SHARP Health Plan

2027 Formulary

List of covered prescription drugs

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

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This drug list applies to all HMO products and the following Small Group HMO products: Sharp Platinum 90 Performance HMO, Sharp $0 Cost Share Performance HMO AI-AN, Sharp $0 Cost Share Premier HMO AI-AN, Sharp Bronze 60 HDHP HMO 7800/0%/0% + Child Dental (Pe/V/C), Sharp Bronze 60 HMO 5800/60/40% + Child Dental (Pr/V/C), Sharp Bronze 60 Performance HMO, Sharp Bronze 60 Performance HMO AI-AN, Sharp Bronze 60 Premier HDHP HMO, Sharp Bronze 60 Premier HDHP HMO AI-AN, Sharp Gold 80 HMO 325/40/600 + Child Dental (Pe/V/C), Sharp Gold 80 HMO 500/30/20% + Child Dental (Pr/V/C), Sharp Gold 80 Performance HMO, Sharp Gold 80 Performance HMO AI-AN, Sharp Gold 80 Premier HMO, Sharp Gold 80 Premier HMO AI-AN, Sharp Minimum Coverage Performance HMO, Sharp Performance Bronze 60 HMO 5800/60 PCP + Child Dental, Sharp Performance Bronze 60 HMO 5800/60 PCP + Child Dental INF, Sharp Performance Gold 80 HMO 500/30 PCP + Child Dental, Sharp Performance Gold 80 HMO 500/30 PCP + Child Dental INF, Sharp Performance Platinum 90 HMO 0/25 PCP + Child Dental, Sharp Performance Platinum 90 HMO 0/25 PCP + Child Dental INF, Sharp Performance Silver 70 HMO 2500/60 PCP + Child Dental, Sharp Performance Silver 70 HMO 2500/60 PCP + Child Dental INF, Sharp Platinum 90 HMO 0/25/10% + Child Dental (Pr/V/C), Sharp Platinum 90 HMO 0/25/300 + Child Dental (Pe/V/C), Sharp Platinum 90 Performance HMO AI-AN, Sharp Platinum 90 Premier HMO, Sharp Platinum 90 Premier HMO AI-AN, Sharp Premier Bronze 60 HDHP HMO 7800/0% PCP + Child Dental, Sharp Premier Bronze 60 HDHP HMO 7800/0% PCP + Child Dental INF, Sharp Premier Gold 80 HMO 325/40 PCP + Child Dental, Sharp Premier Gold 80 HMO 325/40 PCP + Child Dental INF, Sharp Premier Platinum 90 HMO 0/25 PCP + Child Dental, Sharp Premier Platinum 90 HMO 0/25 PCP + Child Dental INF, Sharp Premier Silver 70 HDHP HMO 3200/25% PCP + Child Dental, Sharp Premier Silver 70 HDHP HMO 3200/25% PCP + Child Dental, Sharp Premier Silver 70 HDHP HMO 3200/25% PCP + Child Dental INF, Sharp Premier Silver 70 HMO 2500/60 PCP + Child Dental, Sharp Premier Silver 70 HMO 2500/60 PCP + Child Dental INF, Sharp Silver 70 HDHP HMO 3200/25%/25% + Child Dental (Pe/V/C), Sharp Silver 70 HMO 2500/60/40% + Child Dental (Pr/V/C-40%), Sharp Silver 70 HMO 2500/60/40% + Child Dental (Pe/V/C-300), Sharp Silver 70 Off Exchange Performance HMO, Sharp Silver 70 Off Exchange Premier HMO, Sharp Silver 70 Performance HMO, Sharp Silver 70 Performance HMO AI-AN, Sharp Silver 70 Premier HMO, Sharp Silver 70 Premier HMO AI-AN, Sharp Silver 73 Performance HMO, Sharp Silver 73 Premier HMO, Sharp Silver 87 Performance HMO, Sharp Silver 87 Premier HMO, Sharp Silver 94 Performance HMO, Sharp Silver 94 Premier HMO

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Introduction

January 2027

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

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

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

1. Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU), provided that these formulas and special foodins exceed the cost of a normal diet.

2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office and self-injectable drugs covered under the medical benefit.

3. FDA-approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by, or under direct supervision of, a physician.

4. Immunization or immunological agents, including, but not limited to: biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials

5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under the outpatient prescription drug benefit.

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

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Definitions

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

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

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

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

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

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

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

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

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

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

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

"Exigent Circumstances" are when an Enrollee is suffering from a health condition that may

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seriously jeopardize the Enrollee's life, health, or ability to regain maximum function, or when an Enrollee is undergoing a current course of treatment using a Nonformulary Drug.

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

"Generic Drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality,

performance, and intended use. A Generic Drug is listed in ***bold and italicized*** lowercase letters.

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

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

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

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

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

"Prescription Drug" is a drug that is approved by the federal Food and Drug Administration (FDA), that is prescribed by the Enrollee's Prescribing Provider and requires a Prescription under applicable law.

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

"Step Therapy" is a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health Plan may require the Enrollee to try one or more drugs to treat the Enrollee's medical condition before Sharp Health Plan will cover a particular drug for the condition pursuant to a Step Therapy request. If the Enrollee's Prescribing Provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.

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

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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

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

How do I locate a Prescription Drug on the Formulary?

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

Within the Formulary, drugs are listed alphabetically under the column titled "Prescription Drug Name" by its Brand or Generic name under the therapeutic category and class to which it belongs. If a generic for a Brand Name Drug is not available or is not covered, the Generic Drug name will not be listed separately by its generic name.

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

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

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

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

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

Here is how this is listed on the Formulary:

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

Some drugs are commercially available as both a Brand-Name and a Generic-Name. Contracted

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pharmacies are required to dispense the Generic version of the drug, unless Prior Authorization for the Brand-Name Drug is obtained from Sharp Health Plan.

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

What is a Drug Tier?

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

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

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

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

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MB	MB	Drugs covered under the Medical Benefit. Please refer to your Medical Benefit coverage information.

Are There Any Coverage Requirements or Limits?

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

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

What is Prior Authorization?

Drugs with a PA symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization. Your Prescribing Provider must request Prior Authorization, or approval for coverage, from Sharp Health Plan by calling our Customer Service department,

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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?

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

When a provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the provider should submit their justification and clinical documentation supporting the provider's determination with a Step Therapy Exception Request, and the Plan will approve the Step Therapy Exception Request.

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

If you have moved from another insurance plan to Sharp Health Plan and are taking a medication that your previous insurer covered, Sharp Health Plan will not require you to follow Step Therapy in order to obtain the medication. Your doctor may need to submit a request to Sharp Health Plan in order to provide you with this continuity of coverage.

What Is MO?

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

What is a Specialty Drug?

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

What is an Oral Anti-Cancer Drug?

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

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

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

Where Can I Fill My Prescription Drug?

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

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

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

What is Therapeutic Interchange?

Sharp Health Plan employs therapeutic interchange as part of its prescription drug benefit. Therapeutic interchange is the practice of replacing (with the Prescribing Provider's approval) a Prescription Drug originally prescribed for a patient with a Prescription Drug that is preferred on

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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.

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

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

Questions

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

Exclusions and Limitations to the Outpatient Prescription Drug Benefit

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

1. Drugs dispensed by a person or entity other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency Medical Condition or urgent care condition or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.

2. Drugs prescribed by non-Plan Providers and not authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an Emergency Medical Condition or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.

3. Over-the-counter medications or supplies, except for over-the-counter FDA-approved contraceptive drugs,devices and products, even if written on Prescription, except as specifically identified as covered in this Formulary. This exclusion does not apply to over-the-counter products that Sharp Health Plan must cover as a "preventive care" benefit under federal law with a Prescription or if the prescription legend drug is Medically Necessary due to a documented failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.

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

5. Drugs that are packaged with over-the-counter medications or other non-

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prescription items/supplies, except for over-the-counter FDA-approved contraceptive drugs, devices and products.

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

7. Drugs and supplies prescribed solely for the treatment of hair loss, athletic performance, sexual dysfunction, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders.)

8. Herbal, nutritional and dietary supplements.

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

10. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical condition (such as antibiotics to treat an infection) are covered.

11. Drugs and supplies prescribed in connection with a service or supply that is not a Covered Benefit, unless required to treat a complication that arises as a result of the service or supply.

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

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

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

15. Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity or Mental Health and Substance Use Disorders. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage, when prescribed for treatment of morbid obesity.

16. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated

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by at least two studies published in a nationally recognized, major peer-reviewed journal.

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

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

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

20. Any Prescription Drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the Prescription Drug, except for over-the-counter FDA-approved contraceptive drugs, devices and products.

The exclusions listed above do not apply to:

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

2. Drugs listed in this Formulary.

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

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

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

Some drugs are commercially available as both a brand-name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the Brand-Name Drug is obtained. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1

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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 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 /

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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.

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Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

ਪੰਜਾਬੀ (Punjabi):

ਿ ਧਆਨ ਿ ਦਓ: ਜੇ ਤੁਸੀ ਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿ ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-

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2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ បសវាជំនួយខ្នកភាសា ដោយមិនគិតឈ្លួន ល គឺអាចមានសំរាំរំបរអ្ើ នងួរ 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).

ह िंदी (Hindi):
ध्यान दें: यहद आप ह िंदी बोलते ै तो आपके हलए मुफ्त में भाषा स ायता सेवाएिं उपलब्ध ै। 1-800-359-2002 (TTY:711) पर कॉल करें।कॉल करें।

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

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Disclaimer: This document is intended to display targeted step therapy products. Please refer to the actual criteria when reviewing coverage determination requests.

Step Therapy Criteria

Step Therapy Group	DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS 1009-D
Drug Names	ALOGLIPTIN, ALOGLIPTIN/METFORMIN HCL, ALOGLIPTIN/METFORMIN HYDR, SITAGLIPTIN PHOSPHATE, SITAGLIPTIN PHOSPHATE/MET
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days
Step Therapy Group	EUCRISA 3199-E
Drug Names	EUCRISA
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a one day supply of a medium or higher potency topical corticosteroid within the past 180 days.
Step Therapy Group	GIP AND GLP-1 AGONIST 676-D
Drug Names	MOUNJARO
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30 day supply of metformin when the date of a metformin fill is AT LEAST 10 days prior to the claim for a GLP-1 receptor agonist or a GIP-GLP-1 receptor agonist within the past 180 days
Step Therapy Group	GLP-1 AGONIST 676-D
Drug Names	LIRAGLUTIDE, OZEMPIC, TRULICITY
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30 day supply of metformin when the date of a metformin fill is AT LEAST 10 days prior to the claim for a GLP-1 receptor agonist or a GIP-GLP-1 receptor agonist within the past 180 days

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Disclaimer: This document is intended to display targeted step therapy products. Please refer to the actual criteria when reviewing coverage determination requests.

Step Therapy Group	OPIOID ER 2219-M
Drug Names	BELBUCA, BUPRENORPHINE, FENTANYL, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, METHADONE HYDROCHLORIDE, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER, NUCYNTA ER, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER, XTAMPZA ER
Step Therapy Criteria	Coverage will be provided if the member has filled a cumulative 8-day or greater supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative 30 days or greater within the past 90 days.
Step Therapy Group	OPIOID IR 2221-M
Drug Names	CODEINE SULFATE, HYDROMORPHONE HCL, MORPHINE SULFATE, NUCYNTA, OXYCODONE HCL, OXYCODONE HYDROCHLORIDE, OXYMORPHONE HYDROCHLORIDE, TAPENTADOL HYDROCHLORIDE, TRAMADOL HYDROCHLORIDE
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 8-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.
Step Therapy Group	OPIOID IR COMBO PRODUCTS 1358-E
Drug Names	ACETAMINOPHEN/CODEINE, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, TRAMADOL HYDROCHLORIDE/AC
Step Therapy Criteria	Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 8-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.

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Disclaimer: This document is intended to display targeted step therapy products. Please refer to the actual criteria when reviewing coverage determination requests.

Step Therapy Group	ORAL CGRP RECEPTOR ANTAGONISTS 3481-E
Drug Names	NURTEC, QULIPTA, UBRELVY
Step Therapy Criteria	For Nurtec: Coverage will be provided if the member has filled a prescription for at least a 30 day supply of two triptan 5-HT1 receptor agonists (include combinations) within the past 180 days OR at least a 56 day supply of divalproex sodium, topiramate, valproate sodium, valproic acid, metoprolol, propranolol, timolol, atenolol, nadolol, candesartan, amitriptyline, or venlafaxine within the past 730 days. For Qulipta: Coverage will be provided if the member has filled a prescription for at least a 56 day supply of divalproex sodium, topiramate, valproate sodium, valproic acid, metoprolol, propranolol, timolol, atenolol, nadolol, candesartan, amitriptyline, or venlafaxine within the past 730 days. For Ubrelvy: Coverage will be provided if the member has filled a prescription for at least a 30 day supply of two triptan 5-HT1 receptor agonists (include combinations) within the past 180 days.
Step Therapy Group	SIMVA 80MG 981-D
Drug Names	SIMVASTATIN
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for 80mg strength of simvastatin (Zocor) or 10-80mg strength of ezetimibe-simvastatin (Vytorin) (at least a 290 day supply within the past 365 days)
Step Therapy Group	SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR (SGLT2) AND SGLT2 COMBINATIONS 676-D
Drug Names	DAPAGLIFLOZIN, DAPAGLIFLOZIN/METFORMIN H, GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY XR
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for a 30 day supply of metformin within the past 180 days

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Step Therapy Group	TACROLIMUS 1254-F
Drug Names	TACROLIMUS
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 14 day supply of at least one corticosteroid of medium or higher potency within the past 180 days.
Step Therapy Group	ULORIC 540-D
Drug Names	FEBUXOSTAT
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for allopurinol (at least a 30 day supply within the past 180 days)
Step Therapy Group	VELPHORO 2048-D
Drug Names	VELPHORO
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30-day supply of calcium acetate within the past 120 days.
Step Therapy Group	VITAMIN D ANALOGS TOPICAL 1381-E
Drug Names	CALCIPOTRIENE, CALCIPOTRIENE/BETAMETHASO, CALCITRIOL
Step Therapy Criteria	Coverage will be provided if the member has filled a prescription for at least a 30-day supply of a topical steroid within the past 180 days.

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Sharp CA 4T Effective 01/01/2027

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

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPIOID ANALGESICS - DRUGS TO TREAT PAIN		
acetaminophen w/ codeine soln 120-12 mg/5ml	Tier 1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-15 mg	Tier 1	ST, QL (400 tabs every 30 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-30 mg	Tier 1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-60 mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit, PA**; if age 19 or younger, subject to initial 3-day limit
butorphanol tartrate soln 1mg/ml, 2mg/ml	MB	
butorphanol tartrate soln 10mg/ml	Tier 1	QL (2 bottles every 30 days)
codeine sulfate tabs 30mg	Tier 1	ST, QL (42 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
CODEINE SULFATE TABS 60mg	Tier 3	ST, QL (42 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
endocet tab 2.5-325	Tier 1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
endocet tab 5-325mg	Tier 1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
endocet tab 7.5-325	Tier 1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
endocet tab 10-325mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
fentanyl pt72 12mcg/hr, 25mcg/hr, 37.5mcg/hr	Tier 1	ST, QL (10 patches every 30 days)
fentanyl pt72 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	Tier 1	ST, PA; High Strength Requires PA
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	Tier 1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 2.5-325 mg	Tier 1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit
hydrocodone-acetaminophen tab 5-325 mg	Tier 1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 7.5-325 mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-acetaminophen tab 10-325 mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 10-200 mg	Tier 1	ST, QL (50 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl soln 2mg/ml	MB	
hydromorphone hcl tabs 2mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tabs 4mg	Tier 1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tabs 8mg	Tier 1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tb24 8mg, 12mg, 16mg	Tier 1	ST, QL (30 tabs every 30 days)
hydromorphone hcl tb24 32mg	Tier 1	ST, PA; High Strength Requires PA
methadone hcl conc 10mg/ml	Tier 1	QL (30 mL every 30 days); (indicated for opioid addiction)
methadone hcl soln 5mg/5ml	Tier 1	ST, QL (450 mL every 30 days)
methadone hcl soln 10mg/5ml	Tier 1	ST, QL (225 mL every 30 days)
methadone hcl tabs 5mg	Tier 1	ST, QL (90 tabs every 30 days)
methadone hcl tabs 10mg	Tier 1	ST, QL (30 tabs every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methadone hydrochloride i conc 10mg/ml (Methadone Hydrochloride I)	Tier 1	ST, QL (45 mL every 30 days); (generic of Methadone Intensol, indicated for pain)
methadose tbso 40mg (Methadose)	Tier 1	QL (9 tabs every 30 days)
morphine sulfate soln 4mg/ml, 10mg/ml	MB	
morphine sulfate soln 10mg/5ml	Tier 1	ST, QL (900 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate soln 20mg/5ml	Tier 1	ST, QL (675 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate soln 100mg/5ml	Tier 1	ST, QL (135 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tabs 15mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tabs 30mg	Tier 1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
morphine sulfate tbcr 15mg, 30mg	Tier 1	ST, QL (90 tabs every 30 days)
morphine sulfate tbcr 60mg, 100mg, 200mg	Tier 1	ST, PA; High Strength Requires PA
morphine sulfate beads cp24 30mg, 45mg, 60mg, 75mg, 90mg	Tier 1	ST, QL (30 caps every 30 days)
morphine sulfate beads cp24 120mg	Tier 1	ST, PA; High Strength Requires PA
nalbuphine hcl soln 10mg/ml, 20mg/ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NUCYNTA TABS 50mg ***(tapentadol hcl)***	Tier 3	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA TABS 75mg ***(tapentadol hcl)***	Tier 3	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA TABS 100mg ***(tapentadol hcl)***	Tier 3	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
NUCYNTA ER TB12 50mg, 100mg ***(tapentadol hcl)***	Tier 3	ST, QL (60 tabs every 30 days)
NUCYNTA ER TB12 150mg, 200mg, 250mg ***(tapentadol hcl)***	Tier 3	ST, PA; High Strength Requires PA
oxycodone hcl caps 5mg	Tier 1	ST, QL (180 caps every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl conc 100mg/5ml	Tier 1	ST, QL (90 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl soln 5mg/5ml	Tier 1	ST, QL (900 mL every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 5mg, 10mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone hcl tabs 15mg	Tier 1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 20mg	Tier 1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone hcl tabs 30mg	Tier 1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 2.5-325 mg	Tier 1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 5-325 mg	Tier 1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 7.5-325 mg	Tier 1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 10-325 mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tabs 5mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxymorphone hcl tabs 10mg	Tier 1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tb12 5mg, 7.5mg, 10mg, 15mg	Tier 1	ST, QL (60 tabs every 30 days)
oxymorphone hcl tb12 20mg, 30mg, 40mg	Tier 1	ST, PA; High Strength Requires PA
tapentadol hcl tabs 50mg	Tier 1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
tapentadol hcl tabs 75mg	Tier 1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
tapentadol hcl tabs 100mg	Tier 1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
tramadol hcl tabs 50mg	Tier 1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
tramadol hcl tb24 100mg	Tier 1	ST, QL (30 tabs every 30 days)
tramadol hcl tb24 200mg, 300mg	Tier 1	ST, PA; High Strength Requires PA
tramadol-acetaminophen tab 37.5-325 mg	Tier 1	ST, QL (40 tabs every 30 days); Subject to initial 7-day limit; if age 19 or younger, subject to initial 3-day limit
XTAMPZA ER C12A 9mg, 13.5mg, 18mg, 27mg ***(oxycodone)***	Tier 2	ST, QL (60 caps every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XTAMPZA ER C12A 36mg ***(oxycodone)***	Tier 2	ST, PA; High Strength Requires Prior Auth
OPIOID PARTIAL AGONISTS		
BELBUCA FILM 75mcg, 150mcg, 300mcg, 450mcg ***(buprenorphine hcl)***	Tier 2	ST, QL (60 films every 30 days)
BELBUCA FILM 600mcg, 750mcg, 900mcg ***(buprenorphine hcl)***	Tier 2	ST, PA; High Strength Requires Prior Auth
buprenorphine ptwk 5mcg/hr, 7.5mcg/hr, 10mcg/hr	Tier 1	ST, QL (4 patches every 30 days)
buprenorphine ptwk 15mcg/hr, 20mcg/hr	Tier 1	ST, PA; High Strength Requires Prior Auth
buprenorphine hcl soln .3mg/ml	MB	
SUBLOCADE SOSY 100mg/0.5ml, 300mg/1.5ml ***(buprenorphine)***	MB	
SALICYLATES		
aspirin ec adult low dose tbec 81mg (Aspirin Ec Adult Low Dose)	PV	QL (100 tabs every 30 days); $0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tabs 500mg	Tier 1	MO
goodsense aspirin chew 81mg (Goodsense Aspirin)	PV	QL (100 tabs every 30 days); $0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered
ANDROGENS-ANABOLIC		
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
methyltestosterone caps 10mg	Tier 1	MO
ANESTHETICS - DRUGS FOR NUMBING		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) soln .5%, 1%, 2%; sosy 100mg/5ml	MB	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTHELMINTICS		
EMVERM CHEW 100mg ***(mebendazole)***	Tier 3	QL (12 tabs every 365 days)
ivermectin tabs 3mg	Tier 1	
praziquantel tabs 600mg	Tier 1	QL (24 tabs every 365 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTI-BACTERIALS - MISCELLANEOUS		
amikacin sulfate soln 1gm/4ml, 500mg/2ml	MB	
fosfomycin tromethamine pack 3gm	Tier 1	
gentamicin sulfate soln 40mg/ml	MB	
neomycin sulfate tabs 500mg	Tier 1	
sulfadiazine tabs 500mg	Tier 1	
tinidazole tabs 250mg, 500mg	Tier 1	
tobramycin sulfate soln 80mg/2ml; solr 1.2gm	MB	
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
amphotericin b solr 50mg	MB	
CRESEMBA CAPS 74.5mg, 186mg ***(isavuconazonium sulfate)***	Tier 3	
fluconazole susr 10mg/ml, 40mg/ml; tabs 50mg, 100mg, 150mg, 200mg	Tier 1	
griseofulvin microsize susp 125mg/5ml; tabs 500mg	Tier 1	
griseofulvin ultramicrosize tabs 125mg, 250mg	Tier 1	
itraconazole caps 100mg; soln 10mg/ml	Tier 1	PA
nystatin tabs 500000unit	Tier 1	
posaconazole susp 40mg/ml	Tier 1	PA, MO
posaconazole tbec 100mg	Tier 2	PA, MO
terbinafine hcl tabs 250mg	Tier 1	
voriconazole susr 40mg/ml; tabs 50mg, 200mg	Tier 2	PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl tab 62.5-25 mg	Tier 1	
atovaquone-proguanil hcl tab 250-100 mg	Tier 1	
chloroquine phosphate tabs 250mg, 500mg	Tier 1	MO
COARTEM TAB 20-120MG ***(artemether-lumefantrine)***	Tier 3	
mefloquine hcl tabs 250mg	Tier 1	MO
primaquine phosphate tabs 26.3mg	Tier 1	
quinine sulfate caps 324mg	Tier 1	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate soln 20mg/ml	Tier 1	SP, QL (900 mL every 30 days)
abacavir sulfate tabs 300mg	Tier 1	SP, QL (60 tabs every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
APRETUDE SUER 600mg/3ml ***(cabotegravir)***	MB	
APTIVUS CAPS 250mg ***(tipranavir)***	Tier 2	SP, QL (120 caps every 30 days)
atazanavir sulfate caps 150mg, 300mg	Tier 1	SP, QL (30 caps every 30 days)
atazanavir sulfate caps 200mg	Tier 1	SP, QL (60 caps every 30 days)
darunavir tabs 600mg	Tier 1	SP, QL (60 tabs every 30 days)
darunavir tabs 800mg	Tier 1	SP, QL (30 tabs every 30 days)
EDURANT PED TBSO 2.5mg ***(rilpivirine hcl)***	Tier 2	SP, QL (180 tabs every 30 days)
efavirenz tabs 600mg	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine caps 200mg	Tier 1	SP, QL (30 caps every 30 days)
EMTRIVA SOLN 10mg/ml ***(emtricitabine)***	Tier 2	SP, QL (680 ml every 28 days)
etravirine tabs 100mg	Tier 1	SP, QL (120 tabs every 30 days)
etravirine tabs 200mg	Tier 1	SP, QL (60 tabs every 30 days)
fosamprenavir calcium tabs 700mg	Tier 1	SP, QL (120 tabs every 30 days)
INTELENCE TABS 25mg ***(etravirine)***	Tier 2	SP, QL (120 tabs every 30 days)
ISENTRESS CHEW 25mg, 100mg ***(raltegravir potassium)***	Tier 2	SP, QL (180 tabs every 30 days)
ISENTRESS PACK 100mg ***(raltegravir potassium)***	Tier 2	SP, QL (60 packets every 30 days)
ISENTRESS TABS 400mg ***(raltegravir potassium)***	Tier 2	SP, QL (120 tabs every 30 days)
ISENTRESS HD TABS 600mg ***(raltegravir potassium)***	Tier 2	SP, QL (60 tabs every 30 days)
lamivudine soln 10mg/ml	Tier 1	SP, QL (960 ml every 30 days)
lamivudine tabs 150mg	Tier 1	SP, QL (60 tabs every 30 days)
lamivudine tabs 300mg	Tier 1	SP, QL (30 tabs every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
maraviroc tabs 150mg	Tier 1	SP, QL (60 tabs every 30 days)
maraviroc tabs 300mg	Tier 1	SP, QL (120 tabs every 30 days)
nevirapine susp 50mg/5ml	Tier 1	SP, QL (1200 mL every 30 days)
nevirapine tabs 200mg	Tier 1	SP, QL (60 tabs every 30 days)
nevirapine tb24 400mg	Tier 1	SP, QL (30 tabs every 30 days)
NORVIR PACK 100mg ***(ritonavir)***	Tier 2	SP, QL (360 packets every 30 days)
PREZISTA SUSP 100mg/ml ***(darunavir)***	Tier 2	SP, QL (400 ml every 30 days)
PREZISTA TABS 75mg ***(darunavir)***	Tier 2	SP, QL (300 tabs every 30 days)
PREZISTA TABS 150mg ***(darunavir)***	Tier 2	SP, QL (180 tabs every 30 days)
RETROVIR IV INFUSION SOLN 10mg/ml ***(zidovudine)***	MB	
REYATAZ PACK 50mg ***(atazanavir sulfate)***	Tier 2	SP, QL (180 packets every 30 days)
rilpivirine hcl tabs 25mg	Tier 1	SP, QL (60 tabs every 30 days)
ritonavir tabs 100mg	Tier 1	SP, QL (360 tabs every 30 days)
SELZENTRY SOLN 20mg/ml ***(maraviroc)***	Tier 2	SP, QL (1840 mL every 30 days)
tenofovir disoproxil fumarate tabs 300mg	Tier 1	SP, QL (30 tabs every 30 days)
TIVICAY TABS 50mg ***(dolutegravir sodium)***	Tier 2	SP, QL (60 tabs every 30 days)
TIVICAY PD TBSO 5mg ***(dolutegravir sodium)***	Tier 2	SP, QL (360 tabs every 30 days)
TROGARZO SOLN 200mg/1.33ml ***(ibalizumab-uiyk)***	MB	
VIREAD POWD 40mg/gm ***(tenofovir disoproxil fumarate)***	Tier 2	SP, QL (240 gm every 30 days)
VIREAD TABS 150mg, 200mg, 250mg ***(tenofovir disoproxil fumarate)***	Tier 2	SP, QL (30 tabs every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
YEZTUGO SOLN 463.5mg/1.5ml ***(lenacapavir sodium)***	MB	
YEZTUGO TABS 300mg ***(lenacapavir sodium)***	Tier 2	SP, QL (8 tabs every 4 days)
zidovudine caps 100mg	Tier 1	SP, QL (180 caps every 30 days)
zidovudine syrp 50mg/5ml	Tier 1	SP, QL (1920 ml every 30 days)
zidovudine tabs 300mg	Tier 1	SP, QL (60 tabs every 30 days)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg	Tier 1	SP, QL (30 tabs every 30 days)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	Tier 2	SP, QL (30 tabs every 30 days)
CABENUVA SUS 400-600 ***(cabotegravir & rilpivirine)***	MB	
CABENUVA SUS 600-900 ***(cabotegravir & rilpivirine)***	MB	
CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	Tier 2	SP, QL (30 tabs every 30 days)
DELSTRIGO TAB ***(doravirine-lamivudine-tenofovir disoproxil fumarate)***	Tier 2	SP, QL (30 tabs every 30 days)
DESCOVY TAB 120-15MG ***(emtricitabine-tenofovir alafenamide fumarate)***	Tier 3	SP, QL (30 tabs every 30 days)
DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)***	Tier 3	SP, QL (30 tabs every 30 days); $0 copay for PrEP
DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)***	Tier 2	SP, QL (30 tabs every 30 days)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	Tier 1	SP, QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	Tier 1	SP, QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	Tier 1	SP, QL (30 tabs every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	Tier 1	SP, QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	PV	SP, QL (30 tabs every 30 days); $0 copay for PrEP
GENVOYA TAB ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)***	Tier 2	SP, QL (30 tabs every 30 days)
KALETRA SOL ***(lopinavir-ritonavir)***	Tier 2	SP, QL (480 ml every 30 days)
lamivudine-zidovudine tab 150-300 mg	Tier 1	SP, QL (60 tabs every 30 days)
lopinavir-ritonavir tab 100-25 mg	Tier 1	SP, QL (240 tabs every 30 days)
lopinavir-ritonavir tab 200-50 mg	Tier 1	SP, QL (120 tabs every 30 days)
ODEFSEY TAB ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)***	Tier 2	SP, QL (30 tabs every 30 days)
PREZCOBIX TAB 675/150 ***(darunavir-cobicistat)***	Tier 3	SP, QL (30 tabs every 30 days)
PREZCOBIX TAB 800-150 ***(darunavir-cobicistat)***	Tier 3	SP, QL (30 tabs every 30 days)
TRIUMEQ PD TAB ***(abacavir-dolutegravir-lamivudine)***	Tier 3	SP, QL (180 tabs every 30 days)
TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)***	Tier 3	SP, QL (30 tabs every 30 days)
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine caps 250mg	Tier 1	
ethambutol hcl tabs 100mg, 400mg	Tier 1	
isoniazid soln 100mg/ml	MB	
isoniazid syrp 50mg/5ml; tabs 100mg, 300mg	Tier 1	MO
PRIFTIN TABS 150mg ***(rifapentine)***	Tier 2	
pyrazinamide tabs 500mg	Tier 1	
rifabutin caps 150mg	Tier 1	
rifampin caps 150mg, 300mg	Tier 1	
rifampin solr 600mg	MB	
rifapentine tabs 150mg	Tier 1	
SIRTURO TABS 20mg, 100mg ***(bedaquiline fumarate)***	Tier 3	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir caps 200mg; susp 200mg/5ml; tabs 400mg, 800mg	Tier 1	
cidofovir soln 75mg/ml	MB	
famciclovir tabs 125mg, 250mg, 500mg	Tier 1	
oseltamivir phosphate caps 30mg	Tier 1	QL (40 caps every 90 days)
oseltamivir phosphate caps 45mg, 75mg	Tier 1	QL (20 caps every 90 days)
oseltamivir phosphate susr 6mg/ml	Tier 1	QL (360 mL every 90 days)
PAXLOVID PAK ***(nirmatrelvir-ritonavir)***	PV	QL (22 tabs every 30 days)
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)
RELENZA DISKHALER AEPB 5mg/blister ***(zanamivir)***	Tier 2	QL (2 inhalers every 90 days)
rimantadine hydrochloride tabs 100mg	Tier 1	
valacyclovir hcl tabs 1gm, 500mg	Tier 1	
valganciclovir hcl solr 50mg/ml	Tier 4	PA, QL (1144 mL every 30 days)
valganciclovir hcl tabs 450mg	Tier 4	PA, QL (120 tabs every 30 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor caps 250mg, 500mg; susr 250mg/5ml	Tier 1	
cefadroxil caps 500mg; susr 250mg/5ml, 500mg/5ml; tabs 1gm	Tier 1	
cefazolin sodium solr 1gm	MB	
cefdinir caps 300mg; susr 125mg/5ml, 250mg/5ml	Tier 1	
cefepime hcl solr 1gm, 2gm	MB	
cefixime caps 400mg; susr 100mg/5ml, 200mg/5ml	Tier 1	
cefpodoxime proxetil susr 50mg/5ml, 100mg/5ml; tabs 100mg, 200mg	Tier 1	
cefprozil susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
ceftazidime solr 2gm	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ceftriaxone sodium solr 1gm, 2gm, 10gm, 250mg, 500mg	MB	
cefuroxime axetil tabs 250mg, 500mg	Tier 1	
cephalexin caps 250mg, 500mg, 750mg; susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
tazicef solr 1gm (Tazicef)	MB	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin susr 100mg/5ml, 200mg/5ml; tabs 250mg, 500mg, 600mg	Tier 1	
clarithromycin susr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg; tb24 500mg	Tier 1	
DIFICID SUSR 40mg/ml ***(fidaxomicin)***	Tier 2	PA
e.e.s. 400 tabs 400mg (E.e.s. 400)	Tier 1	
erythromycin base cpep 250mg; tabs 250mg, 500mg; tbec 250mg, 333mg, 500mg	Tier 1	
erythromycin ethylsuccinate susr 200mg/5ml, 400mg/5ml	Tier 1	
fidaxomicin tabs 200mg	Tier 1	PA
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO SUSR 500mg/5ml ***(ciprofloxacin)***	Tier 3	
ciprofloxacin hcl tabs 250mg, 500mg, 750mg	Tier 1	
levofloxacin soln 25mg/ml	MB	
levofloxacin soln 25mg/ml; tabs 250mg, 500mg, 750mg	Tier 1	
moxifloxacin hcl tabs 400mg	Tier 1	
ofloxacin tabs 300mg, 400mg	Tier 1	
HEPATITIS B		
adefovir dipivoxil tabs 10mg	Tier 4	SP
BARACLUDE SOLN .05mg/ml ***(entecavir)***	Tier 4	SP, PA, QL (630 mL every 30 days)
entecavir tabs .5mg, 1mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
lamivudine (hbv) tabs 100mg	Tier 1	SP
HEPATITIS C		
MAVYRET PAK 50-20MG ***(glecaprevir-pibrentasvir)***	Tier 2	SP, PA, QL (140 packets every 28 days)
MAVYRET TAB 100-40MG ***(glecaprevir-pibrentasvir)***	Tier 2	SP, PA, QL (84 tabs every 28 days)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml ***(peginterferon alfa-2a)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ribavirin (hepatitis c) caps 200mg; tabs 200mg	Tier 1	SP
SOVALDI PACK 150mg ***(sofosbuvir)***	Tier 4	SP, PA, QL (28 pellets every 28 days)
SOVALDI PACK 200mg ***(sofosbuvir)***	Tier 4	SP, PA, QL (56 pellets every 28 days)
SOVALDI TABS 200mg ***(sofosbuvir)***	Tier 4	SP, PA, QL (56 tabs every 28 days)
SOVALDI TABS 400mg ***(sofosbuvir)***	Tier 4	SP, PA, QL (28 tabs every 28 days)
MISCELLANEOUS		
atovaquone susp 750mg/5ml	Tier 1	
aztreonam solr 1gm, 2gm	MB	
clindamycin hcl caps 75mg, 150mg, 300mg	Tier 1	
clindamycin palmitate hydrochloride solr 75mg/5ml	Tier 1	
dapsone tabs 25mg, 100mg	Tier 1	MO
ertapenem sodium solr 1gm	MB	
linezolid soln 600mg/300ml	MB	
linezolid susr 100mg/5ml; tabs 600mg	Tier 1	
meropenem solr 1gm, 500mg	MB	
methenamine hippurate tabs 1gm	Tier 1	
metronidazole caps 375mg; tabs 250mg, 500mg	Tier 1	
metronidazole soln 500mg/100ml	MB	
nitazoxanide tabs 500mg	Tier 1	QL (20 tabs every 30 days)
nitrofurantoin susp 25mg/5ml	Tier 1	
nitrofurantoin macrocrystal caps 25mg, 50mg, 100mg	Tier 1	
nitrofurantoin monohyd macro caps 100mg	Tier 1	
pentamidine isethionate solr 300mg	Tier 1	
pentamidine isethionate solr 300mg	MB	
polymyxin b sulfate solr 500000unit	MB	
pyrimethamine tabs 25mg	Tier 2	PA
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	Tier 1	
sulfamethoxazole-trimethoprim tab 400-80 mg	Tier 1	
sulfamethoxazole-trimethoprim tab 800-160 mg	Tier 1	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
trimethoprim tabs 100mg	Tier 1	
vancomycin hcl caps 125mg, 250mg	Tier 1	QL (80 caps every 10 days)
vancomycin hcl solr 1gm, 5gm, 10gm, 500mg, 750mg	MB	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
amoxicillin caps 250mg, 500mg; chew 125mg, 250mg; susr 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; tabs 500mg, 875mg	Tier 1	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	Tier 1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	Tier 1	
amoxicillin & k clavulanate tab 250-125 mg	Tier 1	
amoxicillin & k clavulanate tab 500-125 mg	Tier 1	
amoxicillin & k clavulanate tab 875-125 mg	Tier 1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	Tier 1	
ampicillin caps 500mg	Tier 1	
ampicillin sodium solr 1gm, 2gm	MB	
dicloxacillin sodium caps 250mg, 500mg	Tier 1	
penicillin g potassium solr 5000000unit, 20000000unit	MB	
penicillin g sodium solr 5000000unit	MB	
penicillin v potassium solr 125mg/5ml, 250mg/5ml; tabs 250mg, 500mg	Tier 1	
pfizerpen solr 20000000unit (Pfizerpen)	MB	
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	MB	
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	MB	
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	MB	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
avidoxy tabs 100mg (Avidoxy)	Tier 1	
demeclocycline hcl tabs 150mg, 300mg	Tier 1	
doxy 100 solr 100mg (Doxy 100)	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
doxycycline (monohydrate) caps 50mg, 100mg; susr 25mg/5ml; tabs 50mg, 75mg, 150mg	Tier 1	
doxycycline hyclate caps 50mg, 100mg; tabs 100mg	Tier 1	
doxycycline hyclate solr 100mg	MB	
minocycline hcl caps 50mg, 75mg, 100mg; tabs 50mg, 75mg, 100mg	Tier 1	
tetracycline hcl caps 250mg, 500mg	Tier 1	
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
fluticasone propionate hfa aero 44mcg/act, 110mcg/act, 220mcg/act	Tier 1	QL (6 inhalers per 75 days), MO
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
neostigmine methylsulfate soln 10mg/10ml	MB	
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS		
PRETOMANID TABS 200mg	Tier 3	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
busulfan soln 6mg/ml	MB	
carmustine solr 100mg	MB	
cyclophosphamide caps 25mg, 50mg	Tier 1	OAC
cyclophosphamide solr 1gm, 2gm, 500mg	MB	
dacarbazine solr 100mg, 200mg	MB	
GLIADEL WAF 7.7MG ***(carmustine in polifeprosan)***	MB	
ifosfamide soln 1gm/20ml, 3gm/60ml; solr 1gm	MB	
LEUKERAN TABS 2mg ***(chlorambucil)***	Tier 2	OAC
lomustine caps 10mg, 40mg, 100mg	Tier 1	SP; OAC
MATULANE CAPS 50mg ***(procarbazine hcl)***	Tier 2	OAC
melphalan hcl solr 50mg	MB	
TEMODAR SOLR 100mg ***(temozolomide)***	MB	
temozolomide caps 5mg, 20mg, 100mg, 140mg, 180mg, 250mg	Tier 4	SP, PA; OAC
ANTIBIOTICS		
adriamycin solr 50mg (Adriamycin)	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bleomycin sulfate solr 15unit, 30unit	MB	
daunorubicin hcl soln 20mg/4ml	MB	
doxorubicin hcl soln 2mg/ml; solr 10mg	MB	
doxorubicin hcl liposomal susp 2mg/ml	MB	
idarubicin hcl soln 5mg/5ml, 10mg/10ml, 20mg/20ml	MB	
mitomycin solr 5mg, 20mg, 40mg	MB	
mitoxantrone hcl conc 2mg/ml	MB	
ANTIMETABOLITES		
azacitidine susr 100mg	MB	
capecitabine tabs 150mg, 500mg	Tier 4	SP, PA; OAC
cladribine soln 10mg/10ml	MB	
clofarabine soln 1mg/ml	MB	
cytarabine soln 20mg/ml, 100mg/ml	MB	
decitabine solr 50mg	MB	
fludarabine phosphate soln 50mg/2ml; solr 50mg	MB	
fluorouracil soln 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	MB	
gemcitabine hcl soln 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; solr 1gm, 2gm, 200mg	MB	
mercaptopurine tabs 50mg	Tier 1	OAC
methotrexate sodium soln 1gm/40ml, 50mg/2ml, 250mg/10ml; solr 1gm	MB	
NIPENT SOLR 10mg ***(pentostatin)***	MB	
pemetrexed disodium solr 100mg, 500mg	MB	
TABLOID TABS 40mg ***(thioguanine)***	Tier 2	OAC
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA TABS 10mg, 50mg ***(venetoclax)***	Tier 4	PA, QL (120 every 30 days); OAC
VENCLEXTA TABS 100mg ***(venetoclax)***	Tier 4	PA, QL (180 every 30 days); OAC
VENCLEXTA TAB START PK ***(venetoclax)***	Tier 4	PA, QL (1 pack every 28 days); OAC
BIOLOGIC RESPONSE MODIFIERS		
ERBITUX SOLN 100mg/50ml, 200mg/100ml ***(cetuximab)***	MB	
ERIVEDGE CAPS 150mg ***(vismodegib)***	Tier 4	SP, PA, QL (30 caps every 30 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KADCYLA SOLR 100mg, 160mg ***(ado-trastuzumab emtansine)***	MB	
KEYTRUDA SOLN 100mg/4ml ***(pembrolizumab)***	MB	
lenalidomide caps 2.5mg, 5mg, 10mg, 15mg	Tier 4	SP, PA, QL (28 caps every 28 days); OAC
lenalidomide caps 20mg, 25mg	Tier 4	SP, PA, QL (21 caps every 28 days); OAC
PADCEV SOLR 20mg, 30mg ***(enfortumab vedotin-ejfv)***	MB	
pomalidomide caps 1mg, 2mg, 3mg, 4mg	Tier 4	SP, PA, QL (21 caps every 28 days); OAC
THALOMID CAPS 50mg ***(thalidomide)***	Tier 4	SP, PA, QL (28 caps every 28 days); OAC
THALOMID CAPS 100mg ***(thalidomide)***	Tier 4	SP, PA, QL (112 caps every 28 days); OAC
TICE BCG SUSR 50mg ***(bcg live intravesical)***	MB	
BIOSIMILARS		
GAZYVA SOLN 1000mg/40ml ***(obinutuzumab)***	MB	
RUXIENCE SOLN 100mg/10ml, 500mg/50ml ***(rituximab-pvvr)***	MB	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate tabs 250mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
abiraterone acetate tabs 500mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
anastrozole tabs 1mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
bicalutamide tabs 50mg	Tier 1	OAC
ELIGARD KIT 7.5mg ***(leuprolide acetate)***	MB	
ELIGARD KIT 22.5mg ***(leuprolide acetate (3 month))***	MB	
ELIGARD KIT 30mg ***(leuprolide acetate (4 month))***	MB	
ELIGARD KIT 45mg ***(leuprolide acetate (6 month))***	MB	
ERLEADA TABS 60mg ***(apalutamide)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ERLEADA TABS 240mg ***(apalutamide)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
exemestane tabs 25mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
fulvestrant sosy 250mg/5ml	MB	
letrozole tabs 2.5mg	Tier 1	MO; OAC
leuprolide acetate kit 1mg/0.2ml	MB	
LYSODREN TABS 500mg ***(mitotane)***	Tier 2	OAC
megestrol acetate tabs 20mg, 40mg	Tier 1	OAC
nilutamide tabs 150mg	Tier 1	OAC
NUBEQA TABS 300mg ***(darolutamide)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
tamoxifen citrate tabs 10mg, 20mg	Tier 1	MO; OAC; $0 copay ages 35 and older for the primary prevention of breast cancer
toremifene citrate tabs 60mg	Tier 1	MO; OAC
XTANDI CAPS 40mg ***(enzalutamide)***	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
XTANDI TABS 40mg ***(enzalutamide)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
XTANDI TABS 80mg ***(enzalutamide)***	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
YONSA TABS 125mg ***(abiraterone acetate micronized)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
KINASE INHIBITORS		
ALECENSA CAPS 150mg ***(alectinib hcl)***	Tier 4	SP, PA, QL (240 caps every 30 days); OAC
BRAFTOVI CAPS 75mg ***(encorafenib)***	Tier 4	SP, PA, QL (180 caps every 30 days); OAC
BRUKINSA CAPS 80mg ***(zanubrutinib)***	Tier 4	PA, QL (120 caps every 30 days); OAC
BRUKINSA TABS 160mg ***(zanubrutinib)***	Tier 4	PA, QL (60 tabs every 30 days); OAC
CABOMETYX TABS 20mg, 40mg, 60mg ***(cabozantinib s-malate)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
CALQUENCE TABS 100mg ***(acalabrutinib maleate)***	Tier 4	PA, QL (60 tabs every 30 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CAPRELSA TABS 100mg ***(vandetanib)***	Tier 4	PA, QL (60 tabs every 30 days); OAC
CAPRELSA TABS 300mg ***(vandetanib)***	Tier 4	PA, QL (30 tabs every 30 days); OAC
COMETRIQ KIT 20mg ***(cabozantinib s-malate)***	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 100MG ***(cabozantinib s-malate)***	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
COMETRIQ KIT 140MG ***(cabozantinib s-malate)***	Tier 4	SP, PA, QL (1 kit every 28 days); OAC
dasatinib tabs 20mg	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
dasatinib tabs 50mg, 70mg, 80mg, 100mg, 140mg	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
erlotinib hcl tabs 25mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
erlotinib hcl tabs 100mg, 150mg	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus tabs 2.5mg, 5mg, 7.5mg, 10mg	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
everolimus tbso 2mg, 5mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
everolimus tbso 3mg	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
IBTROZI CAPS 200mg ***(taletrectinib adipate)***	Tier 4	PA, QL (90 caps every 30 days); OAC
imatinib mesylate tabs 100mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
imatinib mesylate tabs 400mg	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
IMBRUVICA CAPS 70mg ***(ibrutinib)***	Tier 4	PA, QL (30 caps every 30 days); OAC
IMBRUVICA CAPS 140mg ***(ibrutinib)***	Tier 4	PA, QL (90 caps every 30 days); OAC
IMBRUVICA SUSP 70mg/ml ***(ibrutinib)***	Tier 4	PA, QL (216 ml every 36 days); OAC
IMBRUVICA TABS 140mg, 280mg, 420mg ***(ibrutinib)***	Tier 4	PA, QL (30 tabs every 30 days); OAC
INLYTA TABS 1mg ***(axitinib)***	Tier 4	SP, PA, QL (240 tabs every 30 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INLYTA TABS 5mg ***(axitinib)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
ITOVEBI TABS 3mg ***(inavolisib)***	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
ITOVEBI TABS 9mg ***(inavolisib)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg ***(ruxolitinib phosphate)***	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	Tier 4	SP, PA, QL (21 tabs every 28 days); 200 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	Tier 4	SP, PA, QL (42 tabs every 28 days); 400 mg dose; OAC
KISQALI TBPK 200mg ***(ribociclib succinate)***	Tier 4	SP, PA, QL (63 tabs every 28 days); 600 mg dose; OAC
lapatinib ditosylate tabs 250mg	Tier 4	SP, PA, QL (180 tabs every 30 days); OAC
LENVIMA 4 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
LENVIMA 8 MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA 10 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
LENVIMA 12MG DAILY DOSE CPPK 4mg ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (90 caps every 30 days); OAC
LENVIMA 20 MG DAILY DOSE CPPK 10mg ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA CAP 14 MG ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (60 caps every 30 days); OAC
LENVIMA CAP 18 MG ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (90 caps every 30 days); OAC
LENVIMA CAP 24 MG ***(lenvatinib mesylate)***	Tier 4	SP, PA, QL (90 caps every 30 days); OAC
LORBRENA TABS 25mg ***(lorlatinib)***	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
LORBRENA TABS 100mg ***(lorlatinib)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
MEKINIST SOLR .05mg/ml ***(trametinib dimethyl sulfoxide)***	Tier 4	SP, PA, QL (12 bottles every 28 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MEKINIST TABS 2mg ***(trametinib dimethyl sulfoxide)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
MEKINIST TABS .5mg ***(trametinib dimethyl sulfoxide)***	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
MEKTOVI TABS 15mg ***(binimetinib)***	Tier 4	SP, PA, QL (180 tabs every 30 days); OAC
nilotinib hcl caps 50mg, 150mg, 200mg	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
pazopanib hcl tabs 200mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
RYDAPT CAPS 25mg ***(midostaurin)***	Tier 4	SP, PA, QL (224 caps every 28 days); OAC
SCEMBLIX TABS 20mg, 40mg ***(asciminib hcl)***	Tier 4	PA, QL (60 tabs every 30 days); OAC
SCEMBLIX TABS 100mg ***(asciminib hcl)***	Tier 4	PA, QL (120 tabs every 30 days); OAC
sorafenib tosylate tabs 200mg	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
STIVARGA TABS 40mg ***(regorafenib)***	Tier 4	SP, PA, QL (84 tabs every 28 days); OAC
sunitinib malate caps 12.5mg, 25mg, 37.5mg, 50mg	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
TAFINLAR CAPS 50mg, 75mg ***(dabrafenib mesylate)***	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
TAFINLAR TBSO 10mg ***(dabrafenib mesylate)***	Tier 4	SP, PA, QL (4 bottles every 28 days); OAC
TAGRISSO TABS 40mg, 80mg ***(osimertinib mesylate)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
TRUQAP TABS 200mg; TBPK 160mg, 200mg ***(capivasertib)***	Tier 4	PA, QL (64 tabs every 28 days); OAC
TRUQAP TBPK 200mg ***(capivasertib)***	Tier 4	PA, QL (32 tabs every 28 days); OAC
TUKYSA TABS 50mg, 150mg ***(tucatinib)***	Tier 4	PA, QL (120 tabs every 30 days); OAC
VERZENIO TABS 50mg, 100mg, 150mg, 200mg ***(abemaciclib)***	Tier 4	SP, PA, QL (56 tabs every 28 days); OAC
VITRAKVI CAPS 25mg ***(larotrectinib sulfate)***	Tier 4	SP, PA, QL (180 caps every 30 days); OAC
VITRAKVI CAPS 100mg ***(larotrectinib sulfate)***	Tier 4	SP, PA, QL (60 caps every 30 days); OAC

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VITRAKVI SOLN 20mg/ml ***(larotrectinib sulfate)***	Tier 4	SP, PA, QL (300 mL every 30 days); OAC
XALKORI CAPS 200mg, 250mg ***(crizotinib)***	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
XALKORI CPSP 20mg, 50mg ***(crizotinib)***	Tier 4	SP, PA, QL (120 pellets every 30 days); OAC
XALKORI CPSP 150mg ***(crizotinib)***	Tier 4	SP, PA, QL (180 pellets every 30 days); OAC
ZYDELIG TABS 100mg, 150mg ***(idelalisib)***	Tier 4	SP, PA, QL (60 tabs every 30 days); OAC
ZYKADIA TABS 150mg ***(ceritinib)***	Tier 4	SP, PA, QL (90 tabs every 30 days); OAC
MISCELLANEOUS		
arsenic trioxide soln 10mg/10ml, 12mg/6ml	MB	
bexarotene caps 75mg	Tier 4	SP, PA; OAC
hydroxyurea caps 500mg	Tier 1	OAC
IDHIFA TABS 50mg, 100mg ***(enasidenib mesylate)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
LYNPARZA TABS 100mg, 150mg ***(olaparib)***	Tier 4	SP, PA, QL (120 tabs every 30 days); OAC
ODOMZO CAPS 200mg ***(sonidegib phosphate)***	Tier 4	SP, PA, QL (30 caps every 30 days); OAC
ONCASPAR SOLN 750unit/ml ***(pegaspargase)***	MB	
PHOTOFRIN SOLR 75mg ***(porfimer sodium)***	MB	
POLIVY SOLR 30mg, 140mg ***(polatuzumab vedotin-piiq)***	MB	
tretinoin (chemotherapy) caps 10mg	Tier 1	OAC
VISTOGARD PACK 10gm ***(uridine triacetate (emergency treatment))***	Tier 4	QL (20 packets every 5 days); OAC
ZEJULA TABS 100mg, 200mg, 300mg ***(niraparib tosylate)***	Tier 4	SP, PA, QL (30 tabs every 30 days); OAC
ZOLINZA CAPS 100mg ***(vorinostat)***	Tier 4	SP, PA, QL (120 caps every 30 days); OAC
MITOTIC INHIBITORS		
docetaxel conc 20mg/ml, 80mg/4ml, 160mg/8ml; soln 20mg/2ml, 80mg/8ml, 160mg/16ml	MB	
paclitaxel conc 30mg/5ml, 100mg/16.7ml, 150mg/25ml, 300mg/50ml	MB	
vinblastine sulfate soln 1mg/ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
vincristine sulfate soln 1mg/ml	MB	
vinorelbine tartrate soln 10mg/ml, 50mg/5ml	MB	
PLATINUM-BASED AGENTS		
carboplatin soln 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	MB	
cisplatin soln 50mg/50ml, 100mg/100ml, 200mg/200ml	MB	
oxaliplatin soln 50mg/10ml, 100mg/20ml; solr 50mg, 100mg	MB	
PROTECTIVE AGENTS		
dexrazoxane hcl solr 250mg, 500mg	MB	
leucovorin calcium solr 50mg, 100mg, 200mg, 350mg, 500mg	MB	
leucovorin calcium tabs 5mg, 10mg, 15mg, 25mg	Tier 1	OAC
mesna soln 100mg/ml	MB	
mesna tabs 400mg	Tier 1	OAC
TOPOISOMERASE INHIBITORS		
etoposide caps 50mg	Tier 1	OAC
etoposide soln 1gm/50ml, 100mg/5ml, 500mg/25ml	MB	
irinotecan hcl soln 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	MB	
topotecan hcl solr 4mg	MB	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ANTINEOPLASTICS MISC.		
INTRON A SOLR 10000000unit, 18000000unit, 50000000unit ***(interferon alfa-2b)***	MB	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIRETROVIRALS		
EVOTAZ TAB 300-150 ***(atazanavir sulfate-cobicistat)***	Tier 4	SP, QL (1 tab per 1 day)
SYMTUZA TAB ***(darunavir-cobicistat-emtricitabine-tenofovir alafenamide)***	Tier 4	SP, QL (1 tab per 1 day)
VIRACEPT TABS 250mg ***(nelfinavir mesylate)***	Tier 4	SP, QL (10 tab per 1 day)
VIRACEPT TABS 625mg ***(nelfinavir mesylate)***	Tier 4	SP, QL (4 tab per 1 day)
HEPATITIS AGENTS		
MAVYRET TAB 100-40MG ***(glecaprevir-pibrentasvir)***	Tier 4	SP, PA

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PEGINTRON KIT 50mcg/0.5ml ***(peginterferon alfa-2b)***	MB	
VEMLIDY TABS 25mg ***(tenofovir alafenamide fumarate)***	Tier 4	SP, PA
ZEPATIER TAB 50-100MG ***(elbasvir-grazoprevir)***	Tier 4	SP, PA
MISC. ANTIVIRALS		
LAGEVRIO CAPS 200mg ***(molnupiravir)***	PV	QL (40 caps every 30 days)
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-10 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-20 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 5-40 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 10-20 mg	Tier 1	MO
amlodipine besylate-benazepril hcl cap 10-40 mg	Tier 1	MO
benazepril & hydrochlorothiazide tab 5-6.25 mg	Tier 1	MO
benazepril & hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO
benazepril & hydrochlorothiazide tab 20-12.5 mg	Tier 1	MO
benazepril & hydrochlorothiazide tab 20-25 mg	Tier 1	MO
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	Tier 1	MO
enalapril maleate & hydrochlorothiazide tab 10-25 mg	Tier 1	MO
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	Tier 1	MO
lisinopril & hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lisinopril & hydrochlorothiazide tab 20-12.5 mg	Tier 1	MO
lisinopril & hydrochlorothiazide tab 20-25 mg	Tier 1	MO
quinapril-hydrochlorothiazide tab 10-12.5 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 1-240 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 2-180 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 2-240 mg	Tier 1	MO
trandolapril-verapamil hcl tab er 4-240 mg	Tier 1	MO
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl tabs 5mg, 10mg, 20mg, 40mg	Tier 1	MO
captopril tabs 12.5mg, 25mg, 50mg, 100mg	Tier 1	MO
enalapril maleate tabs 2.5mg, 5mg, 10mg, 20mg	Tier 1	MO
fosinopril sodium tabs 10mg, 20mg, 40mg	Tier 1	MO
lisinopril tabs 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	Tier 1	MO
moexipril hcl tabs 7.5mg, 15mg	Tier 1	MO
perindopril erbumine tabs 2mg, 4mg, 8mg	Tier 1	MO
quinapril hcl tabs 5mg, 10mg, 20mg, 40mg	Tier 1	MO
ramipril caps 1.25mg, 2.5mg, 5mg, 10mg	Tier 1	MO
trandolapril tabs 1mg, 2mg, 4mg	Tier 1	MO
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
eplerenone tabs 25mg, 50mg	Tier 1	MO
KERENDIA TABS 10mg, 20mg, 40mg ***(finerenone)***	Tier 3	PA, MO
spironolactone tabs 25mg, 50mg, 100mg	Tier 1	MO
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
prazosin hcl caps 1mg, 2mg, 5mg	Tier 1	MO
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-valsartan tab 5-160 mg	Tier 1	MO
amlodipine besylate-valsartan tab 5-320 mg	Tier 1	MO
amlodipine besylate-valsartan tab 10-160 mg	Tier 1	MO
amlodipine besylate-valsartan tab 10-320 mg	Tier 1	MO
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	Tier 1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	Tier 1	MO
irbesartan-hydrochlorothiazide tab 150-12.5 mg	Tier 1	MO
irbesartan-hydrochlorothiazide tab 300-12.5 mg	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	Tier 1	MO
losartan potassium & hydrochlorothiazide tab 100-25 mg	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	Tier 1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	Tier 1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	Tier 1	MO
telmisartan-hydrochlorothiazide tab 40-12.5 mg	Tier 1	MO
telmisartan-hydrochlorothiazide tab 80-12.5 mg	Tier 1	MO
telmisartan-hydrochlorothiazide tab 80-25 mg	Tier 1	MO
valsartan-hydrochlorothiazide tab 80-12.5 mg	Tier 1	MO
valsartan-hydrochlorothiazide tab 160-12.5 mg	Tier 1	MO
valsartan-hydrochlorothiazide tab 160-25 mg	Tier 1	MO
valsartan-hydrochlorothiazide tab 320-12.5 mg	Tier 1	MO
valsartan-hydrochlorothiazide tab 320-25 mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil tabs 4mg, 8mg, 16mg, 32mg	Tier 1	MO
irbesartan tabs 75mg, 150mg, 300mg	Tier 1	MO
losartan potassium tabs 25mg, 50mg, 100mg	Tier 1	MO
olmesartan medoxomil tabs 5mg, 20mg, 40mg	Tier 1	MO
telmisartan tabs 20mg, 40mg, 80mg	Tier 1	MO
valsartan tabs 40mg, 80mg, 160mg, 320mg	Tier 1	MO
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl tabs 200mg, 400mg	Tier 1	MO
disopyramide phosphate caps 100mg, 150mg	Tier 1	MO
dofetilide caps 125mcg, 250mcg, 500mcg	Tier 1	SP
flecainide acetate tabs 50mg, 100mg, 150mg	Tier 1	MO
lidocaine hcl (cardiac) sosy 50mg/5ml, 100mg/5ml	MB	
MULTAQ TABS 400mg ***(dronedarone hcl)***	Tier 2	PA, MO
NORPACE CR CP12 100mg, 150mg ***(disopyramide phosphate)***	Tier 2	MO
pacerone tabs 100mg, 200mg (Pacerone)	Tier 1	MO
procainamide hcl soln 100mg/ml	MB	
propafenone hcl cp12 225mg, 325mg, 425mg; tabs 150mg, 225mg, 300mg	Tier 1	MO
sotalol hcl tabs 80mg, 120mg, 160mg, 240mg	Tier 1	MO
sotalol hcl (afib/afl) tabs 80mg, 120mg, 160mg	Tier 1	MO
ANTILIPEMICS, ACL INHIBITORS/COMBINATIONS		
NEXLETOL TABS 180mg ***(bempedoic acid)***	Tier 3	PA, MO
ANTILIPEMICS, BILE ACID RESINS		
cholestyramine pack 4gm; powd 4gm/dose	Tier 1	MO
cholestyramine light pack 4gm; powd 4gm/dose	Tier 1	MO
colesevelam hcl pack 3.75gm; tabs 625mg	Tier 1	MO
colestipol hcl gran 5gm; pack 5gm; tabs 1gm	Tier 1	MO
prevalite powd 4gm/dose (Prevalite)	Tier 1	MO
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR		
ezetimibe tabs 10mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTILIPEMICS, FIBRATES		
choline fenofibrate cpdr 45mg, 135mg	Tier 1	MO
fenofibrate caps 150mg; tabs 48mg, 54mg, 145mg, 160mg	Tier 1	MO
fenofibrate micronized caps 43mg, 67mg, 134mg, 200mg	Tier 1	MO
gemfibrozil tabs 600mg	Tier 1	MO
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS		
atorvastatin calcium tabs 10mg, 20mg	Tier 1	MO; $0 copay for members age 40 through 75
atorvastatin calcium tabs 40mg, 80mg	Tier 1	MO; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
fluvastatin sodium caps 20mg, 40mg; tb24 80mg	Tier 1	MO; $0 copay for members age 40 through 75
lovastatin tabs 10mg, 20mg, 40mg	Tier 1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tabs 1mg, 2mg, 4mg	Tier 1	MO; $0 copay for members age 40 through 75
pravastatin sodium tabs 10mg, 20mg, 40mg, 80mg	Tier 1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tabs 5mg, 10mg	Tier 1	MO; $0 copay for members age 40 through 75
rosuvastatin calcium tabs 20mg, 40mg	Tier 1	MO; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
simvastatin tabs 5mg, 10mg, 20mg, 40mg	Tier 1	MO; $0 copay for members age 40 through 75
simvastatin tabs 80mg	Tier 1	ST, MO; PA**; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg	Tier 1	MO
ezetimibe-simvastatin tab 10-20 mg	Tier 1	MO
ezetimibe-simvastatin tab 10-40 mg	Tier 1	MO
ezetimibe-simvastatin tab 10-80 mg	Tier 1	MO
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
niacin (antihyperlipidemic) tbcr 500mg, 750mg, 1000mg	Tier 1	MO
ANTILIPEMICS, OMEGA-3 FATTY ACIDS		
icosapent ethyl caps .5gm, 1gm	Tier 1	MO
omega-3-acid ethyl esters cap 1 gm	Tier 1	MO
ANTILIPEMICS, PCSK9 INHIBITORS		
REPATHA SOSY 140mg/ml ***(evolocumab)***	MB	
REPATHA SURECLICK SOAJ 140mg/ml ***(evolocumab)***	MB	
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg	Tier 1	MO
atenolol & chlorthalidone tab 100-25 mg	Tier 1	MO
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	Tier 1	MO
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	Tier 1	MO
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	Tier 1	MO
metoprolol & hydrochlorothiazide tab 50-25 mg	Tier 1	MO
metoprolol & hydrochlorothiazide tab 100-25 mg	Tier 1	MO

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

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amlodipine besylate-atorvastatin calcium tab 10-10 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-20 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-40 mg	Tier 1	MO
amlodipine besylate-atorvastatin calcium tab 10-80 mg	Tier 1	MO
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
amlodipine besylate tabs 2.5mg, 5mg, 10mg	Tier 1	MO
cartia xt cp24 120mg, 180mg, 240mg, 300mg (Cartia Xt)	Tier 1	MO
dilt-xr cp24 120mg, 180mg, 240mg (Dilt-xr)	Tier 1	MO
diltiazem hcl cp12 60mg, 90mg, 120mg; tabs 30mg, 60mg, 90mg, 120mg; tb24 120mg	Tier 1	MO
diltiazem hcl soln 25mg/5ml, 125mg/25ml	MB	
diltiazem hcl coated beads cp24 120mg, 180mg, 240mg, 300mg, 360mg	Tier 1	MO
diltiazem hcl extended release beads cp24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	Tier 1	MO
felodipine tb24 2.5mg, 5mg, 10mg	Tier 1	MO
isradipine caps 2.5mg, 5mg	Tier 1	MO
matzim la tb24 180mg, 240mg, 300mg, 360mg, 420mg (Matzim La)	Tier 1	MO
nicardipine hcl caps 20mg, 30mg	Tier 1	MO
nifedipine tb24 30mg, 60mg, 90mg	Tier 1	MO
nimodipine caps 30mg	Tier 1	
nisoldipine tb24 8.5mg, 17mg, 34mg	Tier 1	MO
verapamil hcl cp24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; tabs 40mg, 80mg, 120mg; tbcr 120mg, 180mg, 240mg	Tier 1	MO
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
digoxin soln .05mg/ml; tabs 62.5mcg, 125mcg, 250mcg	Tier 1	MO
DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS		
aliskiren fumarate tabs 150mg, 300mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide cp12 500mg; tabs 125mg, 250mg	Tier 1	MO
amiloride & hydrochlorothiazide tab 5-50 mg	Tier 1	MO
amiloride hcl tabs 5mg	Tier 1	MO
bumetanide tabs .5mg, 1mg, 2mg	Tier 1	MO
chlorthalidone tabs 25mg, 50mg	Tier 1	MO
ethacrynic acid tabs 25mg	Tier 2	MO
furosemide soln 10mg/ml	MB	
furosemide soln 10mg/ml, 40mg/5ml; tabs 20mg, 40mg, 80mg	Tier 1	MO
hydrochlorothiazide caps 12.5mg; tabs 12.5mg, 25mg, 50mg	Tier 1	MO
indapamide tabs 1.25mg, 2.5mg	Tier 1	MO
methazolamide tabs 25mg, 50mg	Tier 1	MO
metolazone tabs 2.5mg, 5mg, 10mg	Tier 1	MO
spironolactone & hydrochlorothiazide tab 25-25 mg	Tier 1	MO
torsemide tabs 5mg, 10mg, 20mg, 100mg	Tier 1	MO
triamterene caps 50mg, 100mg	Tier 1	MO
triamterene & hydrochlorothiazide cap 37.5-25 mg	Tier 1	MO
triamterene & hydrochlorothiazide tab 37.5-25 mg	Tier 1	MO
triamterene & hydrochlorothiazide tab 75-50 mg	Tier 1	MO
HEART FAILURE		
ENTRESTO CAP 6-6MG ***(sacubitril-valsartan)***	Tier 3	MO
ENTRESTO CAP 15-16MG ***(sacubitril-valsartan)***	Tier 3	MO
ENTRESTO TAB 24-26MG ***(sacubitril-valsartan)***	Tier 3	MO
ENTRESTO TAB 49-51MG ***(sacubitril-valsartan)***	Tier 3	MO
ENTRESTO TAB 97-103MG ***(sacubitril-valsartan)***	Tier 3	MO
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	Tier 1	MO
sacubitril-valsartan tab 24-26 mg	Tier 1	MO
sacubitril-valsartan tab 49-51 mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sacubitril-valsartan tab 97-103 mg	Tier 1	MO
MISCELLANEOUS		
clonidine ptwk .1mg/24hr, .2mg/24hr, .3mg/24hr	Tier 1	MO
clonidine hcl tabs .1mg, .2mg, .3mg	Tier 1	MO
guanfacine hcl tabs 1mg, 2mg	Tier 1	MO
hydralazine hcl tabs 10mg, 25mg, 50mg, 100mg	Tier 1	MO
methyldopa tabs 250mg, 500mg	Tier 1	MO
midodrine hcl tabs 2.5mg, 5mg, 10mg	Tier 1	
minoxidil tabs 2.5mg, 10mg	Tier 1	MO
phenoxybenzamine hcl caps 10mg	Tier 4	PA, QL (360 caps every 30 days)
ranolazine tb12 500mg, 1000mg	Tier 1	MO
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate tabs 5mg, 10mg, 20mg, 30mg	Tier 1	MO
isosorbide mononitrate tb24 30mg, 60mg, 120mg	Tier 1	MO
nitro-bid oint 2% (Nitro-bid)	Tier 1	MO
NITRO-DUR PT24 .3mg/hr, .8mg/hr ***(nitroglycerin)***	Tier 2	MO
nitroglycerin pt24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; soln .4mg/spray; subl .3mg, .4mg, .6mg	Tier 1	MO
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg ***(riociguat)***	Tier 4	SP, PA, QL (90 tabs every 30 days)
ambrisentan tabs 5mg, 10mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
bosentan tabs 62.5mg, 125mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
bosentan tbso 32mg	Tier 4	SP, PA, QL (112 tabs every 28 days)
macitentan tabs 10mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
sildenafil citrate (pulmonary hypertension) soln 10mg/12.5ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sildenafil citrate (pulmonary hypertension) tabs 20mg	Tier 4	SP, PA, QL (360 tabs every 30 days)
tadalafil (pulmonary hypertension) tabs 20mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
treprostinil soln 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	MB	
UPTRAVI SOLR 1800mcg ***(selexipag)***	MB	
UPTRAVI TABS 100mcg, 150mcg ***(selexipag)***	Tier 4	SP, PA, QL (280 tabs every 28 days)
UPTRAVI TABS 200mcg ***(selexipag)***	Tier 4	SP, PA, QL (140 tabs every 28 days)
UPTRAVI TABS 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, 1600mcg ***(selexipag)***	Tier 4	SP, PA, QL (60 tabs every 30 days)
UPTRAVI PACK TAB 200/800 ***(selexipag)***	Tier 4	SP, PA, QL (1 pack every 28 days)
YUTREPIA CAPS 26.5mcg, 53mcg, 79.5mcg, 106mcg ***(treprostinil sodium)***	Tier 4	SP, PA, QL (140 caps every 28 days)
CARDIOVASCULAR AGENTS - MISC.		
IMPOTENCE AGENTS		
sildenafil citrate tabs 25mg, 50mg, 100mg	Tier 1	PA, QL (8 tabs every 21 days)
tadalafil tabs 10mg, 20mg	Tier 1	PA, QL (8 tabs every 21 days)
vardenafil hcl tabs 2.5mg, 5mg, 10mg, 20mg; tbdp 10mg	Tier 1	PA, QL (8 tabs every 21 days)
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
acamprosate calcium tbec 333mg	Tier 1	MO
disulfiram tabs 250mg, 500mg	Tier 1	MO
AMYOTROPHIC LATERAL SCLEROSIS (ALS)		
riluzole tabs 50mg	Tier 1	MO
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam tabs .25mg, .5mg, 1mg, 2mg; tbdp .25mg, .5mg, 1mg, 2mg	Tier 1	QL (150 tabs every 30 days)
ALPRAZOLAM INTENSOL CONC 1mg/ml ***(alprazolam)***	Tier 2	QL (300 mL every 30 days)
buspirone hcl tabs 5mg, 7.5mg, 10mg, 15mg, 30mg	Tier 1	
clomipramine hcl caps 25mg, 50mg, 75mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluvoxamine maleate cp24 100mg, 150mg; tabs 25mg, 50mg, 100mg	Tier 1	MO
lorazepam conc 2mg/ml	Tier 1	QL (150 mL every 30 days)
lorazepam tabs .5mg, 1mg, 2mg	Tier 1	QL (150 tabs every 30 days)
meprobamate tabs 200mg, 400mg	Tier 1	
oxazepam caps 10mg, 15mg, 30mg	Tier 1	QL (120 caps every 30 days)
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride tabs 5mg, 10mg, 23mg; tbdp 5mg, 10mg	Tier 1	MO
galantamine hydrobromide cp24 8mg, 16mg, 24mg; soln 4mg/ml; tabs 4mg, 8mg, 12mg	Tier 1	MO
memantine hcl cp24 7mg, 14mg, 21mg, 28mg; soln 2mg/ml; tabs 5mg, 10mg	Tier 1	MO
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	Tier 1	
rivastigmine pt24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	Tier 1	MO
rivastigmine tartrate caps 1.5mg, 3mg, 4.5mg, 6mg	Tier 1	MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
amitriptyline hcl tabs 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	Tier 1	MO
amoxapine tabs 25mg, 50mg, 100mg, 150mg	Tier 1	MO
bupropion hcl tabs 75mg, 100mg; tb12 100mg, 150mg, 200mg; tb24 150mg, 300mg	Tier 1	MO
citalopram hydrobromide soln 10mg/5ml; tabs 10mg, 20mg, 40mg	Tier 1	MO
desipramine hcl tabs 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	Tier 1	MO
desvenlafaxine succinate tb24 25mg, 50mg, 100mg	Tier 1	MO; (generic of Pristiq)
doxepin hcl caps 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; conc 10mg/ml	Tier 1	MO
duloxetine hcl cpep 20mg, 30mg, 60mg	Tier 1	MO
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr ***(selegiline)***	Tier 3	PA, MO
escitalopram oxalate soln 5mg/5ml; tabs 5mg, 10mg, 20mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FETZIMA CP24 20mg, 40mg, 80mg, 120mg ***(levomilnacipran hcl)***	Tier 3	MO
FETZIMA CAP TITRATIO ***(levomilnacipran hcl)***	Tier 3	
fluoxetine hcl caps 10mg, 20mg, 40mg; cpdr 90mg; soln 20mg/5ml	Tier 1	MO
fluoxetine hcl tabs 10mg, 20mg	Tier 1	MO; (generic Sarafem not covered)
imipramine hcl tabs 10mg, 25mg, 50mg	Tier 1	MO
imipramine pamoate caps 75mg, 100mg, 125mg, 150mg	Tier 1	MO
MARPLAN TABS 10mg ***(isocarboxazid)***	Tier 3	MO
mirtazapine tabs 7.5mg, 15mg, 30mg, 45mg; tbdp 15mg, 30mg, 45mg	Tier 1	MO
nefazodone hcl tabs 50mg, 100mg, 150mg, 200mg, 250mg	Tier 1	MO
nortriptyline hcl caps 10mg, 25mg, 50mg, 75mg; soln 10mg/5ml	Tier 1	MO
paroxetine hcl tabs 10mg, 20mg, 30mg, 40mg; tb24 12.5mg, 25mg, 37.5mg	Tier 1	MO
phenelzine sulfate tabs 15mg	Tier 1	MO
protriptyline hcl tabs 5mg, 10mg	Tier 1	MO
sertraline hcl conc 20mg/ml; tabs 25mg, 50mg, 100mg	Tier 1	MO
SPRAVATO 56MG DOSE SOPK 28mg/device ***(esketamine hcl)***	MB	
SPRAVATO 84MG DOSE SOPK 28mg/device ***(esketamine hcl)***	MB	
tranylcypromine sulfate tabs 10mg	Tier 1	MO
trazodone hcl tabs 50mg, 100mg, 150mg, 300mg	Tier 1	MO
trimipramine maleate caps 25mg, 50mg, 100mg	Tier 1	MO
venlafaxine hcl cp24 37.5mg, 75mg, 150mg; tabs 25mg, 37.5mg, 50mg, 75mg, 100mg; tb24 37.5mg, 75mg, 150mg	Tier 1	MO
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl caps 100mg; soln 50mg/5ml; tabs 100mg	Tier 1	MO
APOKYN SOCT 30mg/3ml ***(apomorphine hydrochloride)***	MB	
benztropine mesylate soln 1mg/ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
benztropine mesylate tabs .5mg, 1mg, 2mg	Tier 1	MO
bromocriptine mesylate caps 5mg; tabs 2.5mg	Tier 1	MO
carbidopa tabs 25mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 10-100 mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 25-100 mg	Tier 1	MO
carbidopa & levodopa orally disintegrating tab 25-250 mg	Tier 1	MO
carbidopa & levodopa tab 10-100 mg	Tier 1	MO
carbidopa & levodopa tab 25-100 mg	Tier 1	MO
carbidopa & levodopa tab 25-250 mg	Tier 1	MO
carbidopa & levodopa tab er 25-100 mg	Tier 1	MO
carbidopa & levodopa tab er 50-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 25-100-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	Tier 1	MO
carbidopa-levodopa-entacapone tabs 50-200-200 mg	Tier 1	MO
entacapone tabs 200mg	Tier 1	MO
INBRIJA CAPS 42mg ***(levodopa)***	Tier 4	PA, QL (300 caps every 30 days)
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr ***(rotigotine)***	Tier 2	MO
pramipexole dihydrochloride tabs .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg; tb24 .375mg, .75mg, 1.5mg, 2.25mg, 3mg, 3.75mg, 4.5mg	Tier 1	MO
rasagiline mesylate tabs .5mg, 1mg	Tier 1	MO
ropinirole hydrochloride tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	Tier 1	MO
selegiline hcl caps 5mg; tabs 5mg	Tier 1	MO

DRAFT

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
trihexyphenidyl hcl soln .4mg/ml; tabs 2mg, 5mg	Tier 1	MO
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
aripiprazole soln 1mg/ml; tabs 2mg, 5mg, 10mg, 15mg, 20mg, 30mg; tbdp 10mg, 15mg	Tier 1	MO
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml, 1064mg/3.9ml ***(aripiprazole lauroxil)***	MB	
ARISTADA INITIO PRSY 675mg/2.4ml ***(aripiprazole lauroxil)***	MB	
asenapine maleate subl 2.5mg, 5mg, 10mg	Tier 1	MO
chlorpromazine hcl soln 25mg/ml, 50mg/2ml	MB	
chlorpromazine hcl tabs 10mg, 25mg, 50mg, 100mg, 200mg	Tier 1	MO
clozapine tabs 25mg, 50mg, 100mg, 200mg; tbdp 12.5mg, 25mg, 100mg, 150mg, 200mg	Tier 1	
COBENFY CAP 50-20MG ***(xanomeline tartrate-trospium chloride)***	Tier 3	
COBENFY CAP 100-20MG ***(xanomeline tartrate-trospium chloride)***	Tier 3	MO
COBENFY CAP 125-30MG ***(xanomeline tartrate-trospium chloride)***	Tier 3	MO
COBENFY STRT CAP PACK ***(xanomeline tartrate-trospium chloride)***	Tier 3	
ERZOFRI SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml, 351mg/2.25ml ***(paliperidone palmitate)***	MB	
fluphenazine decanoate soln 25mg/ml	MB	
fluphenazine hcl conc 5mg/ml; elix 2.5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg	Tier 1	MO
fluphenazine hcl soln 2.5mg/ml	MB	
haloperidol tabs .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	Tier 1	MO
haloperidol decanoate soln 50mg/ml, 100mg/ml	MB	
haloperidol lactate conc 2mg/ml	Tier 1	MO
haloperidol lactate soln 5mg/ml	MB	
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml ***(paliperidone palmitate)***	MB	

DRAFT

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INVEGA SUSTENNA SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml ***(paliperidone palmitate)***	MB	
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml ***(paliperidone palmitate)***	MB	
loxapine succinate caps 5mg, 10mg, 25mg, 50mg	Tier 1	MO
lurasidone hcl tabs 20mg, 40mg, 60mg, 80mg, 120mg	Tier 1	MO
olanzapine solr 10mg	MB	
olanzapine tabs 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg; tbdp 5mg, 10mg, 15mg, 20mg	Tier 1	MO
paliperidone tb24 1.5mg, 3mg, 6mg, 9mg	Tier 1	MO
perphenazine tabs 2mg, 4mg, 8mg, 16mg	Tier 1	MO
quetiapine fumarate tabs 25mg, 50mg, 100mg, 200mg, 300mg, 400mg; tb24 50mg, 150mg, 200mg, 300mg, 400mg	Tier 1	MO
risperidone soln 1mg/ml; tabs .25mg, .5mg, 1mg, 2mg, 3mg, 4mg; tbdp .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	Tier 1	MO
RYKINDO SRER 25mg, 37.5mg, 50mg ***(risperidone)***	MB	
thioridazine hcl tabs 10mg, 25mg, 50mg, 100mg	Tier 1	MO
thiothixene caps 1mg, 2mg, 5mg, 10mg	Tier 1	MO
trifluoperazine hcl tabs 1mg, 2mg, 5mg, 10mg	Tier 1	MO
VRAYLAR CAPS .5mg, .75mg, 1.5mg, 3mg, 4.5mg, 6mg ***(cariprazine hcl)***	Tier 2	MO
ziprasidone hcl caps 20mg, 40mg, 60mg, 80mg	Tier 1	MO
ANTISEIZURE AGENTS		
carbamazepine chew 100mg, 200mg; cp12 100mg, 200mg, 300mg; susp 100mg/5ml; tabs 200mg; tb12 100mg, 200mg, 400mg	Tier 1	MO
clobazam susp 2.5mg/ml; tabs 10mg, 20mg	Tier 1	MO
clonazepam tabs .5mg, 1mg, 2mg	Tier 1	
clorazepate dipotassium tabs 3.75mg, 7.5mg, 15mg	Tier 1	QL (180 tabs every 30 days)
diazepam soln 5mg/5ml	Tier 1	QL (1200 mL every 30 days)

DRAFT

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diazepam soln 5mg/ml	MB	
diazepam tabs 2mg, 5mg, 10mg	Tier 1	QL (120 tabs every 30 days)
diazepam intensol conc 5mg/ml (Diazepam Intensol)	Tier 1	QL (240 mL every 30 days)
DILANTIN CAPS 30mg ***(phenytoin sodium extended)***	Tier 3	MO
divalproex sodium csdr 125mg; tb24 250mg, 500mg; tbec 125mg, 250mg, 500mg	Tier 1	MO
ethosuximide caps 250mg; soln 250mg/5ml	Tier 1	MO
felbamate susp 600mg/5ml; tabs 400mg, 600mg	Tier 1	MO
fosphenytoin sodium soln 100mgpe/2ml, 500mgpe/10ml	MB	
gabapentin caps 100mg, 300mg, 400mg; soln 250mg/5ml; tabs 600mg, 800mg	Tier 1	MO
lacosamide soln 10mg/ml; tabs 50mg, 100mg, 150mg, 200mg	Tier 1	MO
lacosamide soln 200mg/20ml	MB	
lamotrigine chew 5mg, 25mg; tabs 25mg, 100mg, 150mg, 200mg; tb24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg; tbdp 25mg, 50mg, 100mg, 200mg	Tier 1	MO
lamotrigine kit 25mg	Tier 1	
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	Tier 1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	Tier 1	
levetiracetam soln 100mg/ml; tabs 250mg, 500mg, 750mg, 1000mg; tb24 500mg, 750mg	Tier 1	MO
levetiracetam soln 500mg/5ml	MB	
levetiracetam in sodium chloride iv soln 500 mg/100ml	MB	
levetiracetam in sodium chloride iv soln 1000 mg/100ml	MB	
levetiracetam in sodium chloride iv soln 1500 mg/100ml	MB	
methsuximide caps 300mg	Tier 1	MO
NAYZILAM SOLN 5mg/0.1ml ***(midazolam (anticonvulsant))***	Tier 2	QL (10 units every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxcarbazepine susp 300mg/5ml; tabs 150mg, 300mg, 600mg	Tier 1	MO
phenobarbital elix 20mg/5ml; tabs 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	Tier 1	MO
phenytoin susp 125mg/5ml	Tier 1	MO
phenytoin infatabs chew 50mg (Phenytoin Infatabs)	Tier 1	MO
phenytoin sodium soln 50mg/ml	MB	
phenytoin sodium extended caps 100mg, 200mg, 300mg	Tier 1	MO
pregabalin caps 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg; soln 20mg/ml	Tier 1	MO
primidone tabs 50mg, 250mg	Tier 1	MO
tiagabine hcl tabs 2mg, 4mg, 12mg, 16mg	Tier 1	MO
topiramate cpsp 15mg, 25mg, 50mg; tabs 25mg, 50mg, 100mg, 200mg	Tier 1	MO
valproate sodium soln 100mg/ml	MB	
valproate sodium soln 250mg/5ml	Tier 1	MO
valproic acid caps 250mg	Tier 1	MO
vigabatrin pack 500mg	Tier 4	SP, PA, QL (180 packets every 30 days)
vigabatrin tabs 500mg	Tier 4	SP, PA, QL (180 tabs every 30 days)
XCOPRI TABS 25mg, 50mg, 100mg, 150mg, 200mg ***(cenobamate)***	Tier 2	MO
XCOPRI PAK 12.5-25 ***(cenobamate)***	Tier 2	
XCOPRI PAK 50-100MG ***(cenobamate)***	Tier 2	
XCOPRI PAK 100-150 ***(cenobamate)***	Tier 2	MO
XCOPRI PAK 150-200 ***(cenobamate)***	Tier 2	
XCOPRI PAK 150-200 ***(cenobamate)***	Tier 2	MO
zonisamide caps 25mg, 50mg, 100mg	Tier 1	MO
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
amphetamine-dextroamphetamine cap er 24hr 5 mg	Tier 1	QL (90 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 10 mg	Tier 1	QL (90 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 15 mg	Tier 1	QL (30 caps every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine cap er 24hr 20 mg	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 25 mg	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine cap er 24hr 30 mg	Tier 1	QL (30 caps every 30 days), MO
amphetamine-dextroamphetamine tab 5 mg	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 7.5 mg	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 10 mg	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 12.5 mg	Tier 1	QL (90 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 15 mg	Tier 1	QL (60 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 20 mg	Tier 1	QL (60 tabs every 30 days), MO
amphetamine-dextroamphetamine tab 30 mg	Tier 1	QL (30 tabs every 30 days), MO
atomoxetine hcl caps 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg	Tier 1	MO
AZSTARYS CAP 26.1-5.2 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	Tier 2	QL (30 caps every 30 days), MO
AZSTARYS CAP 39.2-7.8 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	Tier 2	QL (30 caps every 30 days), MO
AZSTARYS CAP 52.3-10. ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	Tier 2	QL (30 caps every 30 days), MO
dexmethylphenidate hcl cp24 5mg, 10mg, 15mg, 20mg	Tier 1	QL (60 caps every 30 days), MO
dexmethylphenidate hcl cp24 25mg, 30mg, 35mg, 40mg	Tier 1	QL (30 caps every 30 days), MO
dexmethylphenidate hcl tabs 2.5mg, 5mg	Tier 1	QL (120 tabs every 30 days), MO
dexmethylphenidate hcl tabs 10mg	Tier 1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate cp24 5mg, 10mg	Tier 1	QL (120 caps every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dextroamphetamine sulfate cp24 15mg	Tier 1	QL (60 caps every 30 days), MO
dextroamphetamine sulfate soln 5mg/5ml	Tier 1	QL (1,200 mL every 30 days), MO
dextroamphetamine sulfate tabs 5mg, 10mg	Tier 1	QL (120 tabs every 30 days), MO
dextroamphetamine sulfate tabs 15mg, 20mg	Tier 1	QL (60 tabs every 30 days), MO
dextroamphetamine sulfate tabs 30mg	Tier 1	QL (30 tabs every 30 days), MO
guanfacine hcl (adhd) tb24 1mg, 2mg, 3mg, 4mg	Tier 1	MO
lisdexamfetamine dimesylate caps 10mg, 20mg, 30mg	Tier 1	QL (60 caps every 30 days), MO
lisdexamfetamine dimesylate caps 40mg, 50mg, 60mg, 70mg	Tier 1	QL (30 caps every 30 days), MO
lisdexamfetamine dimesylate chew 10mg, 20mg, 30mg	Tier 1	QL (60 chew tabs every 30 days), MO
lisdexamfetamine dimesylate chew 40mg, 50mg, 60mg	Tier 1	QL (30 chew tabs every 30 days), MO
methamphetamine hcl tabs 5mg	Tier 1	QL (150 tabs every 30 days), MO
methylphenidate hcl chew 2.5mg, 5mg, 10mg	Tier 1	QL (180 chew tabs every 30 days), MO
methylphenidate hcl cp24 20mg, 30mg; cpcr 10mg, 20mg, 30mg	Tier 1	QL (60 caps every 30 days), MO
methylphenidate hcl cp24 40mg, 60mg; cpcr 40mg, 50mg, 60mg	Tier 1	QL (30 caps every 30 days), MO
methylphenidate hcl soln 5mg/5ml	Tier 1	QL (1800 mL every 30 days), MO
methylphenidate hcl soln 10mg/5ml	Tier 1	QL (900 mL every 30 days), MO
methylphenidate hcl tabs 5mg, 10mg	Tier 1	QL (180 tabs every 30 days), MO
methylphenidate hcl tabs 20mg; tbcr 10mg, 20mg	Tier 1	QL (90 tabs every 30 days), MO
methylphenidate hcl tbcr 18mg, 27mg, 36mg	Tier 1	QL (60 tabs every 30 days), MO
methylphenidate hcl tbcr 54mg	Tier 1	QL (30 tabs every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
zenzedi tabs 2.5mg, 7.5mg (Zenzedi)	Tier 1	QL (120 tabs every 30 days), MO
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg ***(suvorexant)***	Tier 2	
eszopiclone tabs 1mg, 2mg, 3mg	Tier 1	QL (15 tabs every 30 days)
ramelteon tabs 8mg	Tier 1	QL (15 tabs every 30 days)
tasimelteon caps 20mg	Tier 4	SP, PA, QL (30 caps every 30 days)
temazepam caps 7.5mg, 15mg, 22.5mg, 30mg	Tier 1	QL (15 caps every 30 days)
zaleplon caps 5mg, 10mg	Tier 1	QL (15 caps every 30 days)
zolpidem tartrate tabs 5mg, 10mg; tbcr 6.25mg, 12.5mg	Tier 1	QL (15 tabs every 30 days)
MIGRAINE - ERGOTAMINE DERIVATIVES		
dihydroergotamine mesylate soln 1mg/ml	MB	
ergotamine w/ caffeine tab 1-100 mg	Tier 2	
MIGRAINE - MISCELLANEOUS		
NURTEC TBDP 75mg ***(rimegepant sulfate)***	Tier 2	ST, QL (16 tabs every 30 days); PA**
QULIPTA TABS 10mg, 30mg, 60mg ***(atogepant)***	Tier 2	ST, QL (30 tabs every 30 days), MO; PA**
UBRELVY TABS 50mg, 100mg ***(ubrogepant)***	Tier 2	ST, QL (16 tabs every 30 days); PA**
MIGRAINE - MONOCLONAL ANTIBODIES		
AIMOVIG SOAJ 70mg/ml, 140mg/ml ***(erenumab-aooe)***	MB	
EMGALITY SOAJ 120mg/ml; SOSY 100mg/ml, 120mg/ml ***(galcanezumab-gnlm)***	MB	
MIGRAINE - TRIPTANS AND COMBINATIONS		
almotriptan malate tabs 6.25mg, 12.5mg	Tier 1	QL (12 tabs every 30 days)
eletriptan hydrobromide tabs 20mg, 40mg	Tier 1	QL (12 tabs every 30 days)
naratriptan hcl tabs 1mg, 2.5mg	Tier 1	QL (12 tabs every 30 days)
rizatriptan benzoate tabs 5mg, 10mg; tbdp 5mg, 10mg	Tier 1	QL (18 tabs every 30 days)
sumatriptan soln 5mg/act	Tier 1	QL (24 sprays every 30 days)
sumatriptan soln 20mg/act	Tier 1	QL (12 sprays every 30 days)
sumatriptan succinate soaj 6mg/0.5ml	Tier 1	QL (12 units every 30 days)
sumatriptan succinate soln 6mg/0.5ml	Tier 1	QL (12 vials every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sumatriptan succinate tabs 25mg, 50mg, 100mg	Tier 1	QL (12 tabs every 30 days)
zolmitriptan soln 5mg	Tier 1	QL (12 sprays every 30 days)
zolmitriptan tabs 2.5mg, 5mg; tbdp 2.5mg, 5mg	Tier 1	QL (12 tabs every 30 days)
MISCELLANEOUS		
EVRYSDI SOLR .75mg/ml ***(risdiplam)***	Tier 4	PA, QL (2 bottles every 24 days)
EVRYSDI TABS 5mg ***(risdiplam)***	Tier 4	PA, QL (30 tabs every 30 days)
MOOD STABILIZERS		
lithium soln 8meq/5ml	Tier 1	MO
lithium carbonate caps 150mg, 300mg, 600mg; tabs 300mg; tbcr 300mg, 450mg	Tier 1	MO
MOVEMENT DISORDERS		
AUSTEDO TABS 6mg ***(deutetrabenazine)***	Tier 4	SP, PA, QL (60 tabs every 30 days)
AUSTEDO TABS 9mg, 12mg ***(deutetrabenazine)***	Tier 4	SP, PA, QL (120 tabs every 30 days)
INGREZZA CAPS 40mg, 60mg, 80mg; CPSP 40mg, 60mg, 80mg ***(valbenazine tosylate)***	Tier 4	SP, PA, QL (30 caps every 30 days)
INGREZZA CAP 40-80MG ***(valbenazine tosylate)***	Tier 4	SP, PA, QL (28 caps every 28 days)
tetrabenazine tabs 12.5mg	Tier 4	SP, PA, QL (120 tabs every 30 days)
tetrabenazine tabs 25mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BETASERON KIT .3mg ***(interferon beta-1b)***	MB	
dalfampridine tb12 10mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
dimethyl fumarate cpdr 120mg	Tier 4	SP, PA, QL (14 caps every 28 days)
dimethyl fumarate cpdr 240mg	Tier 4	SP, PA, QL (60 caps every 30 days)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	Tier 4	SP, PA, QL (1 kit every 30 days)
fingolimod hcl caps .5mg	Tier 4	SP, PA, QL (30 caps every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
glatiramer acetate sosy 40mg/ml	MB	
glatopa sosy 20mg/ml (Glatopa)	MB	
KESIMPTA SOAJ 20mg/0.4ml ***(ofatumumab (ms))***	MB	
teriflunomide tabs 7mg, 14mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
TYRUKO CONC 300mg/15ml ***(natalizumab-sztn)***	MB	
TYSABRI CONC 300mg/15ml ***(natalizumab)***	MB	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
baclofen tabs 5mg, 10mg, 20mg	Tier 1	
carisoprodol tabs 350mg	Tier 1	PA
chlorzoxazone tabs 500mg	Tier 1	
cyclobenzaprine hcl tabs 5mg, 10mg	Tier 1	
dantrolene sodium caps 25mg, 50mg, 100mg	Tier 1	
metaxalone tabs 800mg	Tier 1	
methocarbamol tabs 500mg, 750mg	Tier 1	
orphenadrine citrate soln 30mg/ml	MB	
orphenadrine citrate tb12 100mg	Tier 1	
tizanidine hcl tabs 2mg, 4mg	Tier 1	
MYASTHENIA GRAVIS		
pyridostigmine bromide soln 60mg/5ml; tabs 60mg; tbcr 180mg	Tier 1	
VYVGART SOLN 400mg/20ml ***(efgartigimod alfa-fcab)***	MB	
VYVGART INJ HYTRULO ***(efgartigimod alfa-hyaluronidase-qvfc)***	MB	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil tabs 50mg	Tier 1	PA, QL (60 tabs every 30 days), MO
armodafinil tabs 150mg, 200mg, 250mg	Tier 1	PA, QL (30 tabs every 30 days), MO
modafinil tabs 100mg, 200mg	Tier 1	PA, QL (60 tabs every 30 days), MO
sodium oxybate soln 500mg/ml	Tier 1	SP, PA, QL (540mL every 30 days); ANDA Generics
sodium oxybate soln 500mg/ml	Tier 4	SP, PA, QL (540mL every 30 days); HIKMA AG
XYWAV SOL 0.5GM/ML ***(calcium, magnesium, potassium, & sodium oxybates)***	Tier 4	PA, QL (540 ml every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	Tier 1	
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	Tier 1	
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	Tier 1	
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	Tier 1	
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	Tier 1	
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	Tier 1	
ZUBSOLV SUB 0.7-0.18 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)***	Tier 2	
OPIOID ANTAGONIST		
naloxone hcl liqd 4mg/0.1ml	Tier 1	
naloxone hcl soct .4mg/ml; soln .4mg/ml, 4mg/10ml; sosy 2mg/2ml	MB	
naltrexone hcl tabs 50mg	Tier 1	
VIVITROL SUSR 380mg ***(naltrexone)***	MB	
OPIOID PARTIAL AGONISTS		
buprenorphine hcl subl 2mg, 8mg	Tier 1	
PSYCHOTHERAPEUTIC-MISC		
dextromethorphan hbr-quinidine sulfate cap 20-10 mg	Tier 1	PA, MO
lofexidine hcl tabs .18mg	Tier 1	
NUEDEXTA CAP 20-10MG ***(dextromethorphan hbr-quinidine sulfate)***	Tier 2	PA, MO
pimozide tabs 1mg, 2mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent) tb12 150mg	PV	$0 limited to 2 treatment cycles/year
goodsense nicotine polacr gum 4mg; lozg 4mg (Goodsense Nicotine Polacr)	PV	$0 limited to 2 treatment cycles/year
nicotine pt24 14mg/24hr, 21mg/24hr	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex gum 2mg, 4mg; lozg 2mg	PV	$0 limited to 2 treatment cycles/year
nicotine step 3 pt24 7mg/24hr (Nicotine Step 3)	PV	$0 limited to 2 treatment cycles/year
nicotine transdermal syst pt24 7mg/24hr, 14mg/24hr, 21mg/24hr (Nicotine Transdermal Syst)	PV	$0 limited to 2 treatment cycles/year
NICOTROL INHALER INHA 10mg ***(nicotine)***	PV	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
NICOTROL NS SOLN 10mg/ml ***(nicotine)***	PV	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
varenicline tartrate tabs .5mg, 1mg	PV	$0 limited to 2 treatment cycles/year
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	PV	$0 limited to 2 treatment cycles/year
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
deflazacort susp 22.75mg/ml; tabs 6mg, 18mg, 30mg, 36mg	Tier 4	SP, PA
EMFLAZA SUSP 22.75mg/ml; TABS 6mg, 18mg, 30mg, 36mg ***(deflazacort)***	Tier 4	SP, PA
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ACROMEGALY		
octreotide acetate soln 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; sosy 50mcg/ml, 100mcg/ml, 500mcg/ml	MB	
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml ***(lanreotide acetate)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg ***(pegvisomant)***	MB	
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
testosterone gel 25mg/2.5gm	Tier 1	PA, MO
testosterone cypionate soln 100mg/ml, 200mg/ml	MB	
testosterone enanthate soln 200mg/ml	MB	
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tabs 25mg, 50mg, 100mg	Tier 1	MO
miglitol tabs 25mg, 50mg, 100mg	Tier 1	MO
ANTIDIABETICS, BIGUANIDE		
metformin hcl tabs 500mg, 850mg, 1000mg; tb24 500mg, 750mg	Tier 1	MO
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
glipizide-metformin hcl tab 2.5-250 mg	Tier 1	MO
glipizide-metformin hcl tab 2.5-500 mg	Tier 1	MO
glipizide-metformin hcl tab 5-500 mg	Tier 1	MO
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS		
alogliptin-metformin hcl tab 12.5-500 mg	Tier 1	ST, MO; PA**
alogliptin-metformin hcl tab 12.5-1000 mg	Tier 1	ST, MO; PA**
sitagliptin phosphate-metformin hcl tab 50-500 mg	Tier 1	ST, MO; PA**
sitagliptin phosphate-metformin hcl tab 50-1000 mg	Tier 1	ST, MO; PA**
sitagliptin phosphate-metformin hcl tab er 24hr 50-500 mg	Tier 1	ST, MO; PA**
sitagliptin phosphate-metformin hcl tab er 24hr 50-1000 mg	Tier 1	ST, MO; PA**
sitagliptin phosphate-metformin hcl tab er 24hr 100-1000 mg	Tier 1	ST, MO; PA**
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
alogliptin benzoate tabs 6.25mg, 12.5mg, 25mg	Tier 1	ST, MO; PA**
sitagliptin phosphate tabs 25mg, 50mg, 100mg	Tier 1	ST, MO; PA**
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
liraglutide sopn 18mg/3ml	Tier 1	ST, QL (3 pens every 30 days); PA**

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MOUNJARO SOAJ 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml ***(tirzepatide)***	Tier 2	ST, QL (4 pens every 28 days); PA**
OZEMPIC SOPN 2mg/3ml, 4mg/3ml, 8mg/3ml ***(semaglutide)***	Tier 2	ST, QL (3 mL every 28 days); PA**
OZEMPIC TABS 1.5mg, 4mg, 9mg ***(semaglutide)***	Tier 2	ST, QL (30 tabs every 30 days); PA**
TRULICITY SOAJ .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml ***(dulaglutide)***	Tier 2	ST, QL (4 pens every 28 days); PA**
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA INJ 100/33 ***(insulin glargine-lixisenatide)***	Tier 2	MO
XULTOPHY INJ 100/3.6 ***(insulin degludec-liraglutide)***	Tier 2	MO
ANTIDIABETICS, INSULIN		
AFREZZA POWD 4unit, 8unit, 12unit ***(insulin regular (human))***	Tier 2	MO
AFREZZA POW 4-8 UNIT ***(insulin regular (human))***	Tier 2	MO
AFREZZA POW 4-8-12 ***(insulin regular (human))***	Tier 2	MO
AFREZZA POW 8-12UNIT ***(insulin regular (human))***	Tier 2	MO
AWIQLI FLEXTOUCH SOPN 700unit/ml ***(insulin icodec-abae)***	Tier 2	MO
BASAGLAR KWIKPEN SOPN 100unit/ml ***(insulin glargine)***	Tier 2	MO
FIASP SOLN 100unit/ml ***(insulin aspart (with niacinamide))***	Tier 2	MO
FIASP FLEXTOUCH SOPN 100unit/ml ***(insulin aspart (with niacinamide))***	Tier 2	MO
FIASP PENFILL SOCT 100unit/ml ***(insulin aspart (with niacinamide))***	Tier 2	MO
FIASP PUMPCART SOCT 100unit/ml ***(insulin aspart (with niacinamide))***	Tier 2	MO
HUMULIN INJ 70/30 ***(insulin nph isophane & reg (human))***	Tier 3	MO
HUMULIN INJ 70/30KWP ***(insulin nph isophane & reg (human))***	Tier 3	MO
HUMULIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))***	Tier 3	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HUMULIN N KWIKPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))***	Tier 3	MO
HUMULIN R SOLN 100unit/ml ***(insulin regular (human))***	Tier 3	MO
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml ***(insulin regular (human))***	Tier 2	MO
INSULIN GLARGINE-YFGN SOLN 100unit/ml; SOPN 100unit/ml	Tier 2	MO
NOVOLIN INJ 70/30 ***(insulin nph isophane & reg (human))***	Tier 2	MO; RELION not covered
NOVOLIN INJ 70/30 FP ***(insulin nph isophane & reg (human))***	Tier 2	MO; RELION not covered
NOVOLIN N SUSP 100unit/ml ***(insulin nph (human) (isophane))***	Tier 2	MO; RELION not covered
NOVOLIN N FLEXPEN SUPN 100unit/ml ***(insulin nph (human) (isophane))***	Tier 2	MO; RELION not covered
NOVOLIN R SOLN 100unit/ml ***(insulin regular (human))***	Tier 2	MO; RELION not covered
NOVOLIN R FLEXPEN SOPN 100unit/ml ***(insulin regular (human))***	Tier 2	MO; RELION not covered
NOVOLOG SOLN 100unit/ml ***(insulin aspart)***	Tier 2	MO
NOVOLOG FLEXPEN SOPN 100unit/ml ***(insulin aspart)***	Tier 2	MO
NOVOLOG MIX INJ 70/30 ***(insulin aspart protamine & aspart (human))***	Tier 2	MO
NOVOLOG MIX INJ FLEXPEN ***(insulin aspart protamine & aspart (human))***	Tier 2	MO
NOVOLOG PENFILL SOCT 100unit/ml ***(insulin aspart)***	Tier 2	MO
TRESIBA SOLN 100unit/ml ***(insulin degludec)***	Tier 2	MO
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml ***(insulin degludec)***	Tier 2	MO
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl tabs 15mg, 30mg, 45mg	Tier 1	MO
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl tab 15-500 mg	Tier 1	MO
pioglitazone hcl-metformin hcl tab 15-850 mg	Tier 1	MO
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride tab 30-2 mg	Tier 1	MO
pioglitazone hcl-glimepiride tab 30-4 mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETICS, MEGLITINIDE		
nateglinide tabs 60mg, 120mg	Tier 1	MO
repaglinide tabs .5mg, 1mg, 2mg	Tier 1	MO
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
dapagliflozin-metformin hcl tab er 24hr 5-500 mg	Tier 1	ST, MO; PA**
dapagliflozin-metformin hcl tab er 24hr 5-1000 mg	Tier 1	ST, MO; PA**
dapagliflozin-metformin hcl tab er 24hr 10-500 mg	Tier 1	ST, MO; PA**
dapagliflozin-metformin hcl tab er 24hr 10-1000 mg	Tier 1	ST, MO; PA**
SYNJARDY TAB ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY TAB 5-500MG ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY TAB 5-1000MG ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY TAB 12.5-500 ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY XR TAB ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 5-1000MG ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 10-1000 ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
SYNJARDY XR TAB 25-1000 ***(empagliflozin-metformin hcl)***	Tier 2	ST, MO; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI TAB 10-5 MG ***(empagliflozin-linagliptin)***	Tier 2	ST, MO; PA**
GLYXAMBI TAB 25-5 MG ***(empagliflozin-linagliptin)***	Tier 2	ST, MO; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
dapagliflozin tabs 5mg, 10mg	Tier 1	ST, MO; PA**
JARDIANCE TABS 10mg, 25mg ***(empagliflozin)***	Tier 2	ST, MO; PA**

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETICS, SULFONYLUREA		
glimepiride tabs 1mg, 2mg, 4mg	Tier 1	MO
glipizide tabs 5mg, 10mg; tb24 2.5mg, 5mg, 10mg	Tier 1	MO
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl tabs 30mg, 60mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
cinacalcet hcl tabs 90mg	Tier 4	SP, PA, QL (120 tabs every 30 days)
CALCIUM REGULATORS, BISPHOSPHONATES		
alendronate sodium soln 70mg/75ml; tabs 10mg, 35mg, 70mg	Tier 1	MO
FOSAMAX + D TAB 70-2800 ***(alendronate sodium-cholecalciferol)***	Tier 3	MO
FOSAMAX + D TAB 70-5600 ***(alendronate sodium-cholecalciferol)***	Tier 3	MO
ibandronate sodium soln 3mg/3ml	MB	
ibandronate sodium tabs 150mg	Tier 1	MO
pamidronate disodium soln 30mg/10ml	MB	
risedronate sodium tabs 5mg, 35mg, 150mg; tbec 35mg	Tier 1	MO
risedronate sodium tabs 30mg	Tier 1	
zoledronic acid conc 4mg/5ml; soln 5mg/100ml	MB	
CALCIUM REGULATORS, MISCELLANEOUS		
calcitonin (salmon) soln 200unit/act	Tier 1	MO
OSPOMYV SOSY 60mg/ml ***(denosumab-dssb)***	MB	
STOBOCLO SOSY 60mg/ml ***(denosumab-bmwo)***	MB	
CALCIUM REGULATORS, PARATHYROID HORMONES		
TYMLOS SOPN 3120mcg/1.56ml ***(abaloparatide)***	MB	
CENTRAL PRECOCIOUS PUBERTY		
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg ***(leuprolide acetate (cpp))***	MB	
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg ***(leuprolide acetate (cpp) (3 month))***	MB	
LUPRON DEPOT-PED (6-MONTH KIT 45mg ***(leuprolide acetate (cpp) (6 month))***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SUPPRELIN LA KIT 50mg ***(histrelin acetate (cpp))***	MB	
TRIPTODUR SRER 22.5mg ***(triptorelin pamoate (cpp))***	MB	
CHELATING AGENTS		
CHEMET CAPS 100mg ***(succimer)***	Tier 3	
deferiprone tabs 500mg, 1000mg	Tier 4	SP, PA
FERRIPROX SOLN 100mg/ml ***(deferiprone)***	Tier 4	PA
FERRIPROX TWICE-A-DAY TABS 1000mg ***(deferiprone)***	Tier 4	PA
penicillamine tabs 250mg	Tier 4	SP
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
altavera (Altavera)	PV	MO
alyacen 1/35 (Alyacen 1/35)	PV	MO
alyacen 7/7/7 (Alyacen 7/7/7)	PV	MO
amethyst (Amethyst)	PV	MO
ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)***	PV	QL (1 every 300 days), MO
apri (Apri)	PV	MO
aranelle (Aranelle)	PV	MO
ashlyna (Ashlyna)	PV	MO
AVERI TAB ***(desogestrel-ethinyl estradiol & iron)***	PV	MO
aviane (Aviane)	PV	MO
azurette (Azurette)	PV	MO
camila tabs .35mg (Camila)	PV	MO
camrese (Camrese)	PV	MO
CAYA DPR ***(diaphragm arc-spring)***	MB	
chateal eq (Chateal Eq)	PV	MO
CONDOMS MIS	PV	QL (12 condoms every 30 days)
dasetta 1/35 (Dasetta 1/35)	PV	MO
dasetta 7/7/7 (Dasetta 7/7/7)	PV	MO
delyla (Delyla)	PV	MO
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml ***(medroxyprogesterone acetate (contraceptive))***	MB	
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	PV	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	PV	MO
drospirenone-ethinyl estradiol tab 3-0.02 mg	PV	MO
drospirenone-ethinyl estradiol tab 3-0.03 mg	PV	MO
DUREX MIS REALFEEL ***(condoms non-latex lubricated - male)***	PV	QL (12 condoms every 30 days)
elinest (Elinest)	PV	MO
ELLA TABS 30mg ***(ulipristal acetate)***	PV	
enskyce (Enskyce)	PV	MO
errin tabs .35mg (Errin)	PV	MO
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	PV	QL (13 every 300 days), MO
falmina (Falmina)	PV	MO
FC2 FEMALE MIS CONDOM ***(condoms - female)***	PV	QL (12 condoms every 30 days)
FEMCAP MIS 22MM ***(cervical caps)***	MB	
FEMCAP MIS 26MM ***(cervical caps)***	MB	
FEMCAP MIS 30MM ***(cervical caps)***	MB	
FEMLYV TAB 1/0.02MG ***(norethindrone acet & eth estra)***	PV	MO
galbriela (Galbriela)	PV	MO
gemmily (Gemmily)	PV	MO
GWYN LO DIS 220-20 ***(norelgestromin-ethinyl estradiol)***	PV	MO
heather tabs .35mg (Heather)	PV	MO
introvale (Introvale)	PV	MO
jolessa (Jolessa)	PV	MO
junel 1.5/30 (Junel 1.5/30)	PV	MO
junel 1/20 (Junel 1/20)	PV	MO
junel fe 1.5/30 (Junel Fe 1.5/30)	PV	MO
junel fe 1/20 (Junel Fe 1/20)	PV	MO
junel fe 24 (Junel Fe 24)	PV	MO
kariva (Kariva)	PV	MO
kelnor 1/35 (Kelnor 1/35)	PV	MO
kurvelo (Kurvelo)	PV	MO
KYLEENA IUD 19.5mg ***(levonorgestrel (iud))***	MB	
larin 1.5/30 (Larin 1.5/30)	PV	MO
lessina (Lessina)	PV	MO
levonest (Levonest)	PV	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	PV	MO
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	PV	MO
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)	PV	MO
LILETTA IUD 20.1mcg/day ***(levonorgestrel (iud))***	MB	
LO LOESTRIN TAB 1-10-10 ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))***	PV	MO
lojaimiess (Lojaimiess)	PV	MO
loryna (Loryna)	PV	MO
low-ogestrel (Low-ogestrel)	PV	MO
marlissa (Marlissa)	PV	MO
medroxyprogesterone acetate (contraceptive) susp 150mg/ml; susy 150mg/ml	MB	
microgestin 1.5/30 (Microgestin 1.5/30)	PV	MO
MIRENA IUD 21mcg/day ***(levonorgestrel (iud))***	MB	
MIUDELLA IUD ***(copper (iud))***	MB	
mono-linyah (Mono-linyah)	PV	MO
NATAZIA TAB ***(estradiol valerate-dienogest)***	PV	MO
necon 0.5/35-28 (Necon 0.5/35-28)	PV	MO
NEXPLANON IMPL 68mg ***(etonogestrel)***	MB	
NEXTSTELLIS TAB 3-14.2MG ***(drospirenone-estetrol)***	PV	MO
nikki (Nikki)	PV	MO
nora-be tabs .35mg (Nora-be)	PV	MO
norethindrone (contraceptive) tabs .35mg	PV	MO
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	PV	MO
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)	PV	MO
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	PV	MO
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	PV	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	PV	MO
nortrel 0.5/35 (28) (Nortrel 0.5/35 (28))	PV	MO
nortrel 1/35 (Nortrel 1/35)	PV	MO
nortrel 7/7/7 (Nortrel 7/7/7)	PV	MO
nylia 1/35 (Nylia 1/35)	PV	MO
OMNIFLEX DPR ***(diaphragms)***	MB	
OPILL TABS .075mg ***(norgestrel)***	PV	MO
PARAGARD IUD T380A ***(copper (iud))***	MB	
portia-28 (Portia-28)	PV	MO
reclipsen (Reclipsen)	PV	MO
rivelsa (Rivelsa)	PV	MO
SKYLA IUD 13.5mg ***(levonorgestrel (iud))***	MB	
SLYND TABS 4mg ***(drospirenone)***	PV	MO
sprintec 28 (Sprintec 28)	PV	MO
syeda (Syeda)	PV	MO
take action tabs 1.5mg (Take Action)	PV	
tilia fe (Tilia Fe)	PV	MO
tri-linyah (Tri-linyah)	PV	MO
tri-sprintec (Tri-sprintec)	PV	MO
TRUSTEX/RIA MIS NON-LUB ***(condoms latex non-lubricated - male)***	PV	QL (12 condoms every 30 days)
TRUSTX NON-9 MIS RIB/STUD ***(condoms latex lubricated - male)***	PV	QL (12 condoms every 30 days)
TWIRLA DIS 120-30 ***(levonorgestrel-ethinyl estradiol)***	PV	MO
TYBLUME CHW 0.1-0.02 ***(levonorgestrel & eth estradiol)***	PV	MO
valtya 1/50 (Valtya 1/50)	PV	MO
velivet (Velivet)	PV	MO
viorele (Viorele)	PV	MO
vyfemla (Vyfemla)	PV	MO
wera (Wera)	PV	MO
WIDE-SEAL SILICONE DIAPHR DPRH 2% ***(diaphragm wide seal)***	MB	
xelria fe (Xelria Fe)	PV	MO
xulane (Xulane)	PV	MO
zovia 1/35 (Zovia 1/35)	PV	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DIABETIC SUPPLIES		
ACCU-CHEK BLOOD GLUCOSE TEST KITS ***(blood glucose monitoring supplies)***	MB	
ACCU-CHEK BLOOD GLUCOSE TEST KITS ***(lancets misc.)***	MB	
ACCU-CHEK BLOOD GLUCOSE TEST STRIPS ***(glucose blood)***	MB	
ACCU-CHEK LIQ COMPACT ***(blood glucose calibration)***	MB	
ACCU-CHEK LIQ GUIDE ***(blood glucose calibration)***	MB	
BLOOD GLUCOSE CALIBRATION SOLUTION ***(blood glucose calibration)***	MB	
DEXCOM G6 MIS RECEIVER ***(continuous glucose system receiver)***	MB	
DEXCOM G6 MIS SENSOR ***(continuous glucose system sensor)***	MB	
DEXCOM G6 MIS TRANSMIT ***(continuous glucose system transmitter)***	MB	
DEXCOM G7 MIS RECEIVER ***(continuous glucose system receiver)***	MB	
DEXCOM G7 MIS SENSOR ***(continuous glucose system sensor)***	MB	
DEXCOM G7 MIS SNSR 15D ***(continuous glucose system sensor)***	MB	
FASTCLIX MIS LANCETS ***(lancets)***	MB	
INSULIN PEN NEEDLES ***(insulin pen needle)***	Tier 2	
INSULIN PEN NEEDLES/SYRINGES ***(insulin syringe/needle u-100)***	Tier 2	
LANCETS ***(lancets)***	MB	
NOVOFINE PEN NEEDLES ***(insulin pen needle)***	Tier 2	
OMNIPOD 5 DX KIT INT G7G6 ***(insulin infusion disposable pump)***	MB	
OMNIPOD 5 DX MIS POD G7G6 ***(insulin infusion disposable pump)***	MB	
OMNIPOD 5 G7 KIT INTRO ***(insulin infusion disposable pump)***	MB	
OMNIPOD 5 G7 MIS PODS ***(insulin infusion disposable pump)***	MB	
OMNIPOD DASH KIT INTRO ***(insulin infusion disposable pump)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OMNIPOD DASH KIT PDM ***(insulin infusion disposable pump)***	MB	
OMNIPOD DASH MIS PODS ***(insulin infusion disposable pump)***	MB	
OMNIPOD MIS CLASSIC ***(insulin infusion disposable pump)***	MB	
OMNIPOD PDM KIT CLASSIC ***(insulin infusion disposable pump)***	MB	
TWIIST KIT REFILL ***(insulin infusion disposable pump)***	MB	
TWIIST KIT STARTER ***(insulin infusion disposable pump)***	MB	
TWIIST REFIL KIT INFUSION ***(insulin infusion disposable pump)***	MB	
URINE GLUCOSE MONITORING SUPPLIES ***(urine glucose monitoring supplies)***	MB	
ENDOMETRIOSIS		
danazol caps 50mg, 100mg, 200mg	Tier 1	
ORILISSA TABS 150mg, 200mg ***(elagolix sodium)***	Tier 2	
SYNAREL SOLN 2mg/ml ***(nafarelin acetate)***	Tier 4	PA
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
DEPO-MEDROL SUSP 20mg/ml ***(methylprednisolone acetate)***	MB	
dexamethasone elix .5mg/5ml; soln .5mg/5ml; tabs .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	Tier 1	
DEXAMETHASONE INTENSOL CONC 1mg/ml ***(dexamethasone)***	Tier 2	
dexamethasone sodium phosphate soln 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml; sosy 4mg/ml	MB	
fludrocortisone acetate tabs .1mg	Tier 1	MO
hydrocortisone tabs 5mg, 10mg, 20mg	Tier 1	
hydrocortisone sod succinate solr 100mg	MB	
MEDROL TABS 2mg ***(methylprednisolone)***	Tier 2	
methylprednisolone tabs 4mg, 8mg, 16mg, 32mg; tbpk 4mg	Tier 1	
methylprednisolone acetate susp 40mg/ml, 80mg/ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylprednisolone sod succ solr 125mg, 1000mg	MB	
prednisolone soln 15mg/5ml	Tier 1	
prednisolone sodium phosphate soln 5mg/5ml, 15mg/5ml, 25mg/5ml; tbdp 10mg, 15mg, 30mg	Tier 1	
prednisone soln 5mg/5ml; tabs 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg; tbpk 5mg, 10mg	Tier 1	
PREDNISONE INTENSOL CONC 5mg/ml ***(prednisone)***	Tier 2	
SOLU-CORTEF SOLR 250mg, 500mg, 1000mg ***(hydrocortisone sod succinate)***	MB	
SOLU-MEDROL SOLR 2gm ***(methylprednisolone sod succ)***	MB	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
glucagon solr 1mg	Tier 1	
GVOKE HYPOPEN 1-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml ***(glucagon)***	Tier 2	
GVOKE KIT SOLN 1mg/0.2ml ***(glucagon)***	Tier 2	
GVOKE PFS SOSY 1mg/0.2ml ***(glucagon)***	Tier 2	
HEREDITARY TYROSINEMIA TYPE 1 AGENTS		
nitisinone caps 2mg, 5mg, 10mg, 20mg	Tier 4	SP, PA
ORFADIN SUSP 4mg/ml ***(nitisinone)***	Tier 4	PA
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
NORDIPEN 5 MIS DEVICE ***(injection device)***	MB	
NORDIPEN DEL MIS SYSTEM ***(injection device)***	MB	
NORDITROPIN FLEXPRO SOPN 5mg/1.5ml, 10mg/1.5ml, 15mg/1.5ml ***(somatropin)***	MB	
LYSOSOMAL STORAGE DISORDERS - GAUCHER DISEASE		
CERDELGA CAPS 84mg ***(eliglustat tartrate)***	Tier 4	SP, PA, QL (56 caps every 28 days)
MENOPAUSAL SYMPTOM AGENTS		
BIJUVA CAP 0.5-100 ***(estradiol-progesterone)***	Tier 3	MO
BIJUVA CAP 1-100MG ***(estradiol-progesterone)***	Tier 3	MO
CLIMARA PRO DIS WEEKLY ***(estradiol-levonorgestrel)***	Tier 2	MO
DEPO-ESTRADIOL OIL 5mg/ml ***(estradiol cypionate)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DUAVEE TAB 0.45-20 ***(conjugated estrogens-bazedoxifene)***	Tier 2	MO
ELESTRIN GEL .06% ***(estradiol)***	Tier 3	MO
estradiol gel .06%, .25mg/0.25gm, .5mg/0.5gm, .75mg/0.75gm, 1mg/gm, 1.25mg/1.25gm; pttw .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; ptwk .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr; tabs .5mg, 1mg, 2mg	Tier 1	MO
estradiol & norethindrone acetate tab 0.5-0.1 mg	Tier 1	MO
estradiol & norethindrone acetate tab 1-0.5 mg	Tier 1	MO
estradiol vaginal crea .1mg/gm	Tier 1	MO
estradiol valerate oil 20mg/ml, 40mg/ml	MB	
estrogens, conjugated tabs .3mg, .45mg, .625mg, .9mg, 1.25mg	Tier 1	MO
EVAMIST SOLN 1.53mg/spray ***(estradiol)***	Tier 3	MO
IMVEXXY MAINTENANCE PACK INST 4mcg, 10mcg ***(estradiol vaginal)***	Tier 2	MO
IMVEXXY STARTER PACK INST 4mcg, 10mcg ***(estradiol vaginal)***	Tier 2	MO
jinteli (Jinteli)	Tier 1	MO
mimvey (Mimvey)	Tier 1	MO
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	Tier 1	MO
PREMARIN CREA .625mg/gm ***(estrogens, conjugated vaginal)***	Tier 3	MO
yuvafem tabs 10mcg (Yuvafem)	Tier 1	MO
MISCELLANEOUS		
betaine anhy pow	Tier 4	SP, PA
cabergoline tabs .5mg	Tier 1	
CORTROPHIN GEL 80unit/ml; PRSY 40unit/0.5ml, 80unit/ml ***(corticotropin)***	MB	
CYSTAGON CAPS 50mg, 150mg ***(cysteamine bitartrate)***	Tier 4	SP, PA
INCRELEX SOLN 40mg/4ml ***(mecasermin)***	MB	
INTRAROSA INST 6.5mg ***(prasterone vaginal)***	Tier 3	MO
OSPHENA TABS 60mg ***(ospemifene)***	Tier 3	PA, MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
raloxifene hcl tabs 60mg	Tier 1	MO; $0 copay ages 35 and older for the primary prevention of breast cancer
REZDIFFRA TABS 60mg, 80mg, 100mg ***(resmetirom)***	Tier 3	PA, MO
sapropterin dihydrochloride pack 100mg, 500mg; tabs 100mg	Tier 4	SP, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml ***(pasireotide diaspartate)***	MB	
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
calcium acetate (phosphate binder) caps 667mg; tabs 667mg	Tier 1	MO
sevelamer carbonate pack .8gm, 2.4gm; tabs 800mg	Tier 1	MO
VELPHORO CHEW 500mg ***(sucroferric oxyhydroxide)***	Tier 3	ST, MO; PA**
POTASSIUM-REMOVING AGENTS		
sps susp 15gm/60ml (Sps)	Tier 1	
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
CRINONE GEL 4% ***(progesterone (vaginal))***	Tier 2	
CRINONE GEL 8% ***(progesterone (vaginal))***	Tier 2	PA
medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg	Tier 1	MO
megestrol acetate susp 40mg/ml	Tier 1	OAC
megestrol acetate (appetite) susp 625mg/5ml	Tier 1	MO
norethindrone acetate tabs 5mg	Tier 1	MO
progesterone caps 100mg, 200mg	Tier 1	MO
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
levothyroxine sodium tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 1	MO
levoxyl tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg (Levoxyl)	Tier 1	MO
liothyronine sodium tabs 5mcg, 25mcg, 50mcg	Tier 1	MO
methimazole tabs 5mg, 10mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
propylthiouracil tabs 50mg	Tier 1	MO
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg ***(levothyroxine sodium)***	Tier 2	MO
unithroid tabs 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 200mcg, 300mcg (Unithroid)	Tier 1	MO
UREA CYCLE DISORDER		
carglumic acid tbso 200mg	Tier 4	SP, PA
PHEBURANE PLLT 483mg/gm ***(sodium phenylbutyrate)***	Tier 4	SP, PA, QL (672g every 30 days)
sodium phenylbutyrate powd 3gm/tsp	Tier 4	SP, PA, QL (798g every 30 days)
sodium phenylbutyrate tabs 500mg	Tier 4	SP, PA, QL (1200 tabs every 30 days)
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
desmopressin acetate soln 4mcg/ml	MB	
desmopressin acetate tabs .1mg, .2mg	Tier 1	MO
desmopressin acetate spray soln .01%	Tier 1	MO
desmopressin acetate spray refrigerated soln .01%	Tier 1	MO
VITAMIN D ANALOGS		
calcitriol caps .25mcg, .5mcg; soln 1mcg/ml	Tier 1	MO
doxercalciferol caps .5mcg, 1mcg, 2.5mcg	Tier 1	MO
paricalcitol caps 1mcg, 2mcg, 4mcg	Tier 1	MO
ENDOCRINE AND METABOLIC AGENTS - MISC.		
FERTILITY REGULATORS		
clomiphene citrate tabs 50mg	Tier 1	Only covered if member has supplemental benefit. Limit 3 fills per lifetime
METABOLIC MODIFIERS		
MYALEPT SOLR 11.3mg ***(metreleptin)***	MB	
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tabs 200mg	Tier 1	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
BAXDELA TABS 450mg ***(delafloxacin meglumine)***	Tier 3	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
atropine sulfate sosy 1mg/10ml	MB	
dicyclomine hcl caps 10mg; soln 10mg/5ml; tabs 20mg	Tier 1	
dicyclomine hcl soln 10mg/ml	MB	
glycopyrrolate soln 1mg/5ml	Tier 1	MO
glycopyrrolate soln 1mg/5ml, 4mg/20ml	MB	
glycopyrrolate tabs 1mg, 2mg	Tier 1	
methscopolamine bromide tabs 2.5mg, 5mg	Tier 1	
ANTIDIARRHEALS		
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	Tier 1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	Tier 1	
loperamide hcl caps 2mg	Tier 1	
MOTOFEN TAB 1-0.025 ***(difenoxin w/ atropine)***	Tier 3	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
AKYNZEO CAP 300-0.5 ***(netupitant-palonosetron)***	Tier 3	QL (2 caps every 28 days)
aprepitant caps 40mg	Tier 1	QL (3 caps every 180 days)
aprepitant caps 80mg	Tier 1	QL (4 caps every 28 days)
aprepitant caps 125mg	Tier 1	QL (2 caps every 28 days)
aprepitant capsule therapy pack 80 & 125 mg	Tier 1	QL (2 packs every 28 days)
compro supp 25mg (Compro)	Tier 1	
dronabinol caps 2.5mg, 5mg, 10mg	Tier 1	QL (60 caps every 30 days)
granisetron hcl soln 1mg/ml	MB	
granisetron hcl tabs 1mg	Tier 1	
meclizine hcl tabs 12.5mg, 25mg	Tier 1	
metoclopramide hcl soln 5mg/ml	MB	
metoclopramide hcl soln 10mg/10ml; tabs 5mg, 10mg	Tier 1	
ondansetron tbdp 4mg, 8mg	Tier 1	
ondansetron hcl soln 4mg/2ml, 40mg/20ml; sosy 4mg/2ml	MB	
ondansetron hcl soln 4mg/5ml; tabs 4mg, 8mg, 24mg	Tier 1	
prochlorperazine supp 25mg	Tier 1	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
prochlorperazine maleate tabs 5mg, 10mg	Tier 1	MO
promethazine hcl soln 6.25mg/5ml; supp 12.5mg, 25mg; tabs 12.5mg, 25mg, 50mg	Tier 1	
promethazine hcl soln 25mg/ml, 50mg/ml	MB	
promethegan supp 12.5mg, 25mg, 50mg (Promethegan)	Tier 1	
SANCUSO PTCH 3.1mg/24hr ***(granisetron)***	Tier 2	
scopolamine pt72 1mg/3days	Tier 1	
trimethobenzamide hcl caps 300mg	Tier 1	
VARUBI TBPK 90mg ***(rolapitant hcl)***	Tier 2	
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
cimetidine tabs 200mg	Tier 1	
cimetidine tabs 300mg, 400mg, 800mg	Tier 1	MO
famotidine soln 20mg/2ml	MB	
famotidine susr 40mg/5ml; tabs 20mg, 40mg	Tier 1	MO
famotidine in nacl 0.9% iv soln 20 mg/50ml	MB	
nizatidine caps 150mg, 300mg	Tier 1	MO
ranitidine hcl tabs 150mg, 300mg	Tier 1	MO
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium caps 750mg	Tier 1	
budesonide cpep 3mg; tb24 9mg	Tier 1	
CORTIFOAM FOAM 10% ***(hydrocortisone acetate (intrarectal))***	Tier 2	
DIPENTUM CAPS 250mg ***(olsalazine sodium)***	Tier 3	MO
hydrocortisone (intrarectal) enem 100mg/60ml	Tier 1	
mesalamine cp24 .375gm; cpdr 400mg; tbec 1.2gm	Tier 1	MO
mesalamine enem 4gm; supp 1000mg; tbec 800mg	Tier 1	
sulfasalazine tabs 500mg; tbec 500mg	Tier 1	MO
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS CAPS 72mcg, 145mcg, 290mcg ***(linaclotide)***	Tier 2	MO
lubiprostone caps 8mcg, 24mcg	Tier 1	MO
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl tabs .5mg, 1mg	Tier 1	PA, MO
VIBERZI TABS 75mg, 100mg ***(eluxadoline)***	Tier 2	PA, MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LAXATIVES		
CLENPIQ SOL ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	PV	$0 copay for members age 45 through 75, Tier 2 for all others
enulose soln 10gm/15ml (Enulose)	Tier 1	MO
gavilyte-c (Gavilyte-c)	Tier 1	
gavilyte-g (Gavilyte-g)	Tier 1	
lactulose soln 10gm/15ml	Tier 1	MO
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	Tier 1	
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	PV	$0 copay for members age 45 through 75, otherwise not covered
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	Tier 1	
PEG-PREP KIT ***(bisacodyl-peg 3350-pot chloride-sod bicarb-sod chloride)***	PV	$0 copay for members age 45 through 75, otherwise not covered
PLENVU SOL ***(peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid)***	PV	$0 copay for members age 45 through 75, otherwise not covered
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	PV	$0 copay for members age 45 through 75, otherwise not covered
SUFLAVE SOL ***(peg 3350-kcl-sod chloride-sod sulfate-magnesium sulfate)***	PV	$0 copay for members age 45 through 75, otherwise not covered
SUTAB TAB ***(sodium sulfate-magnesium sulfate-potassium chloride)***	PV	$0 copay for members age 45 through 75, otherwise not covered
MISCELLANEOUS		
cromolyn sodium (mastocytosis), conc 100mg/5ml	Tier 1	MO
IQIRVO TABS 80mg ***(elafibranor)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
misoprostol tabs 100mcg, 200mcg	Tier 1	MO
MOVANTIK TABS 12.5mg, 25mg ***(naloxegol oxalate)***	Tier 2	
SUCRAID SOLN 8500unit/ml ***(sacrosidase)***	Tier 3	PA, QL (354 mL every 30 days), MO
sucralfate tabs 1gm	Tier 1	MO
ursodiol caps 300mg; tabs 250mg, 500mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VOWST CAP ***(fecal microbiota spores, live-brpk)***	Tier 4	PA, QL (12 caps every 30 days)
PANCREATIC ENZYMES		
CREON CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
CREON CAP 6000UNIT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
CREON CAP 12000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
CREON CAP 24000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
CREON CAP 36000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
VIOKACE TAB 10440 ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
VIOKACE TAB 20880 ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 5000UNIT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 10000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 15000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 20000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 25000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 40000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
ZENPEP CAP 60000UNT ***(pancrelipase (lipase-protease-amylase))***	Tier 2	PA, MO
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
esomeprazole magnesium cpdr 20mg, 40mg	Tier 1	MO
esomeprazole magnesium pack 2.5mg, 5mg, 10mg	Tier 1	MO; Covered for age less than 1 year only
lansoprazole cpdr 15mg, 30mg	Tier 1	MO
omeprazole cpdr 10mg, 20mg, 40mg	Tier 1	MO
pantoprazole sodium tbec 20mg, 40mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
rabeprazole sodium tbec 20mg	Tier 1	MO
RECTAL, CORTICOSTEROIDS		
hydrocortisone (rectal) crea 1%, 2.5%	Tier 1	
proctozone-hc crea 2.5% (Proctozone-hc)	Tier 1	
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
alfuzosin hcl tb24 10mg	Tier 1	MO
CARDURA XL TB24 4mg, 8mg ***(doxazosin mesylate (bph))***	Tier 3	MO
doxazosin mesylate tabs 1mg, 2mg, 4mg, 8mg	Tier 1	MO
dutasteride caps .5mg	Tier 1	MO
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	Tier 1	MO
finasteride tabs 5mg	Tier 1	MO
silodosin caps 4mg, 8mg	Tier 1	MO
tadalafil tabs 2.5mg, 5mg	Tier 1	PA, QL (30 tabs every 30 days), MO
tamsulosin hcl caps .4mg	Tier 1	MO
terazosin hcl caps 1mg, 2mg, 5mg, 10mg	Tier 1	MO
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
ENCARE SUPP 100mg ***(nonoxynol-9)***	PV	
OPTIONS GYNOL II VAGINAL GEL 3% ***(nonoxynol-9)***	PV	
PHEXX GEL ***(lactic acid-citric acid-potassium bitartrate)***	PV	
PHEXXI GEL ***(lactic acid-citric acid-potassium bitartrate)***	PV	
TODAY SPONGE MISC 1000mg ***(nonoxynol-9)***	PV	
VCF VAGINAL CONTRACEPTIVE FILM 28%; GEL 4% ***(nonoxynol-9)***	PV	
MISCELLANEOUS		
bethanechol chloride tabs 5mg, 10mg, 25mg, 50mg	Tier 1	
ELMIRON CAPS 100mg ***(pentosan polysulfate sodium)***	Tier 3	
potassium citrate (alkalinizer) tbcr 10meq, 15meq, 540mg	Tier 1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
darifenacin hydrobromide tb24 7.5mg, 15mg	Tier 1	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fesoterodine fumarate tb24 4mg, 8mg	Tier 1	MO
mirabegron srer 8mg/ml; tb24 25mg, 50mg	Tier 1	MO
oxybutynin chloride soln 5mg/5ml; tabs 5mg; tb24 5mg, 10mg, 15mg	Tier 1	MO
solifenacin succinate tabs 5mg, 10mg	Tier 1	MO
tolterodine tartrate cp24 2mg, 4mg; tabs 1mg, 2mg	Tier 1	MO
trospium chloride cp24 60mg; tabs 20mg	Tier 1	MO
VAGINAL ANTI-INFECTIVES		
CLEOCIN SUPP 100mg ***(clindamycin phosphate vaginal)***	Tier 2	
clindamycin phosphate vaginal crea 2%	Tier 1	
GYNAZOLE-1 CREA 2% ***(butoconazole nitrate (one dose))***	Tier 3	
metronidazole vaginal gel .75%	Tier 1	
miconazole 3 supp 200mg (Miconazole 3)	Tier 1	
terconazole vaginal crea .4%, .8%; supp 80mg	Tier 1	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
dabigatran etexilate mesylate caps 75mg, 110mg, 150mg	Tier 1	MO
ELIQUIS CPSP .15mg; TABS 2.5mg, 5mg; TBSO .5mg ***(apixaban)***	Tier 2	MO
ELIQUIS 3X 0.5MG (1.5MG) TBSO .5mg ***(apixaban)***	Tier 2	MO
ELIQUIS 4X 0.5MG (2MG) TBSO .5mg ***(apixaban)***	Tier 2	MO
ELIQUIS STARTER PACK TBPK 5mg ***(apixaban)***	Tier 2	
enoxaparin sodium soln 300mg/3ml; sosy 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	MB	
fondaparinux sodium soln 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FRAGMIN SOLN 10000unit/4ml, 95000unit/3.8ml; SOSY 2500unit/0.2ml, 5000unit/0.2ml, 7500unit/0.3ml, 10000unit/ml, 12500unit/0.5ml, 15000unit/0.6ml, 18000unt/0.72ml ***(dalteparin sodium)***	MB	
heparin sodium (porcine) soln 1000unit/ml, 5000unit/0.5ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	MB	
rivaroxaban susr 1mg/ml; tabs 2.5mg	Tier 1	MO
warfarin sodium tabs 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	Tier 1	MO
XARELTO TABS 10mg, 15mg, 20mg ***(rivaroxaban)***	Tier 2	MO
XARELTO STAR TAB 15/20MG ***(rivaroxaban)***	Tier 2	
HEMATOPOIETIC GROWTH FACTORS		
ARANESP ALBUMIN FREE SOLN 25mcg/ml, 40mcg/ml, 60mcg/ml, 100mcg/ml, 200mcg/ml; SOSY 10mcg/0.4ml, 25mcg/0.42ml, 40mcg/0.4ml, 60mcg/0.3ml, 100mcg/0.5ml, 150mcg/0.3ml, 200mcg/0.4ml, 300mcg/0.6ml, 500mcg/ml ***(darbepoetin alfa)***	MB	
FYLNETRA SOSY 6mg/0.6ml ***(pegfilgrastim-pbbk)***	MB	
MIRCERA SOSY 30mcg/0.3ml, 50mcg/0.3ml, 75mcg/0.3ml, 100mcg/0.3ml, 120mcg/0.3ml, 150mcg/0.3ml, 200mcg/0.3ml ***(methoxy polyethylene glycol-epoetin beta)***	MB	
NIVESTYM SOLN 300mcg/ml, 480mcg/1.6ml; SOSY 300mcg/0.5ml, 480mcg/0.8ml ***(filgrastim-aafi)***	MB	
NYVEPRIA SOSY 6mg/0.6ml ***(pegfilgrastim-apgf)***	MB	
RETACRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml ***(epoetin alfa-epbx)***	MB	
HEMOPHILIA A AGENTS		
HEMLIBRA SOLN 12mg/0.4ml, 30mg/ml, 60mg/0.4ml, 105mg/0.7ml, 150mg/ml, 300mg/2ml ***(emicizumab-kxwh)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MISCELLANEOUS		
anagrelide hcl caps .5mg, 1mg	Tier 1	MO
cilostazol tabs 50mg, 100mg	Tier 1	MO
pentoxifylline tbcr 400mg	Tier 1	MO
tranexamic acid soln 1000mg/10ml	MB	
tranexamic acid tabs 650mg	Tier 1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	Tier 1	MO
clopidogrel bisulfate tabs 75mg	Tier 1	MO
clopidogrel bisulfate tabs 300mg	Tier 1	
dipyridamole tabs 25mg, 50mg, 75mg	Tier 1	MO
prasugrel hcl tabs 5mg, 10mg	Tier 1	MO
SICKLE CELL DISEASE		
DROXIA CAPS 200mg, 300mg, 400mg ***(hydroxyurea (sickle cell disease))***	Tier 2	MO; OAC
THROMBOCYTOPENIA AGENTS		
ALVAIZ TABS 9mg, 54mg ***(eltrombopag choline)***	Tier 4	SP, PA, QL (60 tabs every 30 days)
ALVAIZ TABS 18mg, 36mg ***(eltrombopag choline)***	Tier 4	SP, PA, QL (90 tabs every 30 days)
DOPTELET SPRINKLE CPSP 10mg ***(avatrombopag maleate)***	Tier 4	SP, PA, QL (60 caps every 30 days)
DOPTELET TAB 20MG (10 TABLETS) TABS 20mg ***(avatrombopag maleate)***	Tier 4	SP, PA, QL (1 carton every 5 days)
DOPTELET TAB 20MG (15 TABLETS) TABS 20mg ***(avatrombopag maleate)***	Tier 4	SP, PA, QL (1 carton every 5 days)
DOPTELET TAB 20MG (30 TABLETS) TABS 20mg ***(avatrombopag maleate)***	Tier 4	SP, PA, QL (2 cartons every 30 days)
HEMATOPOIETIC AGENTS		
FOLIC ACID/FOLATES		
folic acid tabs 1mg	Tier 1	MO
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
ACTEMRA SOLN 80mg/4ml, 200mg/10ml, 400mg/20ml ***(tocilizumab)***	MB	
COSENTYX SOLN 125mg/5ml ***(secukinumab)***	MB	
ENTYVIO SOLR 300mg ***(vedolizumab)***	MB	
SIMPONI ARIA SOLN 50mg/4ml ***(golimumab)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SKYRIZI SOLN 600mg/10ml ***(risankizumab-rzaa (crohn's))***	MB	
TREMFYA SOLN 200mg/20ml ***(guselkumab (gastrointestinal))***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ACTEMRA SOSY 162mg/0.9ml ***(tocilizumab)***	MB	
ACTEMRA ACTPEN SOAJ 162mg/0.9ml ***(tocilizumab)***	MB	
ENTYVIO PEN SOAJ 108mg/0.68ml ***(vedolizumab)***	MB	
SIMPONI SOAJ 50mg/0.5ml, 100mg/ml; SOSY 50mg/0.5ml, 100mg/ml ***(golimumab)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), ALOPECIA AREATA		
LITFULO CAPS 50mg ***(ritlecitinib tosylate)***	Tier 4	SP, PA, QL (28 caps every 28 days)
OLUMIANT TABS 1mg, 2mg, 4mg ***(baricitinib)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), ANKYLOSING SPONDYLITIS		
ADALIMUMAB-ADAZ SOAJ 40mg/0.4ml, 80mg/0.8ml; SOSY 10mg/0.1ml, 20mg/0.2ml, 40mg/0.4ml	MB	
ADALIMUMAB-FKJP AJKT 40mg/0.8ml; PSKT 20mg/0.4ml, 40mg/0.8ml	MB	
COSENTYX SOSY 75mg/0.5ml, 150mg/ml ***(secukinumab)***	MB	
COSENTYX SENSOREADY PEN SOAJ 150mg/ml ***(secukinumab)***	MB	
COSENTYX UNOREADY SOAJ 300mg/2ml ***(secukinumab)***	MB	
ENBREL SOLN 25mg/0.5ml; SOSY 25mg/0.5ml, 50mg/ml ***(etanercept)***	MB	
ENBREL MINI SOCT 50mg/ml ***(etanercept)***	MB	
ENBREL SURECLICK SOAJ 50mg/ml ***(etanercept)***	MB	
HYRIMOZ SOAJ 40mg/0.4ml; SOSY 20mg/0.2ml, 40mg/0.4ml ***(adalimumab-adaz)***	MB	
HYRIMOZ SENSOREADY CD/UC/ SOAJ 80mg/0.8ml ***(adalimumab-adaz)***	MB	
HYRIMOZ SENSOREADY PENS SOAJ 80mg/0.8ml ***(adalimumab-adaz)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HYRIMOZ-PLAQ INJ PSORIASI ***(adalimumab-adaz)***	MB	
RINVOQ TB24 15mg ***(upadacitinib)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
tofacitinib citrate tabs 5mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
tofacitinib citrate tb24 11mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), CROHN'S DISEASE		
PYZCHIVA SOAJ 45mg/0.5ml, 90mg/ml; SOLN 45mg/0.5ml; SOSY 45mg/0.5ml, 90mg/ml ***(ustekinumab-ttwe)***	MB	
RINVOQ TB24 45mg ***(upadacitinib)***	Tier 4	SP, PA, QL (One time use only (for CD/UC diagnosis))
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml ***(risankizumab-rzaa (crohn's))***	MB	
TREMFYA SOAJ 200mg/2ml; SOSY 200mg/2ml ***(guselkumab (gastrointestinal))***	MB	
TREMFYA SOPN 100mg/ml; SOSY 100mg/ml ***(guselkumab)***	MB	
TREMFYA PEN SOAJ 100mg/ml ***(guselkumab)***	MB	
YESINTEK SOLN 45mg/0.5ml; SOSY 45mg/0.5ml, 90mg/ml ***(ustekinumab-kfce)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), HIDRADENITIS SUPPURATIVA		
BIMZELX SOAJ 160mg/ml, 320mg/2ml; SOSY 160mg/ml, 320mg/2ml ***(bimekizumab-bkzx)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS		
CIMZIA (1 SYRINGE) PSKT 200mg/ml ***(certolizumab pegol)***	MB	
CIMZIA STARTER KIT PSKT 200mg/ml ***(certolizumab pegol)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), PSORIASIS		
OTEZLA TABS 20mg, 30mg ***(apremilast)***	Tier 4	SP, PA, QL (60 tabs every 30 days)
OTEZLA TAB 10/20 ***(apremilast)***	Tier 4	SP, PA, QL (55 tabs every 28 days)
OTEZLA TAB 10/20/30 ***(apremilast)***	Tier 4	SP, PA, QL (55 tabs every 28 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OTEZLA XR TB24 75mg ***(apremilast)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
OTEZLA/XR TAB 28 DAY ***(apremilast)***	Tier 4	SP, PA, QL (41 tabs every 28 days)
TALTZ SOAJ 80mg/ml; SOSY 20mg/0.25ml, 40mg/0.5ml, 80mg/ml ***(ixekizumab)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), PSORIATIC ARTHRITIS		
RINVOQ LQ SOLN 1mg/ml ***(upadacitinib)***	Tier 4	SP, PA, QL (360 mL every 30 days)
SKYRIZI SOSY 55mg/0.37ml, 150mg/ml ***(risankizumab-rzaa)***	MB	
SKYRIZI PEN SOAJ 150mg/ml ***(risankizumab-rzaa)***	MB	
tofacitinib citrate soln 1mg/ml	Tier 4	SP, PA, QL (240 mL every 24 days)
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), RHEUMATOID ARTHRITIS		
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml; SOSY 200mg/1.14ml ***(sarilumab)***	MB	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED), ULCERATIVE COLITIS		
tofacitinib citrate tabs 10mg	Tier 4	SP, PA, QL (60 tabs every 30 days)
tofacitinib citrate tb24 22mg	Tier 4	SP, PA, QL (30 tabs every 30 days)
VELSIPITY TABS 2mg ***(etrasimod arginine)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
hydroxychloroquine sulfate tabs 200mg	Tier 1	MO
leflunomide tabs 10mg, 20mg	Tier 1	MO
methotrexate sodium tabs 2.5mg	Tier 1	OAC
HEREDITARY ANGIOEDEMA		
icatibant acetate sosy 30mg/3ml	MB	
TAKHZYRO SOSY 150mg/ml, 300mg/2ml ***(lanadelumab-flyo)***	MB	
IMMUNOGLOBULIN		
CUTAQUIG SOLN 1gm/6ml, 1.65gm/10ml, 2gm/12ml, 3.3gm/20ml, 4gm/24ml, 8gm/48ml ***(immune globulin (human)-hipp)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMMUNOMODULATORS		
ACTIMMUNE SOLN 100mcg/0.5ml ***(interferon gamma-1b)***	MB	
ARCALYST SOLR 220mg ***(rilonacept)***	MB	
IMMUNOSUPPRESSANTS		
azathioprine tabs 50mg, 75mg, 100mg	Tier 1	MO
cyclosporine caps 25mg, 100mg	Tier 1	SP
cyclosporine modified (for microemulsion) caps 25mg, 50mg, 100mg; soln 100mg/ml	Tier 1	SP
ENVARSUS XR TB24 .75mg, 1mg, 4mg ***(tacrolimus)***	Tier 3	SP
everolimus (immunosuppressant) tabs .25mg, .5mg, .75mg, 1mg	Tier 1	SP
gengraf caps 25mg, 100mg (Gengraf)	Tier 1	SP
mycophenolate mofetil caps 250mg; susr 200mg/ml; tabs 500mg	Tier 1	SP
mycophenolate mofetil hcl solr 500mg	MB	
mycophenolate sodium tbec 180mg, 360mg	Tier 1	SP
NULOJIX SOLR 250mg ***(belatacept)***	MB	
PROGRAF PACK .2mg, 1mg ***(tacrolimus)***	Tier 3	SP
SANDIMMUNE SOLN 50mg/ml ***(cyclosporine)***	MB	
sirolimus soln 1mg/ml; tabs .5mg, 1mg, 2mg	Tier 1	SP
tacrolimus caps .5mg, 1mg, 5mg; cp24 .5mg, 1mg, 5mg	Tier 1	SP
tacrolimus soln 5mg/ml	MB	
MISCELLANEOUS		
BEYFORTUS SOSY 50mg/0.5ml, 100mg/ml ***(nirsevimab-alip)***	MB	
ENFLONSIA SOSY 105mg/0.7ml ***(clesrovimab-cfor)***	MB	
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
EFFER-K TBEF 25meq ***(potassium bicarbonate)***	Tier 1	MO
klor-con m15 tbcr 15meq (Klor-con M15)	Tier 1	MO
magnesium sulfate soln 2gm/50ml, 50%	MB	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	MB	
MONOJECT SODIUM CHLORIDE SOLN .9% ***(sodium chloride flush)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
potassium chloride cpcr 8meq, 10meq; soln 10%, 20%; tbcr 8meq, 10meq, 15meq, 20meq	Tier 1	MO
potassium chloride soln 2meq/ml	MB	
potassium chloride microencapsulated crystals er tbcr 10meq, 20meq	Tier 1	MO
sodium chloride soln .45%, .9%, 2.5meq/ml, 3%, 5%	MB	
sodium fluoride chew 1mg; tabs 1mg	Tier 1	MO
sodium fluoride chew .25mg, .5mg; soln .5mg/ml; tabs .5mg	PV	MO; $0 applies for ages 5 and under, otherwise not covered
PRENATAL VITAMINS		
elite-ob (Elite-ob)	Tier 1	
pnv-dha (Pnv-dha)	Tier 1	
pnv-select (Pnv-select)	Tier 1	
VITAMINS		
cyanocobalamin soln 1000mcg/ml	MB	
ergocalciferol caps 1.25mg	Tier 1	MO
folic acid caps 800mcg	PV	QL (100 caps every 30 days), MO; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 1mg	Tier 1	MO
folic acid tabs 400mcg	PV	QL (100 tabs every 30 days); $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 800mcg	PV	QL (100 tabs every 30 days), MO; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
phytonadione tabs 5mg	Tier 1	
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	Tier 1	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
neomycin-polymyxin-dexamethasone ophth oint 0.1%	Tier 1	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	Tier 1	
neomycin-polymyxin-hc ophth susp	Tier 1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	Tier 1	
TOBRADEX OIN 0.3-0.1% ***(tobramycin-dexamethasone)***	Tier 2	
TOBRADEX ST SUS 0.3-0.05 ***(tobramycin-dexamethasone)***	Tier 2	
tobramycin-dexamethasone ophth susp 0.3-0.1%	Tier 1	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
AZASITE SOLN 1% ***(azithromycin (ophth))***	Tier 2	
bacitracin-polymyxin b ophth oint	Tier 1	
BESIVANCE SUSP .6% ***(besifloxacin hcl)***	Tier 3	
ciprofloxacin hcl (ophth) soln .3%	Tier 1	
erythromycin (ophth) oint 5mg/gm	Tier 1	
gatifloxacin (ophth) soln .5%	Tier 1	
gentamicin sulfate (ophth) soln .3%	Tier 1	
moxifloxacin hcl (ophth) soln .5%	Tier 1	
NATACYN SUSP 5% ***(natamycin)***	Tier 2	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	Tier 1	
ofloxacin (ophth) soln .3%	Tier 1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	Tier 1	
sulfacetamide sodium (ophth) soln 10%	Tier 1	
tobramycin (ophth) soln .3%	Tier 1	
trifluridine soln 1%	Tier 1	
ZIRGAN GEL .15% ***(ganciclovir ophthalmic)***	Tier 3	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL SOLN .45% ***(ketorolac tromethamine (ophth))***	Tier 2	
bromfenac sodium (ophth) soln .09%	Tier 1	
dexamethasone sodium phosphate (ophth) soln .1%	Tier 1	
diclofenac sodium (ophth) soln .1%	Tier 1	
difluprednate emul .05%	Tier 1	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
flurbiprofen sodium soln .03%	Tier 1	
ILEVRO SUSP .3% ***(nepafenac)***	Tier 2	
ketorolac tromethamine (ophth) soln .4%, .5%	Tier 1	
loteprednol etabonate susp .5%	Tier 1	
NEVANAC SUSP .1% ***(nepafenac)***	Tier 2	
prednisolone acetate (ophth) susp 1%	Tier 1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	Tier 2	
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
ALOCRIL SOLN 2% ***(nedocromil sodium (ophth))***	Tier 3	
azelastine hcl (ophth) soln .05%	Tier 1	
bepotastine besilate soln 1.5%	Tier 1	
cromolyn sodium (ophth) soln 4%	Tier 1	
epinastine hcl (ophth) soln .05%	Tier 1	
olopatadine hcl soln .2%	Tier 1	
ZERVIATE SOLN .24% ***(cetirizine hcl (ophth))***	Tier 3	
ANTIGLAUCOMA BETA-BLOCKERS		
betaxolol hcl (ophth) soln .5%	Tier 1	MO
BETOPTIC-S SUSP .25% ***(betaxolol hcl (ophth))***	Tier 2	MO
carteolol hcl (ophth) soln 1%	Tier 1	MO
levobunolol hcl soln .5%	Tier 1	MO
timolol maleate (ophth) solg .25%, .5%; soln .25%, .5%	Tier 1	MO
ANTIGLAUCOMA COMBINATION AGENTS		
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	Tier 1	MO
dorzolamide hcl-timolol maleate ophth soln 2-0.5%	Tier 1	MO
SIMBRINZA SUS 1-0.2% ***(brinzolamide-brimonidine tartrate)***	Tier 2	MO
CARBONIC ANHYDRASE INHIBITORS		
brinzolamide susp 1%	Tier 1	MO
dorzolamide hcl soln 2%	Tier 1	MO
DRY EYE DISEASE		
cyclosporine (ophth) emul .05%	Tier 1	MO
RESTASIS MULTIDOSE EMUL .05% ***(cyclosporine (ophth))***	Tier 2	MO
TRYPTYR SOLN .003% ***(acoltremon)***	Tier 2	MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VEVYE SOLN .1% ***(cyclosporine (ophth))***	Tier 2	MO
MISCELLANEOUS		
atropine sulfate (ophthalmic) soln 1%	Tier 1	MO
CYSTARAN SOLN .44% ***(cysteamine hcl)***	Tier 4	PA, QL (4 bottles every 28 days)
phenylephrine hcl (mydriatic) soln 2.5%, 10%	Tier 1	
PHOSPHOLINE IODIDE SOLR .125% ***(echothiophate iodide)***	Tier 3	MO
pilocarpine hcl soln 1%	Tier 1	MO
tropicamide soln .5%, 1%	Tier 1	MO
PROSTAGLANDINS		
bimatoprost soln .01%	Tier 1	MO
latanoprost soln .005%	Tier 1	MO
tafluprost soln .015mg/ml	Tier 1	MO
travoprost soln .004%	Tier 1	MO
SYMPATHOMIMETICS		
apraclonidine hcl soln .5%	Tier 1	
brimonidine tartrate soln .1%, .15%, .2%	Tier 1	MO
IOPIDINE SOLN 1% ***(apraclonidine hcl)***	Tier 3	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TABS 100mg ***(flibanserin)***	Tier 3	PA, MO
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS		
PROLASTIN-C SOLN 1000mg/20ml ***(alpha1-proteinase inhibitor (human))***	MB	
ANAPHYLAXIS TREATMENT AGENTS		
epinephrine (anaphylaxis) soaj .15mg/0.3ml, .3mg/0.3ml	Tier 1	QL (4 auto-injectors every 30 days)
epinephrine (anaphylaxis) soaj .15mg/0.15ml	Tier 1	QL (4 auto-injectors every 30 days); (generic of Adrenaclick)
EPIPEN 2-PAK SOAJ .3mg/0.3ml ***(epinephrine (anaphylaxis))***	Tier 2	QL (4 auto-injectors every 30 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
BEVESPI AER 9-4.8MCG ***(glycopyrrolate-formoterol fumarate)***	Tier 2	QL (1 package every 30 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	Tier 1	QL (6 boxes every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STIOLTO AER 2.5-2.5 ***(tiotropium bromide-olodaterol hcl)***	Tier 2	QL (1 package every 30 days), MO
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS		
TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)***	Tier 2	QL (1 package every 30 days), MO
TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)***	Tier 2	QL (1 package every 30 days), MO
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
ipratropium bromide soln .02%	Tier 1	QL (5 boxes every 30 days), MO
ipratropium bromide (nasal) soln .03%, .06%	Tier 1	MO
SPIRIVA RESPIMAT AERS 1.25mcg/act, 2.5mcg/act ***(tiotropium bromide)***	Tier 2	QL (1 package every 30 days), MO
tiotropium bromide caps 18mcg	Tier 1	QL (1 package every 30 days), MO
ANTIHISTAMINE COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	Tier 1	QL (1 package every 30 days)
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
azelastine hcl soln .1%	Tier 1	QL (2 bottles every 30 days)
carbinoxamine maleate soln 4mg/5ml; tabs 4mg	Tier 1	
clemastine fumarate tabs 2.68mg	Tier 1	
cyproheptadine hcl syrp 2mg/5ml; tabs 4mg	Tier 1	
desloratadine tabs 5mg; tbdp 2.5mg, 5mg	Tier 1	
diphenhydramine hcl soln 50mg/ml	MB	
hydroxyzine hcl soln 25mg/ml, 50mg/ml	MB	
hydroxyzine hcl syrp 10mg/5ml; tabs 10mg, 25mg, 50mg	Tier 1	
hydroxyzine pamoate caps 25mg, 50mg, 100mg	Tier 1	
levocetirizine dihydrochloride soln 2.5mg/5ml; tabs 5mg	Tier 1	
olopatadine hcl (nasal) soln .6%	Tier 1	QL (1 container every 30 days)
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate aers 108mcg/act	Tier 1	QL (2 inhalers every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
albuterol sulfate nebu 2.5mg/0.5ml	Tier 1	QL (120 vials every 30 days), MO
albuterol sulfate nebu .083%, .63mg/3ml, 1.25mg/3ml	Tier 1	QL (5 boxes every 30 days), MO
albuterol sulfate syrp 2mg/5ml; tabs 2mg, 4mg	Tier 1	MO
formoterol fumarate nebu 20mcg/2ml	Tier 1	QL (60 vials every 30 days), MO
levalbuterol hcl nebu 1.25mg/0.5ml	Tier 1	QL (45 mL every 30 days), MO
levalbuterol hcl nebu .31mg/3ml, .63mg/3ml, 1.25mg/3ml	Tier 1	QL (300 mL every 30 days), MO
levalbuterol tartrate aero 45mcg/act	Tier 1	QL (2 inhalers every 30 days), MO
STRIVERDI RESPIMAT AERS 2.5mcg/act ***(olodaterol hcl)***	Tier 2	QL (1 package every 30 days), MO
terbutaline sulfate tabs 2.5mg, 5mg	Tier 1	MO
CHRONIC RHINOSINUSITIS WITH NASAL POLYPS		
NUCALA SOAJ 100mg/ml; SOSY 40mg/0.4ml, 100mg/ml ***(mepolizumab)***	MB	
COLD/COUGH		
benzonatate caps 100mg, 200mg	Tier 1	
guaifenesin-codeine soln 100-10 mg/5ml	Tier 1	QL (60 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	Tier 1	QL (30 mL every day); Subject to initial 7-day limit
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	Tier 1	QL (6 tabs every day); Subject to initial 7-day limit
promethazine & phenylephrine syrup 6.25-5 mg/5ml	Tier 1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	Tier 1	QL (30 mL every day); Subject to initial 7-day limit
promethazine-dm syrup 6.25-15 mg/5ml	Tier 1	
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	Tier 1	
CYSTIC FIBROSIS		
CAYSTON SOLR 75mg ***(aztreonam lysine)***	Tier 4	SP, PA, QL (84 vials every 28 days)
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg ***(ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KALYDECO TABS 150mg ***(ivacaftor)***	Tier 4	SP, PA, QL (56 tabs every 28 days); carton consists of 56 tablets
ORKAMBI GRA 75-94MG ***(lumacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)
ORKAMBI GRA 100-125 ***(lumacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)
ORKAMBI GRA 150-188 ***(lumacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)
ORKAMBI TAB 100-125 ***(lumacaftor-ivacaftor)***	Tier 4	SP, PA, QL (112 tabs every 28 days)
ORKAMBI TAB 200-125 ***(lumacaftor-ivacaftor)***	Tier 4	SP, PA, QL (112 tabs every 28 days)
SYMDEKO TAB 50-75MG ***(tezacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 tabs every 28 days)
SYMDEKO TAB 100-150 ***(tezacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 tabs every 28 days)
tobramycin nebu 300mg/4ml	Tier 4	SP, PA, QL (224 mL every 28 days)
tobramycin nebu 300mg/5ml	Tier 4	SP, PA, QL (280 mL every 28 days)
TRIKAFTA PAK 59.5MG ***(elexacaftor-tezacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)
TRIKAFTA PAK 75MG ***(elexacaftor-tezacaftor-ivacaftor)***	Tier 4	SP, PA, QL (56 packets every 28 days)
TRIKAFTA TAB ***(elexacaftor-tezacaftor-ivacaftor)***	Tier 4	SP, PA, QL (84 tabs every 28 days)
LEUKOTRIENE MODIFIERS		
zileuton tb12 600mg	Tier 2	MO
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES		
montelukast sodium chew 4mg, 5mg; pack 4mg; tabs 10mg	Tier 1	MO
zafirlukast tabs 10mg, 20mg	Tier 1	MO
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
cromolyn sodium nebu 20mg/2ml	Tier 1	QL (2 boxes every 30 days), MO
MISCELLANEOUS		
acetylcysteine soln 10%, 20%	Tier 1	
roflumilast tabs 250mcg, 500mcg	Tier 1	PA, MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sodium chloride (inhalant) nebu .9%, 3%, 7%, 10%	Tier 1	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) soln .025%	Tier 1	QL (3 containers every 30 days)
fluticasone propionate (nasal) susp 50mcg/act	Tier 1	QL (1 container every 30 days)
PULMONARY FIBROSIS AGENTS		
pirfenidone caps 267mg	Tier 4	SP, PA, QL (270 caps every 30 days)
pirfenidone tabs 267mg	Tier 4	SP, PA, QL (270 tabs every 30 days)
pirfenidone tabs 801mg	Tier 4	SP, PA, QL (90 tabs every 30 days)
RESPIRATORY THERAPY SUPPLIES		
ADULT RESPIRATORY MASK ***(spacer/aerosol-holding chambers)***	Tier 2	
HOLD CHAMBER MIS MEDIUM ***(spacer/aerosol-holding chambers)***	Tier 2	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	Tier 2	
PEDIATRIC RESPIRATORY MASK ***(spacer/aerosol-holding chamber supplies - masks)***	Tier 2	
SEVERE ASTHMA AGENTS		
DUPIXENT SOAJ 200mg/1.14ml, 300mg/2ml; SOSY 200mg/1.14ml, 300mg/2ml ***(dupilumab)***	MB	
FASENRA PEN SOAJ 30mg/ml ***(benralizumab)***	MB	
XOLAIR SOAJ 75mg/0.5ml, 150mg/ml, 300mg/2ml; SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml, 300mg/2ml ***(omalizumab)***	MB	
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ASMANEX HFA AERO 50mcg/act, 100mcg/act, 200mcg/act ***(mometasone furoate (inhalation))***	Tier 2	QL (1 package every 30 days), MO
budesonide (inhalation) susp 1mg/2ml	Tier 1	QL (1 box every 30 days), MO

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
budesonide (inhalation) susp .5mg/2ml	Tier 1	QL (2 boxes every 30 days), MO
budesonide (inhalation) susp .25mg/2ml	Tier 1	QL (3 boxes every 30 days), MO
fluticasone furoate (inhalation) aepb 50mcg/act, 100mcg/act, 200mcg/act	Tier 1	QL (1 package every 30 days), MO
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
AIRSUPRA AER 90-80MCG ***(albuterol-budesonide)***	Tier 2	QL (3 packages every 30 days)
BREO ELLIPTA INH 50-25MCG ***(fluticasone furoate-vilanterol)***	Tier 2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)***	Tier 2	QL (1 package every 30 days), MO
BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)***	Tier 2	QL (1 package every 30 days), MO
breyna (Breyna)	Tier 1	QL (3 packages every 30 days), MO
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act	Tier 1	QL (3 packages every 30 days), MO
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act	Tier 1	QL (3 packages every 30 days), MO
fluticasone-salmeterol aer powder ba 100-50 mcg/act	Tier 1	QL (1 package every 30 days), MO
fluticasone-salmeterol aer powder ba 250-50 mcg/act	Tier 1	QL (1 package every 30 days), MO
fluticasone-salmeterol aer powder ba 500-50 mcg/act	Tier 1	QL (1 package every 30 days), MO
XANTHINES - DRUGS TO TREAT COPD		
theophylline elix 80mg/15ml; soln 80mg/15ml; tb12 300mg, 450mg; tb24 400mg, 600mg	Tier 1	MO
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
adapalene crea .1%; gel .1%, .3%	Tier 1	PA, QL (45g every 28 days); PA applies for members age 35 and older
adapalene-benzoyl peroxide gel 0.1-2.5%	Tier 1	
adapalene-benzoyl peroxide gel 0.3-2.5%	Tier 1	
benzoyl peroxide-erythromycin gel 5-3%	Tier 1	QL (47g every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	Tier 1	QL (45g every 30 days)
clindamycin phosphate (topical) foam 1%; swab 1%	Tier 1	
clindamycin phosphate (topical) gel 1%	Tier 1	QL (75g every 30 days)
clindamycin phosphate (topical) lotn 1%; soln 1%	Tier 1	QL (60 mL every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1-5%	Tier 1	QL (50g every 30 days)
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	Tier 1	QL (50g every 30 days)
ery pads 2% (Ery)	Tier 1	
erythromycin (acne aid) gel 2%	Tier 1	QL (60g every 30 days)
erythromycin (acne aid) soln 2%	Tier 1	QL (60 mL every 30 days)
isotretinoin caps 10mg, 20mg, 30mg, 40mg	Tier 1	PA
sulfacetamide sodium (acne) lotn 10%	Tier 1	
tretinoin crea .025%, .05%, .1%; gel .01%, .025%, .05%	Tier 1	PA; PA applies for members age 35 and older
tretinoin microsphere gel .04%, .1%	Tier 1	PA; PA applies for members age 35 and older
DERMATOLOGY, ACTINIC KERATOSIS		
fluorouracil (topical) crea 5%; soln 2%, 5%	Tier 1	
imiquimod crea 5%	Tier 1	
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) crea .1%; oint .1%	Tier 1	
mupirocin oint 2%	Tier 1	QL (30g every 30 days)
silver sulfadiazine crea 1%	Tier 1	
ssd crea 1% (Ssd)	Tier 1	
SULFAMYLON CREA 85mg/gm ***(mafenide acetate)***	Tier 3	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox gel .77%	Tier 1	QL (120g every 30 days)
ciclopirox sham 1%	Tier 1	QL (120 mL every 30 days)
ciclopirox soln 8%	Tier 1	
ciclopirox olamine crea .77%	Tier 1	QL (120g every 30 days)
ciclopirox olamine susp .77%	Tier 1	QL (120 mL every 30 days)
clotrimazole (topical) crea 1%	Tier 1	QL (120g every 30 days)
clotrimazole (topical) soln 1%	Tier 1	QL (120 mL every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clotrimazole w/ betamethasone cream 1-0.05%	Tier 1	QL (60g every 30 days)
clotrimazole w/ betamethasone lotion 1-0.05%	Tier 1	QL (60 mL every 30 days)
econazole nitrate crea 1%	Tier 1	QL (60g every 30 days)
ERTACZO CREA 2% ***(sertaconazole nitrate)***	Tier 3	QL (60g every 30 days)
JUBLIA SOLN 10% ***(efinaconazole)***	Tier 3	PA, QL (4 mL every 28 days)
ketoconazole (topical) crea 2%	Tier 1	QL (120g every 30 days)
naftifine hcl crea 1%, 2%	Tier 1	QL (60g every 30 days)
nystatin (topical) crea 100000unit/gm; oint 100000unit/gm; powd 100000unit/gm	Tier 1	QL (120g every 30 days)
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	Tier 1	QL (60g every 30 days)
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	Tier 1	QL (60g every 30 days)
nystop powd 100000unit/gm (Nystop)	Tier 1	QL (120g every 30 days)
oxiconazole nitrate crea 1%	Tier 1	QL (60g every 30 days)
sulconazole nitrate crea 1%	Tier 1	QL (60g every 30 days)
sulconazole nitrate soln 1%	Tier 1	QL (60 mL every 30 days)
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl (antipruritic) crea 5%	Tier 2	
DERMATOLOGY, ANTIPSORIATICS		
acitretin caps 10mg, 17.5mg, 25mg	Tier 1	
calcipotriene soln .005%	Tier 1	ST, QL (60 mL every 30 days); PA**
calcipotriene-betamethasone dipropionate oint 0.005-0.064%	Tier 2	ST, QL (60g every 30 days); PA**
calcitriol (topical) oint 3mcg/gm	Tier 2	ST, QL (100g every 30 days); PA**
methoxsalen rapid caps 10mg	Tier 1	
tazarotene crea .05%, .1%; gel .05%, .1%	Tier 1	PA
ZORYVE CREA .3% ***(roflumilast (topical))***	Tier 2	
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) sham 2%	Tier 1	QL (120 mL every 30 days)
selenium sulfide lotn 2.5%	Tier 1	
ZORYVE FOAM .3% ***(roflumilast (topical))***	Tier 2	
DERMATOLOGY, ATOPIC DERMATITIS		
EBGLYSS SOAJ 250mg/2ml; SOSY 250mg/2ml ***(lebrikizumab-lbkz)***	MB	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
EUCRISA OINT 2% ***(crisaborole)***	Tier 2	ST, QL (60g every 30 days); PA**
RINVOQ TB24 30mg ***(upadacitinib)***	Tier 4	SP, PA, QL (30 tabs every 30 days)
tacrolimus (topical) oint .03%, .1%	Tier 2	ST; PA**
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort crea 1% (Ala-cort)	Tier 1	QL (120g every 30 days)
alclometasone dipropionate crea .05%; oint .05%	Tier 1	QL (120g every 30 days)
amcinonide oint .1%	Tier 1	QL (120g every 30 days)
betamethasone dipropionate (topical) crea .05%	Tier 1	QL (120g every 30 days)
betamethasone dipropionate (topical) lotn .05%	Tier 1	QL (120 mL every 30 days)
betamethasone dipropionate augmented crea .05%; gel .05%; oint .05%	Tier 1	QL (120g every 30 days)
betamethasone dipropionate augmented lotn .05%	Tier 1	QL (120 mL every 30 days)
betamethasone valerate crea .1%; foam .12%; oint .1%	Tier 1	QL (120g every 30 days)
betamethasone valerate lotn .1%	Tier 1	QL (120 mL every 30 days)
clobetasol propionate crea .05%; foam .05%; gel .05%; oint .05%	Tier 1	QL (120g every 30 days)
clobetasol propionate liqd .05%; lotn .05%; sham .05%; soln .05%	Tier 1	QL (120 mL every 30 days)
clobetasol propionate emollient base crea .05%	Tier 1	QL (120g every 30 days)
clocortolone pivalate crea .1%	Tier 2	QL (120g every 30 days)
desonide crea .05%; oint .05%	Tier 1	QL (120g every 30 days)
desonide lotn .05%	Tier 1	QL (120 mL every 30 days)
desoximetasone crea .05%, .25%; gel .05%; oint .25%	Tier 1	QL (120g every 30 days)
diflorasone diacetate crea .05%; oint .05%	Tier 2	QL (120g every 30 days)
fluocinolone acetonide crea .01%, .025%; oint .025%	Tier 1	QL (120g every 30 days)
fluocinolone acetonide oil .01%; soln .01%	Tier 1	QL (120 mL every 30 days)
fluocinonide crea .05%; gel .05%; oint .05%	Tier 1	QL (120g every 30 days)
fluocinonide soln .05%	Tier 1	QL (120 mL every 30 days)
fluticasone propionate crea .05%; oint .005%	Tier 1	QL (120g every 30 days)

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluticasone propionate lotn .05%	Tier 1	QL (120 mL every 30 days)
halobetasol propionate crea .05%; oint .05%	Tier 1	QL (120g every 30 days)
hydrocortisone (topical) crea 1%, 2.5%; oint 2.5%	Tier 1	QL (120g every 30 days)
hydrocortisone (topical) lotn 2.5%	Tier 1	QL (120 mL every 30 days)
hydrocortisone butyrate crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
hydrocortisone butyrate soln .1%	Tier 1	QL (120 mL every 30 days)
hydrocortisone valerate crea .2%; oint .2%	Tier 1	QL (120g every 30 days)
mometasone furoate crea .1%; oint .1%	Tier 1	QL (120g every 30 days)
mometasone furoate soln .1%	Tier 1	QL (120 mL every 30 days)
triamcinolone acetonide (topical) crea .025%, .1%, .5%; oint .025%, .1%, .5%	Tier 1	QL (120g every 30 days)
triamcinolone acetonide (topical) lotn .025%, .1%	Tier 1	QL (120 mL every 30 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine oint 5%	Tier 1	QL (50g every 30 days)
lidocaine ptch 5%	Tier 1	PA, QL (90 patches every 30 days)
lidocaine hcl prsy 2%	MB	
lidocaine hcl soln 4%	Tier 1	QL (50 mL every 30 days)
lidocaine-prilocaine cream 2.5-2.5%	Tier 1	QL (30g every 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
bexarotene (topical) gel 1%	Tier 4	SP, PA
lactic acid (ammonium lactate) crea 12%; lotn 12%	Tier 1	
nitroglycerin (intra-anal) oint .4%	Tier 1	
penciclovir crea 1%	Tier 1	
podofilox gel .5%; soln .5%	Tier 1	
DERMATOLOGY, PRURIGO NODULARIS		
NEMLUVIO AUIJ 30mg ***(nemolizumab-ilto)***	MB	
DERMATOLOGY, ROSACEA		
azelaic acid gel 15%	Tier 1	
brimonidine tartrate (topical) gel .33%	Tier 1	PA
FINACEA FOAM 15% ***(azelaic acid)***	Tier 2	
metronidazole (topical) crea .75%; gel .75%, 1%; lotn .75%	Tier 1	
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
crotan lotn 10% (Crotan)	Tier 1	
malathion lotn .5%	Tier 1	
permethrin crea 5%	Tier 1	

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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
spinosad susp .9%	Tier 1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl caps 30mg	Tier 1	MO
clotrimazole troc 10mg	Tier 1	
lidocaine hcl (mouth-throat) soln 2%	Tier 1	
nystatin (mouth-throat) susp 100000unit/ml	Tier 1	
oralone dental paste pste .1% (Oralone Dental Paste)	Tier 1	
ORAVIG TABS 50mg ***(miconazole (mouth-throat))***	Tier 3	QL (14 tabs every 30 days)
pilocarpine hcl (oral) tabs 5mg, 7.5mg	Tier 1	MO
triamcinolone acetonide (mouth) pste .1%	Tier 1	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
acetic acid (otic) soln 2%	Tier 1	
ciprofloxacin hcl (otic) soln .2%	Tier 1	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	Tier 1	
CORTISPORIN SUS -TC OTIC ***(neomycin-colistin-hc-thonzonium)***	Tier 3	
fluocinolone acetonide (otic) oil .01%	Tier 1	
hydrocortisone w/ acetic acid otic soln 1-2%	Tier 1	
neomycin-polymyxin-hc otic soln 1%	Tier 1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	Tier 1	
ofloxacin (otic) soln .3%	Tier 1	

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