acne)	1	
(Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%) SULFAMEZ WASH	1	
tretinoin cream 0.1%	1	PA; PA Required for age greater than or equal to age 35

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tretinoin cream 0.05%	1	PA; PA Required for age greater than or equal to age 35
tretinoin cream 0.025%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.01%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.05%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.025%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.1%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.04%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.08%	1	PA; PA Required for age greater than or equal to age 35
TWYNEO CRE 0.1-3% ***(tretinoin-benzoyl peroxide)***	2	PA; PA Required for age greater than or equal to age 35
WINLEVI CRE 1% ***(clascoterone)***	2	PA
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac epolamine patch 1.3%	1	
diclofenac sodium soln 1.5%	1	
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream 0.1%	1	
gentamicin sulfate oint 0.1%	1	
mupirocin oint 2%	1	
ANTIFUNGALS - TOPICAL		
ciclopirox gel 0.77%	1	
ciclopirox olamine cream 0.77% (base equiv)	1	
ciclopirox olamine susp 0.77% (base equiv)	1	
ciclopirox shampoo 1%	1	
ciclopirox solution 8%	1	PA
(Ciclopirox Solution 8%) CICLODAN	1	PA
clotrimazole w/ betamethasone cream 1-0.05%	1	
clotrimazole w/ betamethasone lotion 1-0.05%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
econazole nitrate cream 1%	1	
(Iodoquinol-Hydrocortisone In Aloe Vehicle Cream 1-1.9%) IODOQUIMEZ-HC	1	
ketoconazole cream 2%	1	
ketoconazole shampoo 2%	1	
naftifine hcl cream 1%	1	
naftifine hcl cream 2%	1	
naftifine hcl gel 2%	1	
NAFTIN GEL 2% ***(naftifine hcl)***	2	
nystatin cream 100000 unit/gm	1	
nystatin oint 100000 unit/gm	1	
nystatin topical powder 100000 unit/gm	1	
(Nystatin Topical Powder 100000 unit/gm) KLAYESTA	1	
(Nystatin Topical Powder 100000 unit/gm) NYAMYC	1	
(Nystatin Topical Powder 100000 unit/gm) NYSTOP	1	
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1	
oxiconazole nitrate cream 1%	1	
sulconazole nitrate cream 1%	1	
sulconazole nitrate solution 1%	1	
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
bexarotene gel 1%	4	SP, PA
diclofenac sodium (actinic keratoses) gel 3%	1	
fluorouracil cream 5%	1	
fluorouracil soln 2%	1	
fluorouracil soln 5%	1	
ANTIPSORIATICS		
acitretin cap 10 mg	1	PA
acitretin cap 17.5 mg	1	PA
acitretin cap 25 mg	1	PA
calcipotriene oint 0.005%	1	
(Calcipotriene Oint 0.005%) CALCITRENE	1	
calcipotriene soln 0.005% (50 mcg/ml)	1	
COSENTYX INJ 75MG/0.5 ***(secukinumab)***	4	SP, PA, QL (1 syringe every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COSENTYX INJ 150MG/ML ***(secukinumab)***	4	SP, PA, QL (1 syringe every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis
COSENTYX INJ 300DOSE ***(secukinumab)***	4	SP, PA, QL (2 syringes every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis
COSENTYX PEN INJ 150MG/ML ***(secukinumab)***	4	SP, PA, QL (1 pen every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis
COSENTYX PEN INJ 300DOSE ***(secukinumab)***	4	SP, PA, QL (2 pens every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis
COSENTYX UNO INJ 300/2ML ***(secukinumab)***	4	SP, PA, QL (1 pen every 28 days); Preferred for Ankylosing Spondylitis, Hidradenitis Suppurativa, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis
methoxsalen rapid cap 10 mg	1	
SKYRIZI INJ 150MG/ML ***(risankizumab-rzaa)***	4	SP, PA, QL (1 syringe every 63 days); Preferred for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
SKYRIZI PEN INJ 150MG/ML ***(risankizumab-rzaa)***	4	SP, PA, QL (1 pen every 63 days); Preferred for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
SOTYKTU TAB 6MG ***(deucravacitinib)***	4	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tazarotene cream 0.1%	1	PA
tazarotene cream 0.05%	1	PA
tazarotene gel 0.1%	1	PA
tazarotene gel 0.05%	1	PA
TREMFYA INJ 100MG/ML ***(guselkumab)***	4	SP, PA, QL (1 pen every 42 days); Preferred for Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
TREMFYA INJ 100MG/ML ***(guselkumab)***	4	SP, PA, QL (1 syringe every 42 days); Preferred for Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
TREMFYA INJ 200/2ML ***(guselkumab)***	4	SP, PA, QL (1 pen every 21 days); Preferred for Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
TREMFYA INJ 200/2ML ***(guselkumab)***	4	SP, PA, QL (1 syringe every 21 days); Preferred for Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
ZORYVE CRE 0.3% ***(roflumilast (topical))***	2	
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion 2.5%	1	
ZORYVE MIS 0.3% ***(roflumilast (antiseborrheic))***	2	
ANTIVIRALS - TOPICAL		
acyclovir oint 5%	1	
penciclovir cream 1%	1	
BURN PRODUCTS		
mafenide acetate packet for topical soln 5% (50 gm)	1	
silver sulfadiazine cream 1%	1	
(Silver Sulfadiazine Cream 1%) SSD	1	
CORTICOSTEROIDS - TOPICAL		
alclometasone dipropionate cream 0.05%	1	
alclometasone dipropionate oint 0.05%	1	
betamethasone dipropionate augmented cream 0.05%	1	
betamethasone dipropionate augmented gel 0.05%	1	
betamethasone dipropionate augmented lotion 0.05%	1	
betamethasone dipropionate augmented oint 0.05%	1	
betamethasone dipropionate cream 0.05%	1	
betamethasone dipropionate lotion 0.05%	1	
betamethasone valerate aerosol foam 0.12%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
betamethasone valerate cream 0.1% (base equivalent)	1	
betamethasone valerate lotion 0.1% (base equivalent)	1	
betamethasone valerate oint 0.1% (base equivalent)	1	
BRYHALI LOT 0.01% ***(halobetasol propionate)***	2	
clobetasol propionate cream 0.05%	1	
clobetasol propionate emollient base cream 0.05%	1	
clobetasol propionate foam 0.05%	1	
clobetasol propionate gel 0.05%	1	
clobetasol propionate lotion 0.05%	1	
clobetasol propionate oint 0.05%	1	
clobetasol propionate shampoo 0.05%	1	
(Clobetasol Propionate Shampoo 0.05%) CLODAN	1	
clobetasol propionate soln 0.05%	1	
desonide cream 0.05%	1	
desonide lotion 0.05%	1	
desonide oint 0.05%	1	
desoximetasone cream 0.05%	1	
desoximetasone cream 0.25%	1	
desoximetasone gel 0.05%	1	
desoximetasone oint 0.25%	1	
desoximetasone spray 0.25%	1	
ENSTILAR AER ***(calcipotriene-betamethasone dipropionate)***	2	
fluocinolone acetonide cream 0.01%	1	
fluocinolone acetonide cream 0.025%	1	
fluocinolone acetonide oil 0.01% (body oil)	1	
fluocinolone acetonide oil 0.01% (scalp oil)	1	
fluocinolone acetonide oint 0.025%	1	
fluocinolone acetonide soln 0.01%	1	
fluocinonide cream 0.05%	1	
fluocinonide emulsified base cream 0.05%	1	
fluocinonide gel 0.05%	1	
fluocinonide oint 0.05%	1	
fluocinonide soln 0.05%	1	
fluticasone propionate cream 0.05%	1	
fluticasone propionate lotion 0.05%	1	
fluticasone propionate oint 0.005%	1	
halobetasol propionate cream 0.05%	1	
halobetasol propionate oint 0.05%	1	
hydrocortisone butyrate cream 0.1%	1	
hydrocortisone butyrate oint 0.1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocortisone butyrate soln 0.1%	1	
hydrocortisone cream 2.5%	1	
hydrocortisone lotion 2.5%	1	
hydrocortisone oint 2.5%	1	
(Hydrocortisone Soln 2.5%) TEXACORT	1	
hydrocortisone valerate cream 0.2%	1	
hydrocortisone valerate oint 0.2%	1	
lidocaine-hydrocortisone acetate cream 1-1%	1	
mometasone furoate cream 0.1%	1	
mometasone furoate oint 0.1%	1	
mometasone furoate solution 0.1% (lotion)	1	
triamcinolone acetonide cream 0.1%	1	
triamcinolone acetonide cream 0.5%	1	
(Triamcinolone Acetonide Cream 0.5%) TRIDERM	1	
triamcinolone acetonide cream 0.025%	1	
triamcinolone acetonide lotion 0.1%	1	
triamcinolone acetonide lotion 0.025%	1	
triamcinolone acetonide oint 0.1%	1	
triamcinolone acetonide oint 0.5%	1	
triamcinolone acetonide oint 0.025%	1	
ECZEMA AGENTS		
ADBRY INJ 150MG/ML ***(tralokinumab-ldrm)***	4	SP, PA, QL (4 syringes every 28 days)
ADBRY INJ 300/2ML ***(tralokinumab-ldrm)***	4	SP, PA, QL (1 syringe every 28 days)
CIBINQO TAB 50MG ***(abrocitinib)***	4	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 100MG ***(abrocitinib)***	4	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 200MG ***(abrocitinib)***	4	SP, PA, QL (1 tab every 1 day)
DUPIXENT INJ 200/1.14 ***(dupilumab)***	4	SP, PA, QL (2 syringes every 28 days)
DUPIXENT INJ 200MG ***(dupilumab)***	4	SP, PA, QL (2 pens every 28 days)
DUPIXENT INJ 300/2ML ***(dupilumab)***	4	SP, PA, QL (4 pens every 28 days)
DUPIXENT INJ 300/2ML ***(dupilumab)***	4	SP, PA, QL (4 syringes every 28 days)
OPZELURA CRE 1.5% ***(ruxolitinib phosphate (topical))***	2	PA
HAIR GROWTH AGENTS		
LITFULO CAP 50MG ***(ritlecitinib tosylate)***	4	SP, PA, QL (1 cap every 1 day)
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream 3.75%	1	
imiquimod cream 5%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
pimecrolimus cream 1%	1	PA
tacrolimus oint 0.1%	1	PA
tacrolimus oint 0.03%	1	PA
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS		
podofilox gel 0.5%	1	
podofilox soln 0.5%	1	
salicylic acid film forming liquid 27.5%	1	
LOCAL ANESTHETICS - TOPICAL		
ethyl chloride aerosol spray	1	
lidocaine hcl lotion 3%	1	
lidocaine hcl soln 4%	1	QL (50 mL every 25 days)
lidocaine oint 5%	1	QL (50 gm every 25 days)
lidocaine patch 5%	1	PA
(Lidocaine Patch 5%) LIDOCAN	1	PA
(Lidocaine Patch 5%) TRIDACAINE II	1	PA
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30 gm every 25 days)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2% ***(crisaborole)***	2	
ZORYVE CRE 0.15% ***(roflumilast (dermatologic))***	2	
ROSACEA AGENTS		
azelaic acid gel 15%	1	
brimonidine tartrate gel 0.33% (base equivalent)	1	
FINACEA AER 15% ***(azelaic acid)***	2	
metronidazole cream 0.75%	1	
metronidazole gel 0.75%	1	
metronidazole gel 1%	1	
metronidazole lotion 0.75%	1	
ORACEA CAP 40MG ***(doxycycline (rosacea))***	1	
SOOLANTRA CRE 1% ***(ivermectin (rosacea))***	1	
SCABICIDES & PEDICULICIDES		
(Crotamiton Lotion 10%) CROTAN	1	
malathion lotion 0.5%	1	
permethrin cream 5%	1	
spinosad susp 0.9%	1	
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
DIGESTIVE ENZYMES		
CREON CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 6000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CREON CAP 12000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 24000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 36000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
VIOKACE TAB 10440 ***(pancrelipase (lipase-protease-amylase))***	2	MO
VIOKACE TAB 20880 ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 5000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 10000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 15000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 20000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 25000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 40000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 60000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide cap er 12hr 500 mg	1	MO
acetazolamide tab 125 mg	1	MO
acetazolamide tab 250 mg	1	MO
dichlorphenamide tab 50 mg	4	SP, PA, QL (4 tabs every 1 day)
(Dichlorphenamide Tab 50 mg) ORMALVI	4	SP, PA, QL (4 tabs every 1 day)
methazolamide tab 25 mg	1	MO
methazolamide tab 50 mg	1	MO
DIURETIC COMBINATIONS		
amiloride & hydrochlorothiazide tab 5-50 mg	1	MO
spironolactone & hydrochlorothiazide tab 25-25 mg	1	MO
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 75-50 mg	1	MO
LOOP DIURETICS		
bumetanide tab 0.5 mg	1	MO
bumetanide tab 1 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bumetanide tab 2 mg	1	MO
ethacrynic acid tab 25 mg	1	MO
furosemide oral soln 8 mg/ml	1	MO
furosemide oral soln 10 mg/ml	1	MO
furosemide tab 20 mg	1	MO
furosemide tab 40 mg	1	MO
furosemide tab 80 mg	1	MO
torsemide tab 5 mg	1	MO
torsemide tab 10 mg	1	MO
torsemide tab 20 mg	1	MO
torsemide tab 100 mg	1	MO
POTASSIUM SPARING DIURETICS		
amiloride hcl tab 5 mg	1	MO
spironolactone susp 25 mg/5ml	1	MO
spironolactone tab 25 mg	1	MO
spironolactone tab 50 mg	1	MO
spironolactone tab 100 mg	1	MO
triamterene cap 50 mg	1	MO
triamterene cap 100 mg	1	MO
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorthalidone tab 25 mg	1	MO
chlorthalidone tab 50 mg	1	MO
hydrochlorothiazide cap 12.5 mg	1	MO
hydrochlorothiazide tab 12.5 mg	1	MO
hydrochlorothiazide tab 25 mg	1	MO
hydrochlorothiazide tab 50 mg	1	MO
indapamide tab 1.25 mg	1	MO
indapamide tab 2.5 mg	1	MO
metolazone tab 2.5 mg	1	MO
metolazone tab 5 mg	1	MO
metolazone tab 10 mg	1	MO
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES		
BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS		
alendronate sodium oral soln 70 mg/75ml	1	MO
alendronate sodium tab 5 mg	1	MO
alendronate sodium tab 10 mg	1	MO
alendronate sodium tab 35 mg	1	MO
alendronate sodium tab 70 mg	1	MO
calcitonin (salmon) nasal soln 200 unit/act	1	MO
ibandronate sodium tab 150 mg (base equivalent)	1	MO
PROLIA INJ 60MG/ML ***(denosumab)***	4	SP, PA, QL (1 syringe every 6 months)
risedronate sodium tab 5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
risedronate sodium tab 30 mg	1	
risedronate sodium tab 35 mg	1	MO
risedronate sodium tab 150 mg	1	MO
risedronate sodium tab delayed release 35 mg	1	MO
TYMLOS INJ ***(abaloparatide)***	4	SP, PA, QL (1 pen every 30 days)
FERTILITY REGULATORS		
clomiphene citrate tab 50 mg	1	Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
FOLLISTIM AQ INJ 300UNIT ***(follitropin beta)***	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
FOLLISTIM AQ INJ 600UNIT ***(follitropin beta)***	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
FOLLISTIM AQ INJ 900UNIT ***(follitropin beta)***	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
MENOPUR INJ 75UNIT ***(menotropins)***	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
OVIDREL INJ ***(choriogonadotropin alfa)***	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
GNRH/LHRH ANTAGONISTS		
ganirelix acetate soln prefilled syringe 250 mcg/0.5ml	4	SP, PA; Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
ORILISSA TAB 150MG ***(elagolix sodium)***	2	
ORILISSA TAB 200MG ***(elagolix sodium)***	2	
GROWTH HORMONES		
HUMATROPE INJ 6MG ***(somatropin)***	4	SP, PA
HUMATROPE INJ 12MG ***(somatropin)***	4	SP, PA
HUMATROPE INJ 24MG ***(somatropin)***	4	SP, PA
NORDITROPIN INJ 5/1.5ML ***(somatropin)***	4	SP, PA
NORDITROPIN INJ 10/1.5ML ***(somatropin)***	4	SP, PA
NORDITROPIN INJ 15/1.5ML ***(somatropin)***	4	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NORDITROPIN INJ 30/3ML ***(somatropin)***	4	SP, PA
SOGROYA INJ 5MG/1.5 ***(somapacitan-beco)***	4	SP, PA, QL (4 pens every 28 days)
SOGROYA INJ 10MG/1.5 ***(somapacitan-beco)***	4	SP, PA, QL (4 pens every 28 days)
SOGROYA INJ 15MG/1.5 ***(somapacitan-beco)***	4	SP, PA, QL (4 pens every 28 days)
HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS		
raloxifene hcl tab 60 mg	1	MO; $0 copay ages 35 and older for the primary prevention of breast cancer
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
FENSOLVI INJ 45MG ***(leuprolide acetate (cpp) (6 month))***	4	SP, PA
LUPR DEP-PED INJ 3M 30MG ***(leuprolide acetate (cpp) (3 month))***	4	SP, PA
LUPR DEP-PED INJ 7.5MG ***(leuprolide acetate (cpp))***	4	SP, PA
LUPR DEP-PED INJ 11.25MG ***(leuprolide acetate (cpp))***	4	SP, PA
LUPR DEP-PED INJ 11.25MG ***(leuprolide acetate (cpp) (3 month))***	4	SP, PA
LUPR DEP-PED INJ 15MG ***(leuprolide acetate (cpp))***	4	SP, PA
LUPRON DEPOT INJ 45MG ***(leuprolide acetate (cpp) (6 month))***	4	SP, PA
SYNAREL SOL 2MG/ML ***(nafarelin acetate)***	3	
METABOLIC MODIFIERS		
betaine powder for oral solution	4	SP, PA
calcitriol cap 0.5 mcg	1	MO
calcitriol cap 0.25 mcg	1	MO
calcitriol oral soln 1 mcg/ml	1	MO
carglumic acid soluble tab 200 mg	4	SP, PA
cinacalcet hcl tab 30 mg (base equiv)	4	SP, PA, QL (2 tabs every 1 day)
cinacalcet hcl tab 60 mg (base equiv)	4	SP, PA, QL (2 tabs every 1 day)
cinacalcet hcl tab 90 mg (base equiv)	4	SP, PA, QL (4 tabs every 1 day)
doxercalciferol cap 0.5 mcg	1	MO
doxercalciferol cap 1 mcg	1	MO
doxercalciferol cap 2.5 mcg	1	MO
GALAFOLD CAP 123MG ***(migalastat hcl)***	4	SP, PA
levocarnitine oral soln 1 gm/10ml (10%)	1	MO
nitisinone cap 2 mg	4	SP, PA
nitisinone cap 5 mg	4	SP, PA
nitisinone cap 10 mg	4	SP, PA
nitisinone cap 20 mg	4	SP, PA
ORFADIN SUS 4MG/ML ***(nitisinone)***	4	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
paricalcitol cap 1 mcg	1	MO
paricalcitol cap 2 mcg	1	MO
paricalcitol cap 4 mcg	1	MO
PHEBURANE MIS 483/GM ***(sodium phenylbutyrate)***	4	SP, PA, QL (46.4 gm every 1 day)
sapropterin dihydrochloride powder packet 100 mg	4	SP, PA
(Sapropterin Dihydrochloride Powder Packet 100 mg) JAVYGTOR	4	SP, PA
sapropterin dihydrochloride powder packet 500 mg	4	SP, PA
(Sapropterin Dihydrochloride Powder Packet 500 mg) JAVYGTOR	4	SP, PA
sapropterin dihydrochloride tab 100 mg	4	SP, PA
(Sapropterin Dihydrochloride Tab 100 mg) JAVYGTOR	4	SP, PA
sodium phenylbutyrate oral powder 3 gm/teaspoonful	4	SP, PA, QL (26.6 gm every 1 day)
sodium phenylbutyrate tab 500 mg	4	SP, PA, QL (40 tabs every 1 day)
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG ***(finerenone)***	2	PA, MO
KERENDIA TAB 20MG ***(finerenone)***	2	PA, MO
POSTERIOR PITUITARY HORMONES		
desmopressin acetate nasal spray soln 0.01%	1	MO
desmopressin acetate nasal spray soln 0.01% (refrigerated)	1	MO
desmopressin acetate tab 0.1 mg	1	MO
desmopressin acetate tab 0.2 mg	1	MO
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab 200 mg	1	
PROLACTIN INHIBITORS		
cabergoline tab 0.5 mg	1	
VASOPRESSIN RECEPTOR ANTAGONISTS		
tolvaptan tab 15 mg	4	SP, PA
tolvaptan tab 30 mg	4	SP, PA
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
ESTROGEN COMBINATIONS		
BIJUVA CAP 0.5-100 ***(estradiol-progesterone)***	2	MO
BIJUVA CAP 1-100MG ***(estradiol-progesterone)***	2	MO
CLIMARA PRO DIS WEEKLY ***(estradiol-levonorgestrel)***	2	MO
COMBIPATCH DIS ***(estradiol & norethindrone acetate)***	2	MO
DUAVEE TAB 0.45-20 ***(conjugated estrogens-bazedoxifene)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	MO
estradiol & norethindrone acetate tab 1-0.5 mg	1	MO
(Estradiol & Norethindrone Acetate Tab 1-0.5 mg) MIMVEY	1	MO
MYFEMBREE TAB ***(relugolix-estradiol-norethindrone acetate)***	2	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg) FYAVOLV	1	MO
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) FYAVOLV	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) JINTELI	1	MO
ORIAHNN CAP ***(elagolix sodium-estradiol-norethindrone acetate)***	2	
PREMPHASE TAB ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.3-1.5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.45-1.5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.625-5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	1	MO
estradiol tab 0.5 mg	1	MO
estradiol tab 1 mg	1	MO
estradiol tab 2 mg	1	MO
estradiol td gel 0.5 mg/0.5gm (0.1%)	1	MO
estradiol td gel 0.25 mg/0.25gm (0.1%)	1	MO
estradiol td gel 0.75 mg/0.75gm (0.1%)	1	MO
estradiol td gel 1 mg/gm (0.1%)	1	MO
estradiol td gel 1.25 mg/1.25gm (0.1%)	1	MO
estradiol td patch twice weekly 0.1 mg/24hr	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr) LYLLANA	1	MO
estradiol td patch twice weekly 0.05 mg/24hr	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr) LYLLANA	1	MO
estradiol td patch twice weekly 0.025 mg/24hr	1	MO
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr) LYLLANA	1	MO
estradiol td patch twice weekly 0.075 mg/24hr	1	MO
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr) LYLLANA	1	MO
estradiol td patch twice weekly 0.0375 mg/24hr	1	MO
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) LYLLANA	1	MO
estradiol td patch weekly 0.1 mg/24hr	1	MO
estradiol td patch weekly 0.05 mg/24hr	1	MO
estradiol td patch weekly 0.06 mg/24hr	1	MO
estradiol td patch weekly 0.025 mg/24hr	1	MO
estradiol td patch weekly 0.075 mg/24hr	1	MO
estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)	1	MO
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO (5%) SUS 250MG/5 ***(ciprofloxacin)***	3	
CIPRO (10%) SUS 500MG/5 ***(ciprofloxacin)***	3	
ciprofloxacin hcl tab 250 mg (base equiv)	1	
ciprofloxacin hcl tab 500 mg (base equiv)	1	
ciprofloxacin hcl tab 750 mg (base equiv)	1	
levofloxacin oral soln 25 mg/ml	1	
levofloxacin tab 250 mg	1	
levofloxacin tab 500 mg	1	
levofloxacin tab 750 mg	1	
moxifloxacin hcl tab 400 mg (base equiv)	1	
ofloxacin tab 300 mg	1	
ofloxacin tab 400 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
5-HT4 RECEPTOR AGONISTS		
prucalopride succinate tab 1 mg (base equivalent)	1	MO
prucalopride succinate tab 2 mg (base equivalent)	1	MO
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap 300 mg	1	MO
ursodiol tab 250 mg	1	MO
ursodiol tab 500 mg	1	MO
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn sodium oral conc 100 mg/5ml	1	MO
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap 8 mcg	1	PA, MO
lubiprostone cap 24 mcg	1	PA, MO
GASTROINTESTINAL STIMULANTS		
metoclopramide hcl orally disintegrating tab 5 mg (base eq)	1	
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)	1	
metoclopramide hcl tab 5 mg (base equivalent)	1	
metoclopramide hcl tab 10 mg (base equivalent)	1	
INFLAMMATORY BOWEL AGENTS		
balsalazide disodium cap 750 mg	1	
mesalamine cap dr 400 mg	1	MO
mesalamine cap er 24hr 0.375 gm	1	MO
mesalamine enema 4 gm	1	
mesalamine suppos 1000 mg	1	
mesalamine tab delayed release 1.2 gm	1	MO
mesalamine tab delayed release 800 mg	1	
SKYRIZI INJ 180/1.2 ***(risankizumab-rzaa (crohn's))***	4	SP, PA, QL (1.2 mL every 56 days); Preferred for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
SKYRIZI INJ 360/2.4 ***(risankizumab-rzaa (crohn's))***	4	SP, PA, QL (2.4 mL every 56 days); Preferred for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis
sulfasalazine tab 500 mg	1	MO
sulfasalazine tab delayed release 500 mg	1	MO
VELSIPITY TAB 2MG ***(etrasimod arginine)***	4	SP, PA, QL (1 tab every 1 day)
INTESTINAL ACIDIFIERS		
lactulose (encephalopathy) solution 10 gm/15ml	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Lactulose (Encephalopathy) Solution 10 gm/15ml) ENULOSE	1	MO
(Lactulose (Encephalopathy) Solution 10 gm/15ml) GENERLAC	1	MO
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron hcl tab 0.5 mg (base equiv)	1	PA, MO
alosetron hcl tab 1 mg (base equiv)	1	PA, MO
LINZESS CAP 72MCG ***(linaclotide)***	2	PA, MO
LINZESS CAP 145MCG ***(linaclotide)***	2	PA, MO
LINZESS CAP 290MCG ***(linaclotide)***	2	PA, MO
VIBERZI TAB 75MG ***(eluxadoline)***	2	PA, MO
VIBERZI TAB 100MG ***(eluxadoline)***	2	PA, MO
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB 12.5MG ***(naloxegol oxalate)***	2	
MOVANTIK TAB 25MG ***(naloxegol oxalate)***	2	
SYMPROIC TAB 0.2MG ***(naldemedine tosylate)***	2	
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
AURYXIA TAB 210MG ***(ferric citrate)***	2	MO
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	1	MO
sevelamer carbonate packet 0.8 gm	1	MO
sevelamer carbonate packet 2.4 gm	1	MO
sevelamer carbonate tab 800 mg	1	MO
sevelamer hcl tab 400 mg	1	MO
sevelamer hcl tab 800 mg	1	MO
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
ALKALINIZERS		
(Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg) CYTRA K CRYSTALS	1	
potassium citrate tab er 5 meq (540 mg)	1	
potassium citrate tab er 10 meq (1080 mg)	1	
potassium citrate tab er 15 meq (1620 mg)	1	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG ***(cysteamine bitartrate)***	4	SP, PA
CYSTAGON CAP 150MG ***(cysteamine bitartrate)***	4	SP, PA
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl tab er 24hr 10 mg	1	MO
dutasteride cap 0.5 mg	1	MO
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1	MO
finasteride tab 5 mg	1	MO
silodosin cap 4 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
silodosin cap 8 mg	1	MO
tamsulosin hcl cap 0.4 mg	1	MO
URINARY STONE AGENTS		
tiopronin tab 100 mg	4	SP, PA
tiopronin tab delayed release 100 mg	4	SP, PA
tiopronin tab delayed release 300 mg	4	SP, PA
GOUT AGENTS - DRUGS TO TREAT GOUT		
GOUT AGENT COMBINATIONS		
colchicine w/ probenecid tab 0.5-500 mg	1	MO
GOUT AGENTS - DRUGS TO TREAT GOUT		
allopurinol tab 100 mg	1	MO
allopurinol tab 200 mg	1	MO
allopurinol tab 300 mg	1	MO
colchicine tab 0.6 mg	1	
febuxostat tab 40 mg	1	MO
febuxostat tab 80 mg	1	MO
MITIGARE CAP 0.6MG ***(colchicine)***	1	
URICOSURICS		
probenecid tab 500 mg	1	MO
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS		
HEMATORHEOLOGIC AGENTS		
pentoxifylline tab er 400 mg	1	MO
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO CAP 110MG ***(berotralstat hcl)***	4	SP, PA, QL (1 cap every 1 day)
ORLADEYO CAP 150MG ***(berotralstat hcl)***	4	SP, PA, QL (1 cap every 1 day)
TAKHZYRO INJ 150MG/ML ***(lanadelumab-flyo)***	4	SP, PA, QL (2 syringes every 28 days)
TAKHZYRO INJ 300/2ML ***(lanadelumab-flyo)***	4	SP, PA, QL (2 vials every 28 days)
PLATELET AGGREGATION INHIBITORS		
anagrelide hcl cap 0.5 mg	1	MO
anagrelide hcl cap 1 mg	1	MO
aspirin-dipyridamole cap er 12hr 25-200 mg	1	MO
BRILINTA TAB 60MG ***(ticagrelor)***	2	MO
BRILINTA TAB 90MG ***(ticagrelor)***	2	MO
cilostazol tab 50 mg	1	MO
cilostazol tab 100 mg	1	MO
clopidogrel bisulfate tab 75 mg (base equiv)	1	MO
clopidogrel bisulfate tab 300 mg (base equiv)	1	
dipyridamole tab 25 mg	1	MO
dipyridamole tab 50 mg	1	MO
dipyridamole tab 75 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
prasugrel hcl tab 5 mg (base equiv)	1	MO
prasugrel hcl tab 10 mg (base equiv)	1	MO
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG ***(eliglustat tartrate)***	4	SP, PA, QL (2 caps every 1 day)
miglustat cap 100 mg	4	SP, PA, QL (3 caps every 1 day)
(Miglustat Cap 100 mg) YARGESA	4	SP, PA, QL (3 caps every 1 day)
AGENTS FOR SICKLE CELL DISEASE		
SIKLOS TAB 100MG ***(hydroxyurea (sickle cell disease))***	2	
SIKLOS TAB 1000MG ***(hydroxyurea (sickle cell disease))***	2	
FOLIC ACID/FOLATES		
folic acid cap 0.8 mg	PV	QL (100 caps every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Cap 0.8 mg) FA-8	PV	QL (100 caps every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
folic acid tab 400 mcg	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) FOLATE	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) GNP FOLIC ACID	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) SM FOLIC ACID	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Folic Acid Tab 400 mcg) YL FOLIC ACID	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
folic acid tab 800 mcg	PV	QL (100 tabs every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) CVS FOLIC ACID	PV	QL (100 tabs every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) KP FOLIC ACID	PV	QL (100 tabs every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) QC FOLIC ACID	PV	QL (100 tabs every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days), MO; $0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
HEMATOPOIETIC GROWTH FACTORS		
ALVAIZ TAB 9MG ***(eltrombopag choline)***	4	SP, PA, QL (2 tabs every 1 day)
ALVAIZ TAB 18MG ***(eltrombopag choline)***	4	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 36MG ***(eltrombopag choline)***	4	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 54MG ***(eltrombopag choline)***	4	SP, PA, QL (2 tabs every 1 day)
DOPTELET TAB 20MG ***(avatrombopag maleate)***	4	SP, PA; OAC
DOPTELET TAB 20MG ***(avatrombopag maleate)***	4	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 1 blister card (10 tabs)
DOPTELET TAB 20MG ***(avatrombopag maleate)***	4	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 2 blister card (15 tabs)
DOPTELET TAB 20MG ***(avatrombopag maleate)***	4	SP, PA, QL (3 tabs every 1 day); OAC; 1 carton of 1 blister card (15 tabs)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FYLNETRA INJ 6MG/0.6 ***(pegfilgrastim-pbbk)***	4	SP, PA, QL (2 syringes every 28 days)
HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid oral soln 0.25 gm/ml	1	
aminocaproic acid tab 500 mg	1	
aminocaproic acid tab 1000 mg	1	
tranexamic acid tab 650 mg	1	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS		
BARBITURATE HYPNOTICS		
phenobarbital elixir 20 mg/5ml	1	MO
phenobarbital tab 15 mg	1	MO
phenobarbital tab 16.2 mg	1	MO
phenobarbital tab 30 mg	1	MO
phenobarbital tab 32.4 mg	1	MO
phenobarbital tab 60 mg	1	MO
phenobarbital tab 64.8 mg	1	MO
phenobarbital tab 97.2 mg	1	MO
phenobarbital tab 100 mg	1	MO
HYPNOTICS - TRICYCLIC AGENTS		
doxepin hcl (sleep) tab 3 mg (base equiv)	1	
doxepin hcl (sleep) tab 6 mg (base equiv)	1	
NON-BARBITURATE HYPNOTICS		
estazolam tab 1 mg	1	QL (15 tabs every 25 days)
estazolam tab 2 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 1 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 2 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 3 mg	1	QL (15 tabs every 25 days)
midazolam hcl syrup 2 mg/ml (base equivalent)	1	
temazepam cap 7.5 mg	1	QL (15 caps every 25 days)
temazepam cap 15 mg	1	QL (15 caps every 25 days)
temazepam cap 22.5 mg	1	QL (15 caps every 25 days)
temazepam cap 30 mg	1	QL (15 caps every 25 days)
triazolam tab 0.25 mg	1	QL (10 tabs every 25 days)
triazolam tab 0.125 mg	1	QL (10 tabs every 25 days)
zaleplon cap 5 mg	1	QL (15 caps every 25 days)
zaleplon cap 10 mg	1	QL (15 caps every 25 days)
zolpidem tartrate tab 5 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab 10 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab er 6.25 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab er 12.5 mg	1	QL (15 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB 5MG ***(suvorexant)***	2	PA
BELSOMRA TAB 10MG ***(suvorexant)***	2	PA
BELSOMRA TAB 15MG ***(suvorexant)***	2	PA
BELSOMRA TAB 20MG ***(suvorexant)***	2	PA
DAYVIGO TAB 5MG ***(lemborexant)***	2	PA
DAYVIGO TAB 10MG ***(lemborexant)***	2	PA
QUVIVIQ TAB 25MG ***(daridorexant hcl)***	2	PA
QUVIVIQ TAB 50MG ***(daridorexant hcl)***	2	PA
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab 8 mg	1	QL (15 tabs every 25 days)
tasimelteon capsule 20 mg	4	SP, PA, QL (1 cap every 1 day)
LAXATIVES - DRUGS TO TREAT CONSTIPATION		
LAXATIVE COMBINATIONS		
CLENPIQ SOL ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	PV	$0 copay for members age 45 through 75
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm) GAVILYTE-G	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm) GAVILYTE-C	1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
(Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm) GAVILYTE-N/FLAVOR PACK	1	
PREPOPIK PAK ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	PV	$0 copay for members age 45 through 75
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
LAXATIVES - MISCELLANEOUS		
lactulose solution 10 gm/15ml	1	MO
(Lactulose Solution 10 gm/15ml) CONSTULOSE	1	MO
MACROLIDES - DRUGS TO TREAT INFECTIONS		
AZITHROMYCIN		
azithromycin for susp 100 mg/5ml	1	
azithromycin for susp 200 mg/5ml	1	
azithromycin tab 250 mg	1	
azithromycin tab 500 mg	1	
azithromycin tab 600 mg	1	
CLARITHROMYCIN		
clarithromycin for susp 125 mg/5ml	1	
clarithromycin for susp 250 mg/5ml	1	
clarithromycin tab 250 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clarithromycin tab 500 mg	1	
clarithromycin tab er 24hr 500 mg	1	
ERYTHROMYCINS		
erythromycin ethylsuccinate for susp 200 mg/5ml	1	
erythromycin ethylsuccinate for susp 400 mg/5ml	1	
erythromycin ethylsuccinate tab 400 mg	1	
(Erythromycin Ethylsuccinate Tab 400 mg) E.E.S. 400	1	
erythromycin tab 250 mg	1	
erythromycin tab 500 mg	1	
erythromycin tab delayed release 250 mg	1	
(Erythromycin Tab Delayed Release 250 mg) ERY-TAB	1	
erythromycin tab delayed release 333 mg	1	
(Erythromycin Tab Delayed Release 333 mg) ERY-TAB	1	
erythromycin tab delayed release 500 mg	1	
(Erythromycin Tab Delayed Release 500 mg) ERY-TAB	1	
erythromycin w/ delayed release particles cap 250 mg	1	
FIDAXOMICIN		
DIFICID SUS ***(fidaxomicin)***	2	
DIFICID TAB 200MG ***(fidaxomicin)***	2	
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING		
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
CONDOMS MIS	PV	QL (36 condoms every 75 days), MO
DUREX MIS REALFEEL ***(condoms non-latex lubricated - male)***	PV	QL (36 condoms every 75 days), MO
FC2 FEMALE MIS CONDOM ***(condoms - female)***	PV	QL (36 condoms every 75 days)
FC FEMALE MIS CONDOM ***(condoms - female)***	PV	QL (36 condoms every 75 days)
MALE MIS CONDOM ***(condoms latex lubricated - male)***	PV	QL (36 condoms every 75 days)
TRUSTEX MIS FLAVORS ***(condoms latex non-lubricated - male)***	PV	QL (36 condoms every 75 days), MO
PARENTERAL THERAPY SUPPLIES		
BD INSULIN PEN NEEDLES - OTC ***(insulin pen needle)***	2	
BD INSULIN SYRINGE - OTC ***(insulin syringe/needle u-100)***	2	
BD INSULIN SYRINGE - OTC ***(insulin syringes (disposable))***	2	
BD INSULIN SYRINGE - RX ***(insulin syringe/needle u-100)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BD INSULIN SYRINGE - RX ***(insulin syringe/needle u-500)***	2	
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS LRG MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR PLS MIS MED MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR PLS MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR Z- MIS STAT PLS ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS CHAMBER ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS FLOSIGNA ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS MV ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS PLUS ***(spacer/aerosol-holding chambers)***	2	
AEROVENT MIS PLUS ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS LG MASK ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS MED MASK ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS CHAMBER ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS LG MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS MD MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK LG ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK MED ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK SM ***(spacer/aerosol-holding chambers)***	2	
FLEXICHAMBER MIS ***(spacer/aerosol-holding chambers)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FLEXICHAMBER MIS MASK LRG ***(spacer/aerosol-holding chamber supplies - masks)***	2	
FLEXICHAMBER MIS MASK SM ***(spacer/aerosol-holding chamber supplies - masks)***	2	
HOLD CHAMBER MIS ADLT LG ***(spacer/aerosol-holding chambers)***	2	
HOLD CHAMBER MIS MEDIUM ***(spacer/aerosol-holding chambers)***	2	
HOLD CHAMBER MIS SMALL ***(spacer/aerosol-holding chambers)***	2	
INSPIREASE MIS DD SYST ***(spacer/aerosol-holding chambers)***	2	
MICROCHAMBER MIS ***(spacer/aerosol-holding chambers)***	2	
MICROSPACER MIS ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA LG ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA MD ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA SM ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIAMOND ***(spacer/aerosol-holding chambers)***	2	
POCKET CHAMB MIS ***(spacer/aerosol-holding chambers)***	2	
POCKET SPACE MIS ***(spacer/aerosol-holding chambers)***	2	
PROCHAMBER MIS VHC ***(spacer/aerosol-holding chambers)***	2	
RITEFLO MIS ***(spacer/aerosol-holding chambers)***	2	
VORTEX VALVE MIS CHAMBER ***(spacer/aerosol-holding chambers)***	2	
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
AJOVY INJ 225/1.5 ***(fremanezumab-vfrm)***	2	MO
EMGALITY INJ 100MG/ML ***(galcanezumab-gnlm)***	2	MO
EMGALITY INJ 120MG/ML ***(galcanezumab-gnlm)***	2	MO
NURTEC TAB 75MG ODT ***(rimegepant sulfate)***	2	
QULIPTA TAB 10MG ***(atogepant)***	2	MO
QULIPTA TAB 30MG ***(atogepant)***	2	MO
QULIPTA TAB 60MG ***(atogepant)***	2	MO
UBRELVY TAB 50MG ***(ubrogepant)***	2	
UBRELVY TAB 100MG ***(ubrogepant)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MIGRAINE COMBINATIONS		
ergotamine w/ caffeine tab 1-100 mg	3	
SEROTONIN AGONISTS		
almotriptan malate tab 6.25 mg	1	QL (12 tabs every 25 days)
almotriptan malate tab 12.5 mg	1	QL (12 tabs every 25 days)
eletriptan hydrobromide tab 20 mg (base equivalent)	1	QL (12 tabs every 25 days)
eletriptan hydrobromide tab 40 mg (base equivalent)	1	QL (12 tabs every 25 days)
frovatriptan succinate tab 2.5 mg (base equivalent)	1	QL (18 tabs every 25 days)
naratriptan hcl tab 1 mg (base equiv)	1	QL (12 tabs every 25 days)
naratriptan hcl tab 2.5 mg (base equiv)	1	QL (12 tabs every 25 days)
ONZETRA XSAI MIS 11MG ***(sumatriptan succinate)***	2	ST, QL (16 nosepieces (8 pouches) every 25 days); PA**
REYVOW TAB 50MG ***(lasmiditan succinate)***	3	
REYVOW TAB 100MG ***(lasmiditan succinate)***	3	
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	1	QL (18 tabs every 25 days)
rizatriptan benzoate oral disintegrating tab 10 mg (base eq)	1	QL (18 tabs every 25 days)
rizatriptan benzoate tab 5 mg (base equivalent)	1	QL (18 tabs every 25 days)
rizatriptan benzoate tab 10 mg (base equivalent)	1	QL (18 tabs every 25 days)
sumatriptan nasal spray 5 mg/act	1	QL (24 sprays (4 boxes) every 25 days)
sumatriptan nasal spray 20 mg/act	1	QL (12 sprays (2 boxes) every 25 days)
sumatriptan succinate inj 6 mg/0.5ml	1	QL (12 injections every 25 days)
sumatriptan succinate solution auto-injector 4 mg/0.5ml	1	QL (18 injections every 25 days)
sumatriptan succinate solution auto-injector 6 mg/0.5ml	1	QL (12 injections every 25 days)
sumatriptan succinate solution cartridge 4 mg/0.5ml	1	QL (18 injections every 25 days)
sumatriptan succinate solution cartridge 6 mg/0.5ml	1	QL (12 injections every 25 days)
sumatriptan succinate tab 25 mg	1	QL (12 tabs every 25 days)
sumatriptan succinate tab 50 mg	1	QL (12 tabs every 25 days)
sumatriptan succinate tab 100 mg	1	QL (12 tabs every 25 days)
ZEMBRACE SYM INJ 3/0.5ML ***(sumatriptan succinate)***	2	ST, QL (24 injections every 25 days); PA**
zolmitriptan nasal spray 2.5 mg/spray unit	1	QL (12 inhalers every 25 days)
zolmitriptan nasal spray 5 mg/spray unit	1	QL (12 bottles every 25 days)
zolmitriptan orally disintegrating tab 2.5 mg	1	QL (12 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
zolmitriptan orally disintegrating tab 5 mg	1	QL (12 tabs every 25 days)
zolmitriptan tab 2.5 mg	1	QL (12 tabs every 25 days)
zolmitriptan tab 5 mg	1	QL (12 tabs every 25 days)
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION		
FLUORIDE		
FLUORABON DRO ***(sodium fluoride)***	PV	MO; $0 applies for ages 5 and under
sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)	PV	MO; $0 applies for ages 5 and under
sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)	PV	MO; $0 applies for ages 5 and under
sodium fluoride chew tab 1 mg f (from 2.2 mg naf)	1	MO
sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)	PV	MO; $0 applies for ages 5 and under
(Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf)) FLURA-DROPS	PV	MO; $0 applies for ages 5 and under
sodium fluoride tab 0.5 mg f (from 1.1 mg naf)	PV	MO; $0 applies for ages 5 and under
sodium fluoride tab 1 mg f (from 2.2 mg naf)	1	MO
PHOSPHATE		
(Potassium Phosphate Monobasic Tab 500 mg) PHOSPHO-TRIN K500	1	MO
POTASSIUM		
(Potassium Bicarbonate Effer Tab 25 meq) EFFER-K	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) K-PRIME	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) KLOR-CON/EF	1	MO
potassium chloride cap er 8 meq	1	MO
potassium chloride cap er 10 meq	1	MO
potassium chloride microencapsulated crys er tab 10 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 10 meq) KLOR-CON M10	1	MO
potassium chloride microencapsulated crys er tab 15 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 15 meq) KLOR-CON M15	1	MO
potassium chloride microencapsulated crys er tab 20 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 20 meq) KLOR-CON M20	1	MO
potassium chloride oral soln 10% (20 meq/15ml)	1	MO
potassium chloride oral soln 20% (40 meq/15ml)	1	MO
potassium chloride powder packet 20 meq	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Potassium Chloride Powder Packet 20 meq) KLOR-CON	1	MO
potassium chloride tab er 8 meq (600 mg)	1	MO
(Potassium Chloride Tab Er 8 meq (600 mg)) KLOR-CON 8	1	MO
potassium chloride tab er 10 meq	1	MO
(Potassium Chloride Tab Er 10 meq) KLOR-CON 10	1	MO
potassium chloride tab er 15 meq	1	MO
potassium chloride tab er 20 meq (1500 mg)	1	MO
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING		
penicillamine cap 250 mg	4	SP
penicillamine tab 250 mg	4	SP
trientine hcl cap 250 mg	4	SP
IMMUNOMODULATORS - DRUGS TO TREAT CANCER		
lenalidomide cap 5 mg	4	SP, PA, QL (1 cap every 1 day); OAC
lenalidomide cap 10 mg	4	SP, PA, QL (1 cap every 1 day); OAC
lenalidomide cap 15 mg	4	SP, PA, QL (1 cap every 1 day); OAC
lenalidomide cap 20 mg	4	SP, PA, QL (42 caps every 28 days); OAC
lenalidomide cap 25 mg	4	SP, PA, QL (42 caps every 28 days); OAC
lenalidomide caps 2.5 mg	4	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 2.5MG ***(lenalidomide)***	4	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 5MG ***(lenalidomide)***	4	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 10MG ***(lenalidomide)***	4	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 15MG ***(lenalidomide)***	4	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 20MG ***(lenalidomide)***	4	SP, PA, QL (42 caps every 28 days); OAC
REVLIMID CAP 25MG ***(lenalidomide)***	4	SP, PA, QL (42 caps every 28 days); OAC
THALOMID CAP 50MG ***(thalidomide)***	4	SP, PA, QL (1 cap every 1 day); OAC
THALOMID CAP 100MG ***(thalidomide)***	4	SP, PA, QL (4 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT		
azathioprine tab 50 mg	1	MO
azathioprine tab 75 mg	1	MO
(Azathioprine Tab 75 mg) AZASAN	1	MO
azathioprine tab 100 mg	1	MO
(Azathioprine Tab 100 mg) AZASAN	1	MO
cyclosporine cap 25 mg	4	SP
cyclosporine cap 100 mg	4	SP
cyclosporine modified cap 25 mg	4	SP
(Cyclosporine Modified Cap 25 mg) GENGRAF	4	SP
cyclosporine modified cap 50 mg	4	SP
cyclosporine modified cap 100 mg	4	SP
(Cyclosporine Modified Cap 100 mg) GENGRAF	4	SP
cyclosporine modified oral soln 100 mg/ml	4	SP
(Cyclosporine Modified Oral Soln 100 mg/ml) GENGRAF	4	SP
everolimus tab 0.5 mg	4	SP
everolimus tab 0.25 mg	4	SP
everolimus tab 0.75 mg	4	SP
everolimus tab 1 mg	4	SP
mycophenolate mofetil cap 250 mg	4	SP
mycophenolate mofetil for oral susp 200 mg/ml	4	SP
mycophenolate mofetil tab 500 mg	4	SP
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)	4	SP
mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)	4	SP
sirolimus oral soln 1 mg/ml	4	SP
sirolimus tab 0.5 mg	4	SP
sirolimus tab 1 mg	4	SP
sirolimus tab 2 mg	4	SP
tacrolimus cap 0.5 mg	4	SP
tacrolimus cap 1 mg	4	SP
tacrolimus cap 5 mg	4	SP
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM		
sodium polystyrene sulfonate powder	1	
(Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml) SPS	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) KIONEX	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) SPS	1	
VELTASSA POW 1GM ***(patiromer sorbitex calcium)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VELTASSA POW 8.4GM ***(patiromer sorbitex calcium)***	2	MO
VELTASSA POW 16.8GM ***(patiromer sorbitex calcium)***	2	MO
VELTASSA POW 25.2GM ***(patiromer sorbitex calcium)***	2	MO
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
ANESTHETICS TOPICAL ORAL		
lidocaine hcl viscous soln 2%	1	
ANTI-INFECTIVES - THROAT		
clotrimazole troche 10 mg	1	
nystatin susp 100000 unit/ml	1	
STEROIDS - MOUTH/THROAT/DENTAL		
triamcinolone acetonide dental paste 0.1%	1	
(Triamcinolone Acetonide Dental Paste 0.1%) KOURZEQ	1	
(Triamcinolone Acetonide Dental Paste 0.1%) ORALONE DENTAL PASTE	1	
THROAT PRODUCTS - MISC.		
cevimeline hcl cap 30 mg	1	MO
pilocarpine hcl tab 5 mg	1	MO
pilocarpine hcl tab 7.5 mg	1	MO
MULTIVITAMINS - DRUGS FOR NUTRITION		
PRENATAL VITAMINS		
(Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg) PNV-DHA	1	
(Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg) INATAL GT	1	
(Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg) PNV-SELECT	1	
(Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg) PRENATAL 19	1	
(Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg) TRINATE	1	
(Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg) ELITE-OB	1	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
CENTRAL MUSCLE RELAXANTS		
baclofen oral soln 5 mg/5ml	1	
baclofen oral soln 10 mg/5ml	1	
baclofen tab 5 mg	1	
baclofen tab 10 mg	1	
baclofen tab 15 mg	1	
baclofen tab 20 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
carisoprodol tab 350 mg	1	PA
chlorzoxazone tab 500 mg	1	
cyclobenzaprine hcl tab 5 mg	1	
cyclobenzaprine hcl tab 10 mg	1	
LYVISPAH GRA 5MG ***(baclofen)***	2	
LYVISPAH GRA 10MG ***(baclofen)***	2	
LYVISPAH GRA 20MG ***(baclofen)***	2	
metaxalone tab 800 mg	1	
methocarbamol tab 500 mg	1	
methocarbamol tab 750 mg	1	
methocarbamol tab 1000 mg	1	
(Methocarbamol Tab 1000 mg) TANLOR	1	
orphenadrine citrate tab er 12hr 100 mg	1	
tizanidine hcl cap 2 mg (base equivalent)	1	
tizanidine hcl cap 4 mg (base equivalent)	1	
tizanidine hcl cap 6 mg (base equivalent)	1	
tizanidine hcl tab 2 mg (base equivalent)	1	
tizanidine hcl tab 4 mg (base equivalent)	1	
DIRECT MUSCLE RELAXANTS		
dantrolene sodium cap 25 mg	1	
dantrolene sodium cap 50 mg	1	
dantrolene sodium cap 100 mg	1	
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
NASAL AGENT COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	1	QL (1 bottle every 25 days)
NASAL ANTIALLERGY		
azelastine hcl nasal spray 0.1% (137 mcg/spray)	1	QL (2 bottles every 25 days)
olopatadine hcl nasal soln 0.6%	1	QL (1 bottle every 25 days)
NASAL ANTICHOLINERGICS		
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	1	MO
ipratropium bromide nasal soln 0.06% (42 mcg/spray)	1	MO
NASAL STEROIDS		
flunisolide nasal soln 25 mcg/act (0.025%)	1	QL (3 bottles every 25 days)
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES		
ALS AGENTS		
RADICAVA ORS SUS 105/5ML ***(edaravone)***	4	SP, PA, QL (75 mL every 30 days)
RADICAVA ORS SUS STARTER ***(edaravone)***	4	SP, PA, QL (75 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
riluzole tab 50 mg	1	MO
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS		
BETA-BLOCKERS - OPHTHALMIC		
betaxolol hcl ophth soln 0.5%	1	MO
BETOPTIC-S SUS 0.25% OP ***(betaxolol hcl (ophth))***	2	MO
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	1	MO
carteolol hcl ophth soln 1%	1	MO
dorzolamide hcl-timolol maleate ophth soln 2-0.5%	1	MO
dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%	1	MO
levobunolol hcl ophth soln 0.5%	1	MO
timolol maleate ophth gel forming soln 0.5%	1	MO
timolol maleate ophth gel forming soln 0.25%	1	MO
timolol maleate ophth soln 0.5%	1	MO
timolol maleate ophth soln 0.5% (once-daily)	1	MO
timolol maleate ophth soln 0.25%	1	MO
timolol maleate preservative free ophth soln 0.5%	1	MO
timolol maleate preservative free ophth soln 0.25%	1	MO
CYCLOPLEGIC MYDRIATICS		
atropine sulfate ophth soln 1%	1	MO
cyclopentolate hcl ophth soln 1%	1	MO
phenylephrine hcl ophth soln 2.5%	1	
(Phenylephrine Hcl Ophth Soln 2.5%) ALTAFRIN	1	
phenylephrine hcl ophth soln 10%	1	
(Phenylephrine Hcl Ophth Soln 10%) ALTAFRIN	1	
tropicamide ophth soln 0.5%	1	MO
tropicamide ophth soln 1%	1	MO
MIOTICS		
pilocarpine hcl ophth soln 1%	1	MO
pilocarpine hcl ophth soln 2%	1	MO
pilocarpine hcl ophth soln 4%	1	MO
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1% ***(brimonidine tartrate)***	2	MO
ALPHAGAN P SOL 0.15% ***(brimonidine tartrate)***	2	MO
apraclonidine hcl ophth soln 0.5% (base equivalent)	1	
brimonidine tartrate ophth soln 0.1%	1	MO
brimonidine tartrate ophth soln 0.2%	1	MO
brimonidine tartrate ophth soln 0.15%	1	MO
SIMBRINZA SUS 1-0.2% ***(brinzolamide-brimonidine tartrate)***	2	MO
OPHTHALMIC ANTI-INFECTIVES		
bacitracin ophth oint 500 unit/gm	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bacitracin-polymyxin b ophth oint	1	
(Bacitracin-Polymyxin B Ophth Oint) POLYCIN	1	
BESIVANCE SUS 0.6% ***(besifloxacin hcl)***	2	
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	1	
erythromycin ophth oint 5 mg/gm	1	
gatifloxacin ophth soln 0.5%	1	
gentamicin sulfate ophth soln 0.3%	1	
levofloxacin ophth soln 1.5%	1	
moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)	1	
moxifloxacin hcl ophth soln 0.5% (base equiv)	1	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1	
(Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-10000unt Op Oin) NEO-POLYCIN	1	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	1	
ofloxacin ophth soln 0.3%	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
sulfacetamide sodium ophth oint 10%	1	
sulfacetamide sodium ophth soln 10%	1	
tobramycin ophth soln 0.3%	1	
TOBREX OIN 0.3% OP ***(tobramycin (ophth))***	3	
trifluridine ophth soln 1%	1	
XDEMVY DRO 0.25% ***(lotilaner)***	2	
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP ***(cyclosporine (ophth))***	1	MO
RESTASIS MUL EMU 0.05% OP ***(cyclosporine (ophth))***	2	MO
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5% ***(lifitegrast)***	2	MO
OPHTHALMIC STEROIDS		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1	
(Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%) NEO-POLYCIN HC	1	
dexamethasone sodium phosphate ophth soln 0.1%	1	
difluprednate ophth emulsion 0.05%	1	
fluorometholone ophth susp 0.1%	1	
loteprednol etabonate ophth gel 0.5%	1	
loteprednol etabonate ophth susp 0.2%	1	
loteprednol etabonate ophth susp 0.5%	1	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
neomycin-polymyxin-dexamethasone ophth susp 0.1%	1	
neomycin-polymyxin-hc ophth susp	1	
PRED SOD PHO SOL 1% OP	3	
prednisolone acetate ophth susp 1%	1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1% ***(tobramycin-dexamethasone)***	2	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
OPHTHALMICS - MISC.		
azelastine hcl ophth soln 0.05%	1	
bepotastine besilate ophth soln 1.5%	1	
brinzolamide ophth susp 1%	1	MO
bromfenac sodium ophth soln 0.07% (base equivalent)	1	
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	1	
bromfenac sodium ophth soln 0.075% (base equivalent)	1	
cromolyn sodium ophth soln 4%	1	
diclofenac sodium ophth soln 0.1%	1	
dorzolamide hcl ophth soln 2%	1	MO
epinastine hcl ophth soln 0.05%	1	
flurbiprofen sodium ophth soln 0.03%	1	
ILEVRO DRO 0.3% OP ***(nepafenac)***	2	
ketorolac tromethamine ophth soln 0.4%	1	
ketorolac tromethamine ophth soln 0.5%	1	
PROSTAGLANDINS - OPHTHALMIC		
bimatoprost ophth soln 0.03%	1	MO
latanoprost ophth soln 0.005%	1	MO
tafluprost preservative free (pf) ophth soln 0.0015%	1	MO
travoprost ophth soln 0.004% (benzalkonium free) (bak free)	1	MO
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln 2%	1	
OTIC ANTI-INFECTIVES		
ciprofloxacin hcl otic soln 0.2% (base equivalent)	1	
ofloxacin otic soln 0.3%	1	
OTIC COMBINATIONS		
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
neomycin-polymyxin-hc otic soln 1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1	
OTIC STEROIDS		
fluocinolone acetonide (otic) oil 0.01%	1	
(Fluocinolone Acetonide (Otic) Oil 0.01%) FLAC	1	
hydrocortisone w/ acetic acid otic soln 1-2%	1	
OXYTOCICS - DRUGS FOR PREGNANCY		
OXYTOCICS - DRUGS FOR PREGNANCY		
methylergonovine maleate tab 0.2 mg	1	
(Methylergonovine Maleate Tab 0.2 mg) METHERGINE	1	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
AMINOPENICILLINS		
amoxicillin (trihydrate) cap 250 mg	1	
amoxicillin (trihydrate) cap 500 mg	1	
amoxicillin (trihydrate) chew tab 125 mg	1	
amoxicillin (trihydrate) chew tab 250 mg	1	
amoxicillin (trihydrate) for susp 125 mg/5ml	1	
amoxicillin (trihydrate) for susp 200 mg/5ml	1	
amoxicillin (trihydrate) for susp 250 mg/5ml	1	
amoxicillin (trihydrate) for susp 400 mg/5ml	1	
amoxicillin (trihydrate) tab 500 mg	1	
amoxicillin (trihydrate) tab 875 mg	1	
ampicillin cap 500 mg	1	
NATURAL PENICILLINS		
penicillin v potassium for soln 125 mg/5ml	1	
penicillin v potassium for soln 250 mg/5ml	1	
penicillin v potassium tab 250 mg	1	
penicillin v potassium tab 500 mg	1	
PENICILLIN COMBINATIONS		
amoxicillin & k clavulanate chew tab 400-57 mg	1	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	1	
amoxicillin & k clavulanate tab 250-125 mg	1	
amoxicillin & k clavulanate tab 500-125 mg	1	
amoxicillin & k clavulanate tab 875-125 mg	1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
AUGMENTIN SUS 125/5ML ***(amoxicillin & pot clavulanate)***	3	
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin sodium cap 250 mg	1	
dicloxacillin sodium cap 500 mg	1	
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
medroxyprogesterone acetate tab 2.5 mg	1	MO
medroxyprogesterone acetate tab 5 mg	1	MO
medroxyprogesterone acetate tab 10 mg	1	MO
megestrol acetate susp 625 mg/5ml	1	MO
norethindrone acetate tab 5 mg	1	MO
(Norethindrone Acetate Tab 5 mg) GALLIFREY	1	MO
progesterone cap 100 mg	1	MO
progesterone cap 200 mg	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium tab delayed release 333 mg	1	MO
disulfiram tab 250 mg	1	MO
disulfiram tab 500 mg	1	MO
lofexidine hcl tab 0.18 mg (base equivalent)	1	
ANTI-CATAPLECTIC AGENTS		
LUMRYZ PAK 6GM ***(sodium oxybate)***	4	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 7.5GM ***(sodium oxybate)***	4	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 9GM ***(sodium oxybate)***	4	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK STARTER ***(sodium oxybate)***	4	SP, PA, QL (1 packet every 1 day); 28-day starter pack
LUMRYZ PKG 4.5GM ***(sodium oxybate)***	4	SP, PA, QL (1 packet every 1 day)
XYWAV SOL 0.5GM/ML ***(calcium, magnesium, potassium, & sodium oxybates)***	4	SP, PA, QL (18 mL every 1 day)
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride orally disintegrating tab 5 mg	1	MO
donepezil hydrochloride orally disintegrating tab 10 mg	1	MO
donepezil hydrochloride tab 5 mg	1	MO
donepezil hydrochloride tab 10 mg	1	MO
donepezil hydrochloride tab 23 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
galantamine hydrobromide cap er 24hr 8 mg	1	MO
galantamine hydrobromide cap er 24hr 16 mg	1	MO
galantamine hydrobromide cap er 24hr 24 mg	1	MO
galantamine hydrobromide oral soln 4 mg/ml	1	MO
galantamine hydrobromide tab 4 mg	1	MO
galantamine hydrobromide tab 8 mg	1	MO
galantamine hydrobromide tab 12 mg	1	MO
memantine hcl cap er 24hr 7 mg	1	MO
memantine hcl cap er 24hr 14 mg	1	MO
memantine hcl cap er 24hr 21 mg	1	MO
memantine hcl cap er 24hr 28 mg	1	MO
memantine hcl oral solution 2 mg/ml	1	MO
memantine hcl tab 5 mg	1	MO
memantine hcl tab 10 mg	1	MO
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	1	
memantine hcl-donepezil hcl cap er 24hr 14-10 mg	1	MO
memantine hcl-donepezil hcl cap er 24hr 21-10 mg	1	MO
memantine hcl-donepezil hcl cap er 24hr 28-10 mg	1	MO
NAMZARIC CAP 7-10MG ***(memantine hcl-donepezil hcl)***	2	MO
NAMZARIC CAP 14-10MG ***(memantine hcl-donepezil hcl)***	2	MO
NAMZARIC CAP 21-10MG ***(memantine hcl-donepezil hcl)***	2	MO
NAMZARIC CAP 28-10MG ***(memantine hcl-donepezil hcl)***	2	MO
rivastigmine tartrate cap 1.5 mg (base equivalent)	1	MO
rivastigmine tartrate cap 3 mg (base equivalent)	1	MO
rivastigmine tartrate cap 4.5 mg (base equivalent)	1	MO
rivastigmine tartrate cap 6 mg (base equivalent)	1	MO
rivastigmine td patch 24hr 4.6 mg/24hr	1	MO
rivastigmine td patch 24hr 9.5 mg/24hr	1	MO
rivastigmine td patch 24hr 13.3 mg/24hr	1	MO
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide-amitriptyline tab 5-12.5 mg	1	MO
chlordiazepoxide-amitriptyline tab 10-25 mg	1	MO
olanzapine-fluoxetine hcl cap 3-25 mg	1	MO
olanzapine-fluoxetine hcl cap 6-25 mg	1	MO
olanzapine-fluoxetine hcl cap 6-50 mg	1	MO
olanzapine-fluoxetine hcl cap 12-25 mg	1	MO
olanzapine-fluoxetine hcl cap 12-50 mg	1	MO
perphenazine-amitriptyline tab 2-10 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
perphenazine-amitriptyline tab 2-25 mg	1	MO
perphenazine-amitriptyline tab 4-10 mg	1	MO
perphenazine-amitriptyline tab 4-25 mg	1	MO
perphenazine-amitriptyline tab 4-50 mg	1	MO
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB 100MG ***(flibanserin)***	3	PA, MO
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG ***(deutetrabenazine)***	4	SP, PA, QL (2 tabs every 1 day)
AUSTEDO TAB 9MG ***(deutetrabenazine)***	4	SP, PA, QL (4 tabs every 1 day)
AUSTEDO TAB 12MG ***(deutetrabenazine)***	4	SP, PA, QL (4 tabs every 1 day)
AUSTEDO XR TAB 6MG ***(deutetrabenazine)***	4	SP, PA, QL (3 tabs every 1 day)
AUSTEDO XR TAB 12MG ***(deutetrabenazine)***	4	SP, PA, QL (4 tabs every 1 day)
AUSTEDO XR TAB 18MG ***(deutetrabenazine)***	4	SP, PA, QL (1 tab every 1 day)
AUSTEDO XR TAB 24MG ***(deutetrabenazine)***	4	SP, PA, QL (2 tabs every 1 day)
AUSTEDO XR TAB 30MG ER ***(deutetrabenazine)***	4	SP, PA, QL (1 tab every 1 day)
AUSTEDO XR TAB 36MG ER ***(deutetrabenazine)***	4	SP, PA, QL (1 tab every 1 day)
AUSTEDO XR TAB 42MG ER ***(deutetrabenazine)***	4	SP, PA, QL (1 tab every 1 day)
AUSTEDO XR TAB 48MG ER ***(deutetrabenazine)***	4	SP, PA, QL (1 tab every 1 day)
AUSTEDO XR TAB TITR KIT ***(deutetrabenazine)***	4	SP, PA, QL (1 kit every 28 days)
INGREZZA CAP 40-80MG ***(valbenazine tosylate)***	4	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 40MG ***(valbenazine tosylate)***	4	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 60MG ***(valbenazine tosylate)***	4	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 80MG ***(valbenazine tosylate)***	4	SP, PA, QL (1 cap every 1 day)
tetrabenazine tab 12.5 mg	4	SP, PA, QL (4 tabs every 1 day)
tetrabenazine tab 25 mg	4	SP, PA, QL (2 tabs every 1 day)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
AVONEX PEN KIT 30MCG ***(interferon beta-1a)***	4	SP, PA, QL (4 pens every 28 days)
AVONEX PREFL KIT 30MCG ***(interferon beta-1a)***	4	SP, PA, QL (4 syringes every 28 days)
BAFIERTAM CAP 95MG ***(monomethyl fumarate)***	4	SP, PA, QL (4 caps every 1 day)
BETASERON INJ 0.3MG ***(interferon beta-1b)***	4	SP, PA, QL (14 kits every 28 days)
COPAXONE INJ 40MG/ML ***(glatiramer acetate)***	4	SP, PA, QL (12 syringes every 28 days)
dalfampridine tab er 12hr 10 mg	4	SP, PA, QL (2 tabs every 1 day)
dimethyl fumarate capsule delayed release 120 mg	4	SP, PA, QL (14 caps every 28 days)
dimethyl fumarate capsule delayed release 240 mg	4	SP, PA, QL (2 caps every 1 day)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	4	SP, PA, QL (60 caps every 30 days)
fingolimod hcl cap 0.5 mg (base equiv)	4	SP, PA, QL (1 cap every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KESIMPTA INJ 20/.4ML ***(ofatumumab (ms))***	4	SP, PA, QL (1 pen every 28 days)
MAYZENT PAK STARTER ***(siponimod fumarate)***	4	SP, PA, QL (12 tablet starter pack)
MAYZENT PAK STARTER ***(siponimod fumarate)***	4	SP, PA, QL (7 tabs every 4 days)
MAYZENT TAB 0.25MG ***(siponimod fumarate)***	4	SP, PA, QL (12 tabs every 5 days)
MAYZENT TAB 1MG ***(siponimod fumarate)***	4	SP, PA, QL (1 tab every 1 day)
MAYZENT TAB 2MG ***(siponimod fumarate)***	4	SP, PA, QL (1 tab every 1 day)
REBIF INJ 22/0.5 ***(interferon beta-1a)***	4	SP, PA, QL (12 syringes every 28 days)
REBIF INJ 44/0.5 ***(interferon beta-1a)***	4	SP, PA, QL (12 syringes every 28 days)
REBIF REBIDO INJ 22/0.5 ***(interferon beta-1a)***	4	SP, PA, QL (12 syringes every 28 days)
REBIF REBIDO INJ 44/0.5 ***(interferon beta-1a)***	4	SP, PA, QL (12 syringes every 28 days)
REBIF REBIDO INJ TITRATN ***(interferon beta-1a)***	4	SP, PA, QL (12 injections every 28 days)
REBIF TITRTN INJ PACK ***(interferon beta-1a)***	4	SP, PA, QL (12 syringes every 28 days)
teriflunomide tab 7 mg	4	SP, PA, QL (1 tab every 1 day)
teriflunomide tab 14 mg	4	SP, PA, QL (1 tab every 1 day)
ZEPOSIA 7DAY CAP STR PACK ***(ozanimod hcl)***	4	SP, PA, QL (7 caps every 7 days); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
ZEPOSIA CAP 0.92MG ***(ozanimod hcl)***	4	SP, PA, QL (1 cap every 1 day); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
ZEPOSIA CAP STR KIT ***(ozanimod hcl)***	4	SP, PA, QL (28 caps every 28 days); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
gabapentin (once-daily) tab 300 mg	1	MO
gabapentin (once-daily) tab 600 mg	1	MO
GRALISE TAB 450MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 750MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 900MG ***(gabapentin (once-daily))***	2	MO
pregabalin tab er 24hr 82.5 mg	1	MO
pregabalin tab er 24hr 165 mg	1	MO
pregabalin tab er 24hr 330 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
pimozide tab 1 mg	1	MO
pimozide tab 2 mg	1	MO
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex gum 2 mg	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX S	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) EQ NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GNP NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GOODSENSE NICOTINE POLACR	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) HM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) KLS QUIT2	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) NICORELIEF	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE GUM	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) SM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) THRIVE	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex gum 4 mg	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE GUM	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) EQ NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Gum 4 mg) GNP NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GOODSENSE NICOTINE POLACR	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) HM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) KLS QUIT4	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE GUM	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex lozenge 2 mg	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE LOZENGE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) EQ NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE MINI LOZENGE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GOODSENSE NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) HM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) KLS QUIT2	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) NICOTINE MINI LOZENGE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA MINI NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) SM NICOTINE	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex lozenge 4 mg	PV	$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE LOZENGE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE LOZENGES	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX M	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE POLACR	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) KLS QUIT4	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) NICOTINE MINI LOZENGE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA MINI NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) SM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
nicotine td patch 24hr 7 mg/24hr	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) EQ NICOTINE STEP 3	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE STEP 3	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	$0 limited to 2 treatment cycles/year
nicotine td patch 24hr 14 mg/24hr	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Td Patch 24hr 14 mg/24hr) EQ NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) RA NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	$0 limited to 2 treatment cycles/year
nicotine td patch 24hr 21 mg/24hr	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) EQ NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE STEP 1	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE TRANSDERMAL S	PV	$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	$0 limited to 2 treatment cycles/year
NICOTROL INH ***(nicotine)***	PV	$0 limited to 2 treatment cycles/year
NICOTROL NS SPR 10MG/ML ***(nicotine)***	PV	$0 limited to 2 treatment cycles/year
varenicline tartrate tab 0.5 mg (base equiv)	PV	$0 limited to 2 treatment cycles/year
varenicline tartrate tab 1 mg (base equiv)	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
RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS		
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK 25MG ***(ivacaftor)***	4	SP, PA
KALYDECO PAK 50MG ***(ivacaftor)***	4	SP, PA
KALYDECO PAK 75MG ***(ivacaftor)***	4	SP, PA
KALYDECO TAB 150MG ***(ivacaftor)***	4	SP, PA
PULMONARY FIBROSIS AGENTS		
OFEV CAP 100MG ***(nintedanib esylate)***	4	SP, PA, QL (2 caps every 1 day)
OFEV CAP 150MG ***(nintedanib esylate)***	4	SP, PA, QL (2 caps every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
pirfenidone cap 267 mg	4	SP, PA, QL (9 caps every 1 day)
pirfenidone tab 267 mg	4	SP, PA, QL (9 tabs every 1 day)
pirfenidone tab 801 mg	4	SP, PA, QL (3 tabs every 1 day)
SULFONAMIDES - DRUGS TO TREAT INFECTIONS		
SULFONAMIDES - DRUGS TO TREAT INFECTIONS		
sulfadiazine tab 500 mg	1	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
demeclocycline hcl tab 150 mg	1	
demeclocycline hcl tab 300 mg	1	
doxycycline hyclate cap 50 mg	1	
doxycycline hyclate cap 100 mg	1	
doxycycline hyclate tab 100 mg	1	
doxycycline monohydrate cap 50 mg	1	
doxycycline monohydrate cap 100 mg	1	
(Doxycycline Monohydrate Cap 100 mg) MONDOXYNE NL	1	
doxycycline monohydrate for susp 25 mg/5ml	1	
doxycycline monohydrate tab 50 mg	1	
doxycycline monohydrate tab 75 mg	1	
doxycycline monohydrate tab 100 mg	1	
(Doxycycline Monohydrate Tab 100 mg) AVIDOXY	1	
doxycycline monohydrate tab 150 mg	1	
minocycline hcl cap 50 mg	1	
minocycline hcl cap 75 mg	1	
minocycline hcl cap 100 mg	1	
minocycline hcl tab 50 mg	1	
minocycline hcl tab 75 mg	1	
minocycline hcl tab 100 mg	1	
tetracycline hcl cap 250 mg	1	
tetracycline hcl cap 500 mg	1	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
ANTITHYROID AGENTS		
methimazole tab 5 mg	1	MO
methimazole tab 10 mg	1	MO
propylthiouracil tab 50 mg	1	MO
THYROID HORMONES		
levothyroxine sodium tab 25 mcg	1	MO
(Levothyroxine Sodium Tab 25 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 25 mcg) UNITHROID	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levothyroxine sodium tab 50 mcg	1	MO
(Levothyroxine Sodium Tab 50 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 50 mcg) UNITHROID	1	MO
levothyroxine sodium tab 75 mcg	1	MO
(Levothyroxine Sodium Tab 75 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 75 mcg) UNITHROID	1	MO
levothyroxine sodium tab 88 mcg	1	MO
(Levothyroxine Sodium Tab 88 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 88 mcg) UNITHROID	1	MO
levothyroxine sodium tab 100 mcg	1	MO
(Levothyroxine Sodium Tab 100 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 100 mcg) UNITHROID	1	MO
levothyroxine sodium tab 112 mcg	1	MO
(Levothyroxine Sodium Tab 112 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 112 mcg) UNITHROID	1	MO
levothyroxine sodium tab 125 mcg	1	MO
(Levothyroxine Sodium Tab 125 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 125 mcg) UNITHROID	1	MO
levothyroxine sodium tab 137 mcg	1	MO
(Levothyroxine Sodium Tab 137 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 137 mcg) UNITHROID	1	MO
levothyroxine sodium tab 150 mcg	1	MO
(Levothyroxine Sodium Tab 150 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 150 mcg) UNITHROID	1	MO
levothyroxine sodium tab 175 mcg	1	MO
(Levothyroxine Sodium Tab 175 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVO-T	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levothyroxine Sodium Tab 175 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 175 mcg) UNITHROID	1	MO
levothyroxine sodium tab 200 mcg	1	MO
(Levothyroxine Sodium Tab 200 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 200 mcg) UNITHROID	1	MO
levothyroxine sodium tab 300 mcg	1	MO
(Levothyroxine Sodium Tab 300 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 300 mcg) UNITHROID	1	MO
liothyronine sodium tab 5 mcg	1	MO
liothyronine sodium tab 25 mcg	1	MO
liothyronine sodium tab 50 mcg	1	MO
SYNTHROID TAB 25MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 50MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 75MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 88MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 100MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 112MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 125MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 137MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 150MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 175MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 200MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 300MCG ***(levothyroxine sodium)***	2	MO
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID		
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS		
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg	1	
dicyclomine hcl cap 10 mg	1	
dicyclomine hcl oral soln 10 mg/5ml	1	
dicyclomine hcl tab 20 mg	1	
glycopyrrolate oral soln 1 mg/5ml	1	MO
glycopyrrolate tab 1 mg	1	
glycopyrrolate tab 2 mg	1	
hyoscyamine sulfate elixir 0.125 mg/5ml	1	MO
(Hyoscyamine Sulfate Elixir 0.125 mg/5ml) HYOSYNE	1	MO
hyoscyamine sulfate sl tab 0.125 mg	1	MO
(Hyoscyamine Sulfate Sl Tab 0.125 mg) OSCIMIN	1	MO
hyoscyamine sulfate soln 0.125 mg/ml	1	MO
(Hyoscyamine Sulfate Soln 0.125 mg/ml) HYOSYNE	1	MO
hyoscyamine sulfate tab 0.125 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Hyoscyamine Sulfate Tab 0.125 mg) OSCIMIN	1	MO
hyoscyamine sulfate tab disint 0.125 mg	1	MO
(Hyoscyamine Sulfate Tab Disint 0.125 mg) NULEV	1	MO
methscopolamine bromide tab 2.5 mg	1	
methscopolamine bromide tab 5 mg	1	
H-2 ANTAGONISTS		
cimetidine hcl soln 300 mg/5ml	1	MO
cimetidine tab 300 mg	1	MO
cimetidine tab 400 mg	1	MO
cimetidine tab 800 mg	1	MO
famotidine for susp 40 mg/5ml	1	MO
famotidine tab 40 mg	1	MO
nizatidine cap 150 mg	1	MO
nizatidine cap 300 mg	1	MO
MISC. ANTI-ULCER		
sucralfate tab 1 gm	1	MO
PROTON PUMP INHIBITORS		
esomeprazole magnesium cap delayed release 40 mg (base eq)	1	QL (90 caps every year), MO
esomeprazole magnesium for delayed release susp pack 2.5 mg	1	QL (90 packets every year), MO
esomeprazole magnesium for delayed release susp packet 5 mg	1	QL (90 packets every year), MO
esomeprazole magnesium for delayed release susp packet 10 mg	1	QL (90 packets every year), MO
esomeprazole magnesium for delayed release susp packet 20 mg	1	QL (90 packets every year), MO
esomeprazole magnesium for delayed release susp packet 40 mg	1	QL (90 packets every year), MO
lansoprazole cap delayed release 30 mg	1	QL (90 caps every year), MO
omeprazole cap delayed release 10 mg	1	QL (90 caps every year), MO
omeprazole cap delayed release 40 mg	1	QL (90 caps every year), MO
pantoprazole sodium ec tab 20 mg (base equiv)	1	QL (90 tabs every year), MO
pantoprazole sodium ec tab 40 mg (base equiv)	1	QL (90 tabs every year), MO
rabeprazole sodium ec tab 20 mg	1	QL (90 tabs every year), MO
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab 100 mcg	1	MO
misoprostol tab 200 mcg	1	MO
ULCER THERAPY COMBINATIONS		
amoxicil cap &clarithro tab &lansopraz cap dr 500 &500 &30mg	1	
bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TALICIA CAP ***(amoxicillin-rifabutin-omeprazole)***	2	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)	1	MO
darifenacin hydrobromide tab er 24hr 15 mg (base equiv)	1	MO
fesoterodine fumarate tab er 24hr 4 mg	1	MO
fesoterodine fumarate tab er 24hr 8 mg	1	MO
oxybutynin chloride solution 5 mg/5ml	1	MO
oxybutynin chloride tab 5 mg	1	MO
oxybutynin chloride tab er 24hr 5 mg	1	MO
oxybutynin chloride tab er 24hr 10 mg	1	MO
oxybutynin chloride tab er 24hr 15 mg	1	MO
solifenacin succinate tab 5 mg	1	MO
solifenacin succinate tab 10 mg	1	MO
tolterodine tartrate cap er 24hr 2 mg	1	MO
tolterodine tartrate cap er 24hr 4 mg	1	MO
tolterodine tartrate tab 1 mg	1	MO
tolterodine tartrate tab 2 mg	1	MO
trospium chloride cap er 24hr 60 mg	1	MO
trospium chloride tab 20 mg	1	MO
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB 75MG ***(vibegron)***	2	MO
mirabegron tab er 24 hr 25 mg	1	MO
mirabegron tab er 24 hr 50 mg	1	MO
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol chloride tab 5 mg	1	
bethanechol chloride tab 10 mg	1	
bethanechol chloride tab 25 mg	1	
bethanechol chloride tab 50 mg	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
flavoxate hcl tab 100 mg	1	MO
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS		
MISCELLANEOUS VAGINAL PRODUCTS		
INTRAROSA SUP 6.5MG ***(prasterone vaginal)***	3	MO
SPERMICIDES		
ENCARE SUP 100MG ***(nonoxynol-9)***	PV	
GYNOL II GEL 3% ***(nonoxynol-9)***	PV	
SHUR-SEAL GEL 2% ***(nonoxynol-9)***	PV	
TODAY SPONGE MIS ***(nonoxynol-9)***	PV	
VCF VAGINAL AER CONTRACP ***(nonoxynol-9)***	PV	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VCF VAGINAL GEL CONTRACE ***(nonoxynol-9)***	PV	
VCF VAGINAL MIS CONTRACP ***(nonoxynol-9)***	PV	
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal cream 2%	1	
metronidazole vaginal gel 0.75%	1	
(Miconazole Nitrate Vaginal Suppos 200 mg) MICONAZOLE 3	1	
terconazole vaginal cream 0.4%	1	
terconazole vaginal cream 0.8%	1	
terconazole vaginal suppos 80 mg	1	
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL ***(lactic acid-citric acid-potassium bitartrate)***	PV	
VAGINAL ESTROGENS		
estradiol vaginal cream 0.1 mg/gm	1	MO
IMVEXXY MAIN SUP 4MCG ***(estradiol vaginal)***	2	MO
IMVEXXY MAIN SUP 10MCG ***(estradiol vaginal)***	2	MO
IMVEXXY STRT SUP 4MCG ***(estradiol vaginal)***	2	MO
IMVEXXY STRT SUP 10MCG ***(estradiol vaginal)***	2	MO
VAGIFEM TAB 10MCG ***(estradiol vaginal)***	1	MO
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG ***(progesterone (vaginal))***	2	
CRINONE GEL 8% VAG ***(progesterone (vaginal))***	2	PA
ENDOMETRIN SUP 100MG ***(progesterone (vaginal))***	2	
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION		
AUVI-Q INJ 0.1MG ***(epinephrine (anaphylaxis))***	2	
AUVI-Q INJ 0.3MG ***(epinephrine (anaphylaxis))***	2	
AUVI-Q INJ 0.15MG ***(epinephrine (anaphylaxis))***	2	
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)	1	
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	1	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap 100 mg	4	SP, PA, QL (6 caps every 1 day)
droxidopa cap 200 mg	4	SP, PA, QL (6 caps every 1 day)
droxidopa cap 300 mg	4	SP, PA, QL (6 caps every 1 day)
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
midodrine hcl tab 2.5 mg	1	
midodrine hcl tab 5 mg	1	
midodrine hcl tab 10 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VITAMINS - DRUGS FOR NUTRITION		
OIL SOLUBLE VITAMINS		
ergocalciferol cap 1.25 mg (50000 unit)	1	MO
phytonadione tab 5 mg	1	

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