



# 2024 California Access Large Group 3-Tier PPO Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of April 1, 2024 and is subject to change after this date. All previous versions of this PDL are no longer in effect. Your estimated coverage and copay/coinsurance may vary based on the benefit plan you choose and the effective date of the plan.

This PDL can also be accessed online at [myuhc.com](https://myuhc.com) > **Popular Forms** > **Pharmacy Benefits** > **Prescription Drug Lists** > **California plans** > **Large Group - Access**. Plan-specific coverage documents may be accessed online at [uhc.com/statedruglists](https://uhc.com/statedruglists) > **Large Group Plans** > **California**.

If you are a UnitedHealthcare member, please register or log on to [myuhc.com](https://myuhc.com), or call the toll-free number on your member ID card to find pharmacy information specific to your benefit plan.

This PDL is applicable to the following health insurance products offered by UnitedHealthcare:

- Navigate
- Navigate Plus
- Choice
- Choice Plus
- Select
- Select Plus
- Core
- Core Essential
- Options PPO
- Non-Differential PPO

Updated 2/1/2024

# Contents

At UnitedHealthcare, we want to help you better understand your medication options.....	3
How do I use my PDL? .....	4
What are tiers? .....	5
When does the PDL change? .....	5
Utilization Management Programs.....	6
Your Right to Request Access to a Non-formulary Drug .....	6
Requesting a Prior Authorization or Step Therapy Exception .....	7
How do I locate and fill a prescription through a retail network pharmacy? .....	7
How do I locate and fill a prescription through the mail order pharmacy?.....	7
How do I locate and fill a prescription at a specialty pharmacy? .....	8
How do I get updated information about my pharmacy benefit? .....	8
Nondiscrimination notice and access to communication services.....	9
Prescription Drug List .....	12



# At UnitedHealthcare, we want to help you better understand your medication options.

Your pharmacy benefit offers flexibility and choice in determining the right medication for you. To help you get the most out of your pharmacy benefit, we've included some of the most commonly used terms and their definitions as well as frequently asked questions:

**Brand-name drug** means a Prescription Drug Product (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand-name" by the manufacturer, pharmacy, or your Physician will be classified as brand-name by us. A brand-name drug is listed in this PDL in all CAPITAL letters.

**Coinsurance** means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

**Copayment** means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

**Deductible** means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either 1 deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

**Drug Tier** means a group of Prescription Drug Products that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a Prescription Drug Product is placed determines your portion of the cost for the drug.

**Exception request** means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

**Exigent circumstances** means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

**Formulary or Prescription Drug List (PDL)** means a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than 6 times per calendar year).

**Generic drug** means a Prescription Drug Product: (1) that is chemically equivalent to a brand-name drug; or (2) that we identify as a generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a generic by us. A generic drug is listed in this PDL in italicized lowercase letters.

**Medically Necessary** means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

**Non-formulary drug** means a Prescription Drug Product that is not listed on this PDL.

**Out-of-pocket costs** means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

**Prescribing provider** means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

**Prescription** means an oral, written, or electronic order from a prescribing provider authorizing a Prescription Drug Product to be provided to a specific individual.

**Prescription Drug Product** means a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.



We will provide coverage for a Prescription Drug Product which includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. This definition includes: Inhalers (with spacers); Insulin; the following diabetic supplies: standard insulin syringes with needles; blood-testing strips - glucose; urine-testing strips - glucose; ketone-testing strips and tablets; lancets and lancet devices; and glucose meters (including continuous glucose monitors); disposable devices which are medically necessary for the administration of a covered outpatient Prescription Drug Product. Benefits also include FDA-approved contraceptive drugs, devices and products available over-the-counter when prescribed by a Network provider.

**Prior Authorization** means a process by your health insurer to determine that a health care benefit is medically necessary for you. If a Prescription Drug Product is subject to prior authorization in this PDL, your prescribing provider must request approval from your health insurer to cover the drug. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

**Step therapy** means a specific sequence in which Prescription Drug Products for a particular medical condition must be tried. If a drug is subject to step therapy in this PDL, you may have to try 1 or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

## How do I use my PDL?

When choosing a medication, you and your doctor should consult the Prescription Drug List (PDL). It will help you and your doctor choose the most cost-effective prescription drugs. This guide tells you if special programs apply. Bring this list with you when you see your doctor. It is organized by therapeutic category and class. The therapeutic category and class are based on the American Hospital Formulary Service (AHFS) Pharmacologic-Therapeutic Classification.

You may also find a drug by its brand or generic name in the alphabetical index. If a generic equivalent for a brand-name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

This is the way Prescription Drug Products appear in the PDL:

1. A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs;
2. The generic name for a brand-name drug is included after the brand-name in parentheses and all lowercase italicized letters;
3. If a generic equivalent for a brand-name drug is both available and covered, the generic drug will be listed separately from the brand-name drug in all lowercase italicized letters; and
4. If a generic drug is marketed under a proprietary, trademark-protected brand-name, the brand-name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized.

### Example:

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG ( <i>irbesartan</i> )	3	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	

If your medication is not listed in this document, please visit [myuhc.com](http://myuhc.com) or call the toll-free member phone number on your member ID card.

Below is a list of drug tier numbers, abbreviations and designations used in the PDL as well as an explanation for each.

<b>Drug Tier 1</b>	Your lowest cost medications	<b>H</b>	Part of health care reform preventive when age and/or condition appropriate
<b>Drug Tier 2</b>	Your mid-range cost medications	<b>SP</b>	Specialty medication
<b>Drug Tier 3</b>	Your highest cost medications	<b>CM</b>	Orally administered anti-cancer medication
<b>PA</b>	Prior authorization required	<b>E</b>	Excluded from coverage unless covered as part of health care reform preventive
<b>SL</b>	Supply Limit	<b>SM</b>	\$0 cost-share by state mandate when condition appropriate
<b>ST</b>	Step Therapy		



## What are tiers?

Tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, which is determined by your employer or health plan. This is how much you will pay when you fill a prescription. Tier 1 medications are your lowest-cost options. If your medication is placed in Tier 2 or 3, look to see if there is a Tier 1 option available. Discuss these options with your doctor.

For orally administered anti-cancer medications on any Tier, the total amount of copayments and/or coinsurance shall not exceed \$250 for an individual prescription of up to a 30-day supply. For high deductible health plans, the \$250 maximum only applies once the deductible has been met.

Check your benefit plan documents to find out your specific pharmacy plan costs, including any maximum dollar amount of cost sharing that may apply to a drug. Preferred medications are found in Tier 1 or Tier 2 and may vary depending on the medication and the condition it treats.

\$	Drug Tier	Includes	Helpful Tips
\$	<b>Tier 1</b> <b>Your lowest cost</b>	Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
\$\$	<b>Tier 2</b> <b>Your mid-range cost</b>	Medications that provide good overall value. A mix of brand-name and generic drugs.	Use Tier 2 drugs instead of Tier 3 to help reduce your out-of-pocket costs.
\$\$\$	<b>Tier 3</b> <b>Your highest cost</b>	Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Many Tier 3 drugs have lower-cost options in Tier 1 or 2. Ask your doctor if they could work for you.

**Please note:** If you have a high deductible plan, the tier cost levels may apply once you reach your deductible. Refer to your enrollment and plan materials on [myuhc.com](http://myuhc.com), or call the toll-free number on your member ID card for more information about your benefit plan.

## When does the PDL change?

This PDL is required to be updated on a monthly basis.

- Medications may move to a lower tier at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier or become non-formulary most often on Jan. 1, May 1, or Sept. 1.
- Medications may become subject to new or revised utilization management procedures, such as prior authorization, step therapy or supply limits, at any time but most often upon FDA approval of the medication or its generic, Jan. 1, May 1, or Sept. 1.

When a medication changes tiers, you may have to pay a different amount for that medication.

The presence of a Prescription Drug Product on the PDL does not guarantee that you will be prescribed that Prescription Drug Product by your provider for a particular medical condition.

# Utilization Management Programs

---

**Prior authorization required**—Your doctor is required to provide additional information to us to determine coverage. For specific prior authorization requirements, please refer to your Evidence of Coverage.

---

**Supply limit**—Amount of medication covered per copayment or in a specific time period.

---

**Step therapy**—Requires you to try 1 or more other medications before the medication you are requesting may be covered. For specific step therapy requirements, please refer to your Evidence of Coverage.

---

**Health Care Reform Preventive when age and/or condition appropriate**—This medication is part of a health care reform preventive benefit and may be available at no cost to you when used for appropriate preventive purposes. For more information, please refer to the California Traditional, Access, and Enhanced HMO and PPO Prescription Drug List (PDL) PPACA \$0 Cost-Share Preventive Care Medications list.

---

**Designated specialty program**—For certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products, which are identified in the Coverage Requirements and Limits column of the Prescription Drug List (PDL). If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at [myuhc.com](http://myuhc.com) or the telephone number on your member ID card.

---

**State mandated \$0 cost-share when condition appropriate**—This medication is mandated to be covered at \$0 cost-share when used for any of the following conditions:

- Abortion\*
- COVID-19

\*Please Note: If you have a high deductible plan, \$0 cost-share will not apply until your deductible has been met.

---

To learn more about a pharmacy program or to find out if it applies to you, please visit [myuhc.com](http://myuhc.com) or call the toll-free member phone number on your member ID card. If you are a pre-enrollee and you would like to learn more about your specific pharmacy benefit, please contact your employer.

Drugs administered by a health care professional are generally covered under the medical benefit while drugs that are self-administered are covered under the pharmacy benefit. In order to obtain medical benefits for drugs that are administered by a health care professional, your provider may also be required to obtain a prior authorization. The provider may contact UnitedHealthcare for more information or [uhcprovider.com](http://uhcprovider.com).

## Your Right to Request Access to a Non-formulary Drug

This plan must cover all Medically Necessary Prescription Drug Products.

When a Prescription Drug Product is not on our PDL, you or your representative may request an exception to gain access to that Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your member ID card. We will notify you of our determination within 72 hours. If approved, we will cover the Prescription Drug Product for the duration of the prescription, including refills.

### Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours. If approved, we will cover the Prescription Drug Product for the duration of the exigency.

### External Review

If you are not satisfied with our determination of your exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your member ID card. The Independent Review Organization (IRO) will notify you of its determination within 72 hours.

### Expedited External Review

If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your member ID card or by sending a written request to the address set out in the determination letter. The IRO will notify you of our determination within 24 hours.



If we deny your exception request, you may appeal. Please refer to your Evidence of Coverage for details. The complaint and appeals process, including independent review, is described under Section 6: Questions, Complaints and Appeals. You may also call the telephone number listed on your member ID card.

## Requesting a Prior Authorization or Step Therapy Exception

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization or step therapy exception from us. Your prescribing provider can submit a request by phone to Optum Rx® or electronically by contacting us at [uhcprovider.com](http://uhcprovider.com). The Prior Authorization staff of qualified pharmacists and technicians is available Monday – Friday from 5 a.m. – 10 p.m. PST and Saturday from 6 a.m. – 3 p.m. PST to assist licensed physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your licensed physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested Prescription Drug Product meets plan criteria. You may determine whether a particular Prescription Drug Product is subject to prior authorization or step therapy requirements by going online at [myuhc.com](http://myuhc.com) or by calling at the toll-free phone number on the back of your member ID card.

An exception to a step therapy requirement will be granted if your prescribing provider submits necessary justification and supporting clinical documentation supporting their determination that the required Prescription Drug Product is inconsistent with good professional practice for provision of medically necessary covered services, taking into consideration your needs and medical history, along with the professional judgment of your prescribing provider.

If you are currently taking a Prescription Drug Product which was approved by UnitedHealthcare for a specific medical condition and that drug is removed from the Prescription Drug List (PDL) and the prescribing provider continues to prescribe the Prescription Drug Product for your medical condition, we will continue to cover the Prescription Drug Product provided that the drug is appropriately prescribed and is considered safe and effective for treating your medical condition.

In the case of a standard prior authorization or step therapy exception request, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. In the case of an expedited prior authorization or step therapy exception request based on exigent circumstances, we will notify you, your designee, or your prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. If we fail to respond to you, your designee, or your prescribing provider within the prescribed time limits, the request is deemed approved and we may not deny the request thereafter.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described in the Evidence of Coverage under Section 6: Questions, Complaints and Appeals. You may also call at the telephone number on your member ID card.

## How do I locate and fill a prescription through a retail network pharmacy?

UnitedHealthcare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. For a listing of network pharmacies, call the toll-free phone number on your member ID card to help locate a network pharmacy near you or visit our website at [myuhc.com](http://myuhc.com) for an up-to-date list.

## How do I locate and fill a prescription through the mail order pharmacy?

UnitedHealthcare offers a Mail Order Pharmacy Program through Optum Rx. Here's how to fill prescriptions through Optum® Home Delivery.

1. Call your prescribing provider to obtain a new prescription for each medication. When you call, ask the physician to write the prescription for a 90-day supply which represents 3 prescription units with up to 3 additional refills. The doctor will tell you when to pick up the written prescription. (Note: Optum Rx must have a new prescription to process any new Mail Order request.)





2. After picking up the prescription, complete the Mail Order Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, contact UnitedHealthcare's customer service department by calling the telephone number on the back of your ID card. You can also find the form at [optumrx.com](https://www.optumrx.com).)
3. Enclose the prescription and appropriate copayment via check, money order, or credit card. Your Pharmacy Schedule of Benefits will have the applicable copayment for the mail order pharmacy program, Optum Home Delivery. Make the check or money order payable to **Optum Rx**. No cash please.

Important Tip: If you are starting a new Prescription Drug Product, please request 2 prescriptions from your physician. Have 1 filled immediately at a network pharmacy while mailing the second prescription to Optum Home Delivery. Once you receive your medication through the mail order pharmacy program, you should stop filling the prescription at the network pharmacy.

## How do I locate and fill a prescription at a specialty pharmacy?

Call the phone number on the back of your member ID card or visit [specialty.optumrx.com](https://specialty.optumrx.com) to locate a designated specialty pharmacy for your medication.

### Designated Pharmacies

If you require certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. There are both retail and mail pharmacies in the Designated Pharmacy network. Note that not all contracted retail pharmacies are in the Designated Pharmacy network. Only retail pharmacies that are in the Designated Pharmacy network will provide access to these Specialty Prescription Drug Products. If you choose not to obtain your Specialty Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program through the Internet at [myuhc.com](https://myuhc.com) or by calling the telephone number on your member ID card. If you want to opt-out of the program and fill your Specialty Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Specialty Prescription Drug Product and no Benefits will be paid.

In urgent or emergent circumstances, you may contact customer service by calling the telephone number on the back of your member ID card. This will allow you access to the retail network override process and allow the urgent or emergent prescription claim to pay at your local pharmacy for same day access if they have the Prescription Drug Product available.

## How do I get updated information about my pharmacy benefit?

Since the PDL may change during your plan year, we encourage you to visit [myuhc.com](https://myuhc.com) or call the toll-free member phone number on your member ID card for more current information.

### Log in to [myuhc.com](https://myuhc.com) for the following pharmacy information and tools:

- Pharmacy benefit and coverage information
- Possible lower-cost medication options
- Medication interactions and side effects
- Participating retail pharmacies by ZIP code
- Your prescription history

### And, if mail order services are included in your pharmacy benefit, you can also:

- Refill prescriptions
- Check the status of your order
- Set up reminders for refills
- Manage your account

## Learn more

Call the toll-free member phone number on your member ID card, or visit [myuhc.com](https://myuhc.com).





# Nondiscrimination notice and access to communication services

UnitedHealthcare Services, Inc. on behalf of itself and its affiliates does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, you can send a complaint to:

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)  
**Mail:** Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card.

If you think you were treated unfairly because of your race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can also send a complaint to the California Department of Insurance:

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
**1-800-927-HELP (1-800-927-4357)**  
**1-800-482-4833 (TTY)**  
**Internet Website: [www.insurance.ca.gov](http://www.insurance.ca.gov)**

If you think you were treated unfairly because of your sex, age, race, color, national origin, or disability, you can also file a complaint with the U.S. Dept. of Health and Human Services:

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.  
**Phone:** Toll-free **1-800-368-1019, 1-800-537-7697 (TDD)**  
**Mail:** U.S. Dept. of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201



## English

**IMPORTANT:** You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

## Español

**IMPORTANTE:** Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

## 中文

**重要事項：**您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼1-800-842-2656

說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357 (Chinese)

XIN LŪU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

注意事項: **日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फ़ोन नंबर पर काल करें।

CEEBOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer, Cambodian)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

ՈՒՇԱՐԴՈՒԹՅՈՒՆ` Եթե **հայերեն (Armenian)** եք խոսում, անվճար լեզվալսման օգնություն ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչական քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

โปรดทราบ: หากคุณพูด**ภาษาไทย (Thai)** มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่ คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวของคุณ



State of California

Table of Contents of Prescription Drug List

Informational Section.....1  
ANTI-HISTAMINE DRUGS - Drugs for Allergy.....12  
ANTI-INFECTIVE AGENTS - Drugs for Infections.....14  
ANTI-NEOPLASTIC AGENTS - Drugs for Cancer.....33  
ANTITOXINS, IMMUNE GLOB, TOXOIDS, VACCINES - DRUGS FOR THE IMMUNE SYSTEM.....43  
AUTONOMIC DRUGS - Drugs for the Nervous System.....48  
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood.....57  
CARDIOVASCULAR DRUGS - Drugs for the Heart.....69  
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System.....90  
DENTAL AGENTS - Oral Care.....128  
DEVICES - Medical Supplies and Durable Medical Equipment.....129  
DIAGNOSTIC AGENTS.....135  
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants.....137  
ELECTROLYTIC, CALORIC, AND WATER BALANCE.....137  
ENZYMES.....144  
EYE, EAR, NOSE AND THROAT (EENT) PREPS.....145  
GASTROINTESTINAL DRUGS.....154  
GASTROINTESTINAL DRUGS - Drugs for the Stomach.....154  
GOLD COMPOUNDS.....163  
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron.....163  
HORMONES AND SYNTHETIC SUBSTITUTES.....164  
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones.....164  
LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing.....200  
MISCELLANEOUS THERAPEUTIC AGENTS.....200  
NONHORMONAL CONTRACEPTIVES - Drugs for Women.....224  
OXYTOCICS - Drugs for Women.....224  
PHARMACEUTICAL AIDS.....225  
RESPIRATORY TRACT AGENTS - Drugs for the Lungs.....225  
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin.....236  
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles.....259  
VITAMINS.....260

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>ANTIHISTAMINE DRUGS - Drugs for Allergy</b>		
<b>ANTIHISTAMINE DRUGS - Drugs for Allergy</b>		
<i>promethazine hcl oral tablet 25 mg</i>	1	
<b>ETHANOLAMINE DERIVATIVES - Drugs for Allergy</b>		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML ( <i>carbinoxamine maleate</i> )	3	
<b>FIRST GEN. ANTIHIST. DERIVATIVES, MISC. - Drugs for Allergy</b>		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
<b>FIRST GENERATION ANTIHISTAMINES - Drugs for Allergy</b>		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML ( <i>carbinoxamine maleate</i> )	3	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>promethegan rectal suppository 12.5 mg, 25 mg, 50 mg</i>	1	
VISTARIL ORAL CAPSULE 25 MG ( <i>hydroxyzine pamoate</i> )	3	
<b>OTHER ANTIHISTAMINES - Drugs for Allergy</b>		
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>olopatadine hcl nasal solution 0.6 %</i>	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT ( <i>olopatadine-mometasone</i> )	3	
VISTARIL ORAL CAPSULE 25 MG ( <i>hydroxyzine pamoate</i> )	3	
<b>PHENOTHIAZINE DERIVATIVES - Drugs for Allergy</b>		
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml</i>	1	PA
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	1	PA
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1	
<i>promethegan rectal suppository 12.5 mg, 25 mg, 50 mg</i>	1	
<b>PROPYLAMINE DERIVATIVES - Drugs for Allergy</b>		
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML ( <i>pseudoeph-bromphen-dm</i> )	3	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	1	PA
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
RYCLORA ORAL SOLUTION 2 MG/5ML ( <i>dexchlorpheniramine maleate</i> )	3	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG ( <i>chlorpheniramine-codeine</i> )	3	
<b>SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy</b>		
ALOMIDE OPHTHALMIC SOLUTION 0.1 % ( <i>Iodoxamide tromethamine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG ( <i>desloratadine-pseudoephedrine</i> )	3	
<i>desloratadine oral tablet 5 mg</i>	1	
<i>desloratadine oral tablet dispersible 5 mg</i>	1	
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	1	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	1	
<b>ANTI-INFECTIVE AGENTS - Drugs for Infections</b>		
<b>1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics</b>		
<i>cefadroxil oral capsule 500 mg</i>	1	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	1	
<i>cefadroxil oral tablet 1 gm</i>	1	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	1	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	1	
<b>2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics</b>		
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	1	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	1	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	1	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	1	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	1	
<b>3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics</b>		
<i>cefdinir oral capsule 300 mg</i>	1	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>cefixime oral capsule 400 mg</i>	1	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	1	
<b>ADAMANTANE ANTIVIRALS - Drugs for Viral Infections</b>		
<i>amantadine hcl oral capsule 100 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>amantadine hcl oral solution 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
<i>rimantadine hcl oral tablet 100 mg</i>	1	
<b>ALLYLAMINE ANTIFUNGALS - Drugs for Fungus</b>		
<i>terbinafine hcl oral tablet 250 mg</i>	1	
<b>AMEBICIDES - Drugs for the Mouth and Throat</b>		
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA
FLAGYL ORAL CAPSULE 375 MG ( <i>metronidazole</i> )	3	
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	
NUVESSA VAGINAL GEL 1.3 % ( <i>metronidazole</i> )	3	
<b>AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics</b>		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML ( <i>amikacin sulfate liposome</i> )	3	PA; SL (8.4 ml per day.); SP
<i>neomycin sulfate oral tablet 500 mg</i>	1	
TOBI PODHALER INHALATION CAPSULE 28 MG ( <i>tobramycin</i> )	3	PA; SL (224 capsules per 56 days.); SP
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	1	PA; SL (224 ml per 56 days.); SP
<b>AMINOMETHYLCYCLINES - Antibiotics</b>		
NUZYRA ORAL TABLET 150 MG ( <i>omadacycline tosylate</i> )	3	
<b>AMINOPENICILLIN ANTIBIOTICS - Antibiotics</b>		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	1	SL (112 capsules and tablets (1 Package) per 180 days.)
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	
<i>amoxicillin-potassium clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>amoxicillin-potassium clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	1	
<i>amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	1	
<i>amoxicillin-potassium clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	1	
<i>ampicillin oral capsule 500 mg</i>	1	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED 125-31.25 MG/5ML ( <i>amoxicillin-pot clavulanate</i> )	3	
OMECLAMOX-PAK ORAL 500-500-20 MG ( <i>amoxicill-clarithro-omeprazole</i> )	3	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
<b>ANTHELMINTICS - Drugs for Parasites</b>		
<i>albendazole oral tablet 200 mg</i>	1	SL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG ( <i>praziquantel</i> )	3	
EGATEN ORAL TABLET 250 MG ( <i>triclabendazole</i> )	3	
EMVERM ORAL TABLET CHEWABLE 100 MG ( <i>mebendazole</i> )	3	SL (6 tablets per 3 days.)
<i>ivermectin oral tablet 3 mg</i>	1	PA; SL (20 tablets per 3 months.)
<i>praziquantel oral tablet 600 mg</i>	1	
STROMECTOL ORAL TABLET 3 MG ( <i>ivermectin</i> )	3	PA; SL (20 tablets per 3 months.)
<b>ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus</b>		
BREXAFEMME ORAL TABLET 150 MG ( <i>ibrexafungerp citrate</i> )	3	PA
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	1	
<i>griseofulvin microsize oral tablet 500 mg</i>	1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	1	
<b>ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections</b>		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG ( <i>bis subcit-metronid-tetracyc</i> )	3	SL (120 capsules per 180 days.)
<b>ANTIMALARIALS - Drugs for the Mouth and Throat</b>		
ARAKODA ORAL TABLET 100 MG ( <i>tafenoquine succinate</i> )	3	SL (16 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	1	
<i>avidoxy oral tablet 100 mg</i>	1	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	1	
COARTEM ORAL TABLET 20-120 MG ( <i>artemether-lumefantrine</i> )	2	
DARAPRIM ORAL TABLET 25 MG ( <i>pyrimethamine</i> )	3	PA; SP
DORYX MPC ORAL TABLET DELAYED RELEASE 120 MG, 60 MG ( <i>doxycycline hyclate</i> )	3	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 75 mg</i>	1	
<i>doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	1	
DOXYCYCLINE HYCLATE ORAL TABLET DELAYED RELEASE 80 MG	3	
<i>doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
KRINTAFEL ORAL TABLET 150 MG ( <i>tafenoquine succinate</i> )	1	
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG ( <i>atovaquone-proguanil hcl</i> )	3	
<i>mefloquine hcl oral tablet 250 mg</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	1	
<i>mondoxyne nl oral capsule 100 mg</i>	1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	1	
<i>pyrimethamine oral tablet 25 mg</i>	1	PA; SP
QUALAQUIN ORAL CAPSULE 324 MG ( <i>quinine sulfate</i> )	3	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
<i>quinine sulfate oral capsule 324 mg</i>	1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
VIBRAMYCIN ORAL CAPSULE 100 MG ( <i>doxycycline hyclate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML ( <i>doxycycline monohydrate</i> )	3	
<b>ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics</b>		
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
<b>ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat</b>		
ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML ( <i>nitazoxanide</i> )	2	
<i>atovaquone oral suspension 750 mg/5ml</i>	1	
BACTRIM DS ORAL TABLET 800-160 MG ( <i>sulfamethoxazole-trimethoprim</i> )	3	
BACTRIM ORAL TABLET 400-80 MG ( <i>sulfamethoxazole-trimethoprim</i> )	3	
BENZNIDAZOLE ORAL TABLET 100 MG	2	PA; SL (248 tablets per 720 days)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	PA; SL (720 tablets per 720 days.)
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
<i>dapsone oral tablet 100 mg, 25 mg</i>	1	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA
FLAGYL ORAL CAPSULE 375 MG ( <i>metronidazole</i> )	3	
IMPAVIDO ORAL CAPSULE 50 MG ( <i>miltefosine</i> )	2	PA; SL (3 capsules per day.)
LAMPIT ORAL TABLET 120 MG ( <i>nifurtimox</i> )	3	PA; SL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG ( <i>nifurtimox</i> )	3	PA; SL (9 tablets per day.)
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG ( <i>pentamidine isethionate</i> )	3	
<i>nitazoxanide oral tablet 500 mg</i>	1	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PYLERA ORAL CAPSULE 140-125-125 MG ( <i>bis subcit-metronid-tetracyc</i> )	3	SL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM ( <i>secnidazole</i> )	3	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	1	
<b>ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections</b>		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG ( <i>lenacapavir sodium</i> )	3	PA; SL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG ( <i>lenacapavir sodium</i> )	3	PA; SL (5 tablets per 365 days.)
<b>ANTITUBERCULOSIS AGENTS - Antibiotics</b>		
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) ( <i>ciprofloxacin</i> )	3	
CIPRO ORAL TABLET 250 MG, 500 MG ( <i>ciprofloxacin hcl</i> )	3	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
<i>cycloserine oral capsule 250 mg</i>	1	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	1	
<i>isoniazid oral syrup 50 mg/5ml</i>	1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	1	
MYAMBUTOL ORAL TABLET 400 MG ( <i>ethambutol hcl</i> )	3	
MYCOBUTIN ORAL CAPSULE 150 MG ( <i>rifabutin</i> )	3	
PRETOMANID ORAL TABLET 200 MG	3	
PRIFTIN ORAL TABLET 150 MG ( <i>rifapentine</i> )	2	
<i>pyrazinamide oral tablet 500 mg</i>	1	
<i>rifabutin oral capsule 150 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>rifampin oral capsule 150 mg, 300 mg</i>	1	
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML ( <i>rifampin</i> )	3	PA
SIRTURO ORAL TABLET 100 MG, 20 MG ( <i>bedaquiline fumarate</i> )	2	
TRECTOR ORAL TABLET 250 MG ( <i>ethionamide</i> )	2	
<b>ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections</b>		
LIVTENCITY ORAL TABLET 200 MG ( <i>maribavir</i> )	3	PA; SL (4 tablets per day.); SP
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	2	SM
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	2	SM
PREVYMIS ORAL TABLET 240 MG, 480 MG ( <i>letermovir</i> )	2	PA
TPOXX ORAL CAPSULE 200 MG ( <i>tecovirimat</i> )	3	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG ( <i>baloxavir marboxil</i> )	3	SL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG ( <i>baloxavir marboxil</i> )	3	SL (1 tablet per month.)
<b>AZOLE ANTIFUNGALS - Drugs for Fungus</b>		
CRESEMBA ORAL CAPSULE 186 MG ( <i>isavuconazonium sulfate</i> )	3	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	
HEXIOUNYL EXTERNAL LOTION 3-5-20 %	3	
<i>itraconazole oral capsule 100 mg</i>	1	SL (180 capsules per 365 days)
<i>itraconazole oral solution 10 mg/ml</i>	1	SL (1800 ml per 365 days)
<i>ketoconazole oral tablet 200 mg</i>	1	
NOXAFIL ORAL PACKET 300 MG ( <i>posaconazole</i> )	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML ( <i>posaconazole</i> )	3	SL (20 ml per day.)
<i>posaconazole oral suspension 40 mg/ml</i>	1	SL (20 ml per day.)
<i>posaconazole oral tablet delayed release 100 mg</i>	1	
SPORANOX ORAL CAPSULE 100 MG ( <i>itraconazole</i> )	3	SL (180 capsules per 365 days)
SPORANOX ORAL SOLUTION 10 MG/ML ( <i>itraconazole</i> )	3	SL (1800 ml per 365 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML ( <i>voriconazole</i> )	3	
VFEND ORAL TABLET 200 MG, 50 MG ( <i>voriconazole</i> )	3	
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG ( <i>oteseconazole</i> )	3	SL (18 capsules per 84 days.)
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	1	
<i>voriconazole oral tablet 200 mg, 50 mg</i>	1	
<b>ERYTHROMYCIN ANTIBIOTICS - Antibiotics</b>		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML ( <i>erythromycin ethylsuccinate</i> )	3	
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML ( <i>erythromycin ethylsuccinate</i> )	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML ( <i>erythromycin ethylsuccinate</i> )	3	
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG ( <i>erythromycin base</i> )	3	
ERYTHROCIN STEARATE ORAL TABLET 250 MG ( <i>erythromycin stearate</i> )	2	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	1	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	1	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	1	
<b>GLYCOPEPTIDE ANTIBIOTICS - Antibiotics</b>		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML ( <i>vancomycin hcl</i> )	3	
VANCOGIN ORAL CAPSULE 250 MG ( <i>vancomycin hcl</i> )	3	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	1	
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	1	
VANCOMYCIN+SYRSPEND SF ORAL SUSPENSION 50 MG/ML ( <i>vancomycin hcl</i> )	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections</b>		
EPCLUSA ORAL PACKET 150-37.5 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (2 packets per day and 84 packets per 720 days.); SP
EPCLUSA ORAL PACKET 200-50 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (1 packet per day and 84 packets per 720 days.); SP
EPCLUSA ORAL TABLET 200-50 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (1 tablet per day.); SP
EPCLUSA ORAL TABLET 400-100 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (84 tablets per 720 days.); SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.)
HARVONI ORAL TABLET 45-200 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (56 tablets per 720 days.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; SL (56 tablets per 720 days.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; SL (84 tablets per 720 days.); SP
SOVALDI ORAL PACKET 150 MG, 200 MG ( <i>sofosbuvir</i> )	3	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.); SP
SOVALDI ORAL TABLET 200 MG ( <i>sofosbuvir</i> )	3	PA; ST; SL (84 tablets per 720 days.)
SOVALDI ORAL TABLET 400 MG ( <i>sofosbuvir</i> )	3	PA; ST; SL (84 tablets per 720 days.); SP
VOSEVI ORAL TABLET 400-100-100 MG ( <i>sofosbuv-velpatasv-voxilaprev</i> )	2	PA; SL (84 tablets per 720 days); SP
<b>HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections</b>		
MAVYRET ORAL PACKET 50-20 MG ( <i>glecaprevir-pibrentasvir</i> )	2	PA; SL (5 packets per day and 280 packets per 720 days.); SP
MAVYRET ORAL TABLET 100-40 MG ( <i>glecaprevir-pibrentasvir</i> )	2	PA; SL (168 tablets per 720 days); SP
VOSEVI ORAL TABLET 400-100-100 MG ( <i>sofosbuv-velpatasv-voxilaprev</i> )	2	PA; SL (84 tablets per 720 days); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZEPATIER ORAL TABLET 50-100 MG ( <i>elbasvir-grazoprevir</i> )	2	PA; SL (84 tablets per 720 days (12 weeks).); SP
<b>HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections</b>		
EPCLUSA ORAL PACKET 150-37.5 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (2 packets per day and 84 packets per 720 days.); SP
EPCLUSA ORAL PACKET 200-50 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (1 packet per day and 84 packets per 720 days.); SP
EPCLUSA ORAL TABLET 200-50 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (1 tablet per day.); SP
EPCLUSA ORAL TABLET 400-100 MG ( <i>sofosbuvir-velpatasvir</i> )	2	PA; SL (84 tablets per 720 days.); SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.)
HARVONI ORAL TABLET 45-200 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (84 tablets per 720 days.)
HARVONI ORAL TABLET 90-400 MG ( <i>ledipasvir-sofosbuvir</i> )	2	PA; ST; SL (56 tablets per 720 days.)
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; ST; SL (56 tablets per 720 days.)
MAVYRET ORAL PACKET 50-20 MG ( <i>glecaprevir-pibrentasvir</i> )	2	PA; SL (5 packets per day and 280 packets per 720 days.); SP
MAVYRET ORAL TABLET 100-40 MG ( <i>glecaprevir-pibrentasvir</i> )	2	PA; SL (168 tablets per 720 days); SP
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	2	PA; SL (84 tablets per 720 days.); SP
VOSEVI ORAL TABLET 400-100-100 MG ( <i>sofosbuv-velpatasv-voxilaprev</i> )	2	PA; SL (84 tablets per 720 days); SP
ZEPATIER ORAL TABLET 50-100 MG ( <i>elbasvir-grazoprevir</i> )	2	PA; SL (84 tablets per 720 days (12 weeks).); SP
<b>HIV CAPSID INHIBITORS - Drugs for Viral Infections</b>		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG ( <i>lenacapavir sodium</i> )	3	PA; SL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG ( <i>lenacapavir sodium</i> )	3	PA; SL (5 tablets per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections</b>		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG ( <i>enfuvirtide</i> )	3	
<i>maraviroc oral tablet 150 mg, 300 mg</i>	1	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG ( <i>fostemsavir tromethamine</i> )	3	PA
SELZENTRY ORAL SOLUTION 20 MG/ML ( <i>maraviroc</i> )	2	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG ( <i>maraviroc</i> )	3	PA
<b>HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections</b>		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir-emtricitab-tenofovir</i> )	2	SL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG ( <i>dolutegravir-lamivudine</i> )	2	SL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG ( <i>elviteg-cobic-emtricit-tenofaf</i> )	2	SL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG ( <i>raltegravir potassium</i> )	2	
ISENTRESS ORAL PACKET 100 MG ( <i>raltegravir potassium</i> )	2	
ISENTRESS ORAL TABLET 400 MG ( <i>raltegravir potassium</i> )	2	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG ( <i>raltegravir potassium</i> )	2	
JULUCA ORAL TABLET 50-25 MG ( <i>dolutegravir-rilpivirine</i> )	2	SL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i>elviteg-cobic-emtricit-tenofdf</i> )	2	SL (1 tablet per day.)
TIVICAY ORAL TABLET 50 MG ( <i>dolutegravir sodium</i> )	3	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG ( <i>dolutegravir sodium</i> )	3	
TRIUMEQ ORAL TABLET 600-50-300 MG ( <i>abacavir-dolutegravir-lamivud</i> )	2	SL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG ( <i>abacavir-dolutegravir-lamivud</i> )	2	SL (6 tablets per day.)
VOCABRIA ORAL TABLET 30 MG ( <i>cabotegravir sodium</i> )	3	
<b>HIV NONNUCLEOSIDE REV.TRANSSCRIP. INHIB. - Drugs for Viral Infections</b>		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir-emtricitab-tenofovir</i> )	2	SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
COMPLERA ORAL TABLET 200-25-300 MG ( <i>emtricitab- rilpivir-tenofovir</i> )	2	SL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG ( <i>doravirin- lamivudin-tenofov df</i> )	2	SL (1 tablet per day.)
EDURANT ORAL TABLET 25 MG ( <i>rilpivirine hcl</i> )	2	
<i>efavirenz oral tablet 600 mg</i>	1	
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	1	SL (1 tablet per day.)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600- 300-300 mg</i>	1	SL (1 tablet per day.)
<i>etravirine oral tablet 100 mg, 200 mg</i>	1	
INTELENCE ORAL TABLET 100 MG, 200 MG ( <i>etravirine</i> )	3	
INTELENCE ORAL TABLET 25 MG ( <i>etravirine</i> )	2	
JULUCA ORAL TABLET 50-25 MG ( <i>dolutegravir-rilpivirine</i> )	2	SL (1 tablet per day.)
<i>methocarbamol oral tablet 500 mg</i>	1	
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	1	
<i>nevirapine oral suspension 50 mg/5ml</i>	1	
<i>nevirapine oral tablet 200 mg</i>	1	
ODEFSEY ORAL TABLET 200-25-25 MG ( <i>emtricitab- rilpivir-tenofov af</i> )	2	SL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG ( <i>doravirine</i> )	3	
SYMFI LO ORAL TABLET 400-300-300 MG ( <i>efavirenz- lamivudine-tenofovir</i> )	2	SL (1 tablet per day.)
SYMFI ORAL TABLET 600-300-300 MG ( <i>efavirenz-lamivudine- tenofovir</i> )	2	SL (1 tablet per day.)
<b>HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections</b>		
<i>abacavir sulfate oral solution 20 mg/ml</i>	1	
<i>abacavir sulfate oral tablet 300 mg</i>	1	
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	1	SL (1 tablet per day.)
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir- emtricitab-tenofov</i> )	2	SL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG ( <i>lamivudine-tenofovir</i> )	2	SL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG ( <i>emtricitab- rilpivir-tenofovir</i> )	2	SL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG ( <i>doravirin- lamivudin-tenofov df</i> )	2	SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DESCOVY ORAL TABLET 120-15 MG ( <i>emtricitabine-tenofovir af</i> )	2	SL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG ( <i>emtricitabine-tenofovir af</i> )	2	SL (1 tablet per day.); H
DOVATO ORAL TABLET 50-300 MG ( <i>dolutegravir-lamivudine</i> )	2	SL (1 tablet per day.)
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	1	SL (1 tablet per day.)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	1	SL (1 tablet per day.)
<i>emtricitabine oral capsule 200 mg</i>	1	
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	2	SL (1 tablet per day.)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1	SL (1 tablet per day.); H
EMTRIVA ORAL CAPSULE 200 MG ( <i>emtricitabine</i> )	3	
EMTRIVA ORAL SOLUTION 10 MG/ML ( <i>emtricitabine</i> )	2	
EPIVIR ORAL SOLUTION 10 MG/ML ( <i>lamivudine</i> )	3	
EPIVIR ORAL TABLET 150 MG, 300 MG ( <i>lamivudine</i> )	3	
GENVOYA ORAL TABLET 150-150-200-10 MG ( <i>elviteg-cobic-emtricit-tenofaf</i> )	2	SL (1 tablet per day.)
<i>lamivudine oral solution 10 mg/ml</i>	1	
<i>lamivudine oral tablet 100 mg, 150 mg, 300 mg</i>	1	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	1	
ODEFSEY ORAL TABLET 200-25-25 MG ( <i>emtricitab-rilpivir-tenofov af</i> )	2	SL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG ( <i>zidovudine</i> )	3	
RETROVIR ORAL SYRUP 50 MG/5ML ( <i>zidovudine</i> )	3	
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i>elviteg-cobic-emtricit-tenofdf</i> )	2	SL (1 tablet per day.)
SYMFI LO ORAL TABLET 400-300-300 MG ( <i>efavirenz-lamivudine-tenofovir</i> )	2	SL (1 tablet per day.)
SYMFI ORAL TABLET 600-300-300 MG ( <i>efavirenz-lamivudine-tenofovir</i> )	2	SL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	2	SL (1 tablet per day.)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	1	H
TRIUMEQ ORAL TABLET 600-50-300 MG ( <i>abacavir-dolutegravir-lamivud</i> )	2	SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG ( <i>abacavir-dolutegravir-lamivudine</i> )	2	SL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG ( <i>emtricitabine-tenofovir df</i> )	2	SL (1 tablet per day.)
VIREAD ORAL POWDER 40 MG/GM ( <i>tenofovir disoproxil fumarate</i> )	3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG ( <i>tenofovir disoproxil fumarate</i> )	2	
ZIAGEN ORAL SOLUTION 20 MG/ML ( <i>abacavir sulfate</i> )	3	
<i>zidovudine oral capsule 100 mg</i>	1	
<i>zidovudine oral syrup 50 mg/5ml</i>	1	
<i>zidovudine oral tablet 300 mg</i>	1	
<b>HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections</b>		
APTIVUS ORAL CAPSULE 250 MG ( <i>tipranavir</i> )	2	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	1	
<i>darunavir oral tablet 600 mg, 800 mg</i>	1	
EVOTAZ ORAL TABLET 300-150 MG ( <i>atazanavir-cobicistat</i> )	2	
<i>fosamprenavir calcium oral tablet 700 mg</i>	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML ( <i>lopinavir-ritonavir</i> )	3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG ( <i>lopinavir-ritonavir</i> )	3	
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	1	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	1	
NORVIR ORAL PACKET 100 MG ( <i>ritonavir</i> )	2	
PREZCOBIX ORAL TABLET 800-150 MG ( <i>darunavir-cobicistat</i> )	2	
PREZISTA ORAL SUSPENSION 100 MG/ML ( <i>darunavir</i> )	2	
PREZISTA ORAL TABLET 150 MG, 75 MG ( <i>darunavir</i> )	2	
REYATAZ ORAL PACKET 50 MG ( <i>atazanavir sulfate</i> )	2	
<i>ritonavir oral tablet 100 mg</i>	1	
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	2	SL (1 tablet per day.)
VIRACEPT ORAL TABLET 250 MG, 625 MG ( <i>nelfinavir mesylate</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>INTERFERON ANTIVIRALS - Drugs for Viral Infections</b>		
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML ( <i>interferon alfa-n3</i> )	2	
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML ( <i>ropeginterferon alfa-2b-njft</i> )	3	PA; ST; SL (0.08 ml per day.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML ( <i>peginterferon alfa-2a</i> )	2	SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML ( <i>peginterferon alfa-2a</i> )	2	SP
<b>LINCOMYCIN ANTIBIOTICS - Antibiotics</b>		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG ( <i>clindamycin hcl</i> )	3	
CLEOCIN ORAL CAPSULE 75 MG ( <i>clindamycin hcl</i> )	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML ( <i>clindamycin palmitate hcl</i> )	3	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	1	
<b>MONOBACTAM ANTIBIOTICS - Antibiotics</b>		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG ( <i>aztreonam lysine</i> )	3	PA; ST; SL (84 vials per 56 days.); SP
<b>MONOCLONAL ANTIBODY ANTIVIRALS - Drugs for Viral Infections</b>		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML ( <i>nirsevimab-alip</i> )	3	H
<b>NATURAL PENICILLIN ANTIBIOTICS - Antibiotics</b>		
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
<b>NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections</b>		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	1	
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	1	SL (180 ml per month)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT ( <i>zanamivir</i> )	3	
<b>NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections</b>		
<i>acyclovir oral capsule 200 mg</i>	1	
<i>acyclovir oral suspension 200 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	
<i>adefovir dipivoxil oral tablet 10 mg</i>	1	
BARACLUDE ORAL SOLUTION 0.05 MG/ML ( <i>entecavir</i> )	2	
BARACLUDE ORAL TABLET 0.5 MG, 1 MG ( <i>entecavir</i> )	3	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	1	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	1	
LAGEVRIO ORAL CAPSULE 200 MG ( <i>molnupiravir</i> )	3	SM
<i>ribavirin inhalation solution reconstituted 6 gm</i>	1	
<i>ribavirin oral capsule 200 mg</i>	1	
<i>ribavirin oral tablet 200 mg</i>	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML ( <i>brincidofovir</i> )	3	
TEMBEXA ORAL TABLET 100 MG ( <i>brincidofovir</i> )	3	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	1	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	1	
<i>valganciclovir hcl oral tablet 450 mg</i>	1	
VIRAZOLE INHALATION SOLUTION RECONSTITUTED 6 GM ( <i>ribavirin</i> )	3	
<b>OTHER MACROLIDE ANTIBIOTICS - Antibiotics</b>		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	1	SL (112 capsules and tablets (1 Package) per 180 days.)
<i>azithromycin oral packet 1 gm</i>	1	
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML ( <i>fidaxomicin</i> )	3	SL (136 mL per 10 days.)
DIFICID ORAL TABLET 200 MG ( <i>fidaxomicin</i> )	3	SL (20 tablets per 7 days)
OMECLAMOX-PAK ORAL 500-500-20 MG ( <i>amoxicill-clarithro-omeprazole</i> )	3	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
ZITHROMAX ORAL PACKET 1 GM ( <i>azithromycin</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML ( <i>azithromycin</i> )	3	
ZITHROMAX ORAL TABLET 250 MG, 500 MG ( <i>azithromycin</i> )	3	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG ( <i>azithromycin</i> )	3	
ZITHROMAX Z-PAK ORAL TABLET 250 MG ( <i>azithromycin</i> )	3	
<b>OXAZOLIDINONE ANTIBIOTICS - Antibiotics</b>		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	1	
<i>linezolid oral tablet 600 mg</i>	1	
SIVEXTRO ORAL TABLET 200 MG ( <i>tedizolid phosphate</i> )	3	
ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML ( <i>linezolid</i> )	3	
<b>PENICILLINASE-RESISTANT PENICILLINS - Antibiotics</b>		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	1	
<b>POLYENE ANTIFUNGALS - Drugs for Fungus</b>		
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	1	
<i>nystatin oral tablet 500000 unit</i>	1	
<b>POLYMYXIN ANTIBIOTICS - Antibiotics</b>		
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	1	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG ( <i>colistimethate sodium</i> )	3	
<b>PYRIMIDINE ANTIFUNGALS - Drugs for Fungus</b>		
ANCOBON ORAL CAPSULE 250 MG, 500 MG ( <i>flucytosine</i> )	3	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	1	
<b>QUINOLONE ANTIBIOTICS - Antibiotics</b>		
BAXDELA ORAL TABLET 450 MG ( <i>delafloxacin meglumine</i> )	3	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) ( <i>ciprofloxacin</i> )	3	
CIPRO ORAL TABLET 250 MG, 500 MG ( <i>ciprofloxacin hcl</i> )	3	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>levofloxacin oral solution 25 mg/ml</i>	1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>RIFAMYCIN ANTIBIOTICS - Antibiotics</b>		
AEMCOLO ORAL TABLET DELAYED RELEASE 194 MG (rifamycin sodium)	3	
MYCOBUTIN ORAL CAPSULE 150 MG (rifabutin)	3	
PRIFTIN ORAL TABLET 150 MG (rifapentine)	2	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
RIFAMPIN+SYRSPEND SF ORAL SUSPENSION 25 MG/ML (rifampin)	3	PA
XIFAXAN ORAL TABLET 200 MG (rifaximin)	3	
XIFAXAN ORAL TABLET 550 MG (rifaximin)	3	SL (62 tablets per month.)
<b>SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics</b>		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (sulfasalazine)	3	
AZULFIDINE ORAL TABLET 500 MG (sulfasalazine)	3	
BACTRIM DS ORAL TABLET 800-160 MG (sulfamethoxazole- trimethoprim)	3	
BACTRIM ORAL TABLET 400-80 MG (sulfamethoxazole- trimethoprim)	3	
sulfadiazine oral tablet 500 mg	1	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
<b>TETRACYCLINE ANTIBIOTICS - Antibiotics</b>		
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline- suncreen-sal acid)	3	
avidoxy oral tablet 100 mg	1	
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	SL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	SL (120 capsules per 180 days.)
demeclocycline hcl oral tablet 150 mg, 300 mg	1	
DORYX MPC ORAL TABLET DELAYED RELEASE 120 MG, 60 MG (doxycycline hyclate)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	1	
<i>doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	1	
DOXYCYCLINE HYCLATE ORAL TABLET DELAYED RELEASE 80 MG	3	
<i>doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	1	
<i>minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	1	
<i>mondoxylene nl oral capsule 100 mg</i>	1	
PYLERA ORAL CAPSULE 140-125-125 MG ( <i>bis subcit-metronid-tetracyc</i> )	3	SL (120 capsules per 180 days.)
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG ( <i>minocycline hcl</i> )	3	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
VIBRAMYCIN ORAL CAPSULE 100 MG ( <i>doxycycline hyclate</i> )	3	
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML ( <i>doxycycline monohydrate</i> )	3	
<b>URINARY ANTI-INFECTIVES - Drugs for the Urinary System</b>		
BACTRIM DS ORAL TABLET 800-160 MG ( <i>sulfamethoxazole-trimethoprim</i> )	3	
BACTRIM ORAL TABLET 400-80 MG ( <i>sulfamethoxazole-trimethoprim</i> )	3	
<i>fosfomycin tromethamine oral packet 3 gm</i>	1	
HIPREX ORAL TABLET 1 GM ( <i>methenamine hippurate</i> )	3	
MACROBID ORAL CAPSULE 100 MG ( <i>nitrofurantoin monohyd macro</i> )	3	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG ( <i>nitrofurantoin macrocrystal</i> )	3	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>methenamine hippurate oral tablet 1 gm</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>methenamine mandelate oral tablet 0.5 gm, 1 gm</i>	1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystals oral capsule 100 mg</i>	1	
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>sulfatrim pediatric oral suspension 200-40 mg/5ml</i>	1	
<i>trimethoprim oral tablet 100 mg</i>	1	
URELLE ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
URIMAR-T ORAL CAPSULE 120 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<i>urin ds oral tablet 81.6 mg</i>	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG ( <i>methen-hyosc-meth blue-na phos</i> )	2	
VILEVEV MB ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<b>ANTINEOPLASTIC AGENTS - Drugs for Cancer</b>		
<b>ANTINEOPLASTIC AGENTS - Drugs for Cancer</b>		
<i>abiraterone acetate oral tablet 250 mg</i>	1	PA; SL (4 tablets per day.); SP; CM
ALECENSA ORAL CAPSULE 150 MG ( <i>alectinib hcl</i> )	2	PA; SL (8 capsules per day.); SP; CM
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML ( <i>interferon alfa-n3</i> )	2	
ALUNBRIG ORAL TABLET 180 MG, 90 MG ( <i>brigatinib</i> )	2	PA; SL (1 tablet per day); SP; CM
ALUNBRIG ORAL TABLET 30 MG ( <i>brigatinib</i> )	2	PA; SL (6 tablets per day); SP; CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG ( <i>brigatinib</i> )	2	PA; SL (30 packs per year); SP; CM
<i>anastrozole oral tablet 1 mg</i>	1	H
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG ( <i>avapritinib</i> )	3	PA; SL (1 tablet per day.); SP; CM
BALVERSA ORAL TABLET 3 MG ( <i>erdafitinib</i> )	3	PA; SL (3 tablets per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BALVERSA ORAL TABLET 4 MG ( <i>erdafitinib</i> )	3	PA; SL (2 tablets per day.); SP; CM
BALVERSA ORAL TABLET 5 MG ( <i>erdafitinib</i> )	3	PA; SL (1 tablet per day.); SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML ( <i>ropeginterferon alfa-2b-njft</i> )	3	PA; ST; SL (0.08 ml per day.)
<i>bexarotene oral capsule 75 mg</i>	1	CM
<i>bicalutamide oral tablet 50 mg</i>	1	CM
BOSULIF ORAL CAPSULE 100 MG, 50 MG ( <i>bosutinib</i> )	2	PA; ST; SP; CM
BOSULIF ORAL TABLET 100 MG ( <i>bosutinib</i> )	2	PA; ST; SL (4 tablets per day.); SP; CM
BOSULIF ORAL TABLET 400 MG, 500 MG ( <i>bosutinib</i> )	2	PA; ST; SL (1 tablet per day.); SP; CM
BRAFTOVI ORAL CAPSULE 75 MG ( <i>encorafenib</i> )	3	PA; ST; SL (6 capsules per day); SP; CM
BRUKINSA ORAL CAPSULE 80 MG ( <i>zanubrutinib</i> )	3	PA; ST; SL (4 capsules per day.); SP; CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG ( <i>cabozantinib s-malate</i> )	2	PA; SL (1 tablet per day.); SP; CM
CALQUENCE ORAL TABLET 100 MG ( <i>acalabrutinib maleate</i> )	2	PA; SL (2 tablets per day.); SP; CM
<i>capecitabine oral tablet 150 mg, 500 mg</i>	1	SP; CM
CAPRELSA ORAL TABLET 100 MG ( <i>vandetanib</i> )	2	PA; SL (2 tablets per day.); SP; CM
CAPRELSA ORAL TABLET 300 MG ( <i>vandetanib</i> )	2	PA; SL (1 tablet per day.); SP; CM
CASODEX ORAL TABLET 50 MG ( <i>bicalutamide</i> )	3	CM
COMETRIQ ORAL KIT 20 MG ( <i>cabozantinib s-malate</i> )	2	PA; SL (93 capsules per month.); SP; CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG ( <i>cabozantinib s-malate</i> )	2	PA; SL (124 capsules per month.); SP; CM
COMETRIQ ORAL KIT 80 & 20 MG ( <i>cabozantinib s-malate</i> )	2	PA; SL (62 capsules per month.); SP; CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG ( <i>duvelisib</i> )	3	PA; SL (2 capsules per day.); SP; CM
COTELLIC ORAL TABLET 20 MG ( <i>cobimetinib fumarate</i> )	2	PA; SL (63 tablets per 21 days); SP; CM
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	1	CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 50 MG	2	CM
DAURISMO ORAL TABLET 100 MG, 25 MG ( <i>glasdegib maleate</i> )	2	PA; SL (2 tablets per day.); SP; CM
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG ( <i>hydroxyurea</i> )	2	CM
EMCYT ORAL CAPSULE 140 MG ( <i>estramustine phosphate sodium</i> )	2	CM
ERIVEDGE ORAL CAPSULE 150 MG ( <i>vismodegib</i> )	2	PA; SL (1 capsule per day.); SP; CM
ERLEADA ORAL TABLET 240 MG ( <i>apalutamide</i> )	2	PA; SL (1 tablet per year.)
ERLEADA ORAL TABLET 60 MG ( <i>apalutamide</i> )	2	PA; SL (3 tablets per day.); SP; CM
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	1	PA; SL (1 tablet per day.); SP; CM
<i>erlotinib hcl oral tablet 25 mg</i>	1	PA; SL (2 tablets per day.); SP; CM
<i>etoposide oral capsule 50 mg</i>	1	SP; CM
<i>everolimus oral tablet 10 mg, 7.5 mg</i>	1	PA; SL (2 tablets per day.); SP; CM
<i>everolimus oral tablet 2.5 mg, 5 mg</i>	1	PA; SL (1 tablet per day.); SP; CM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	1	PA; SL (1 tablet per day.); SP; CM
<i>exemestane oral tablet 25 mg</i>	1	H
EXKIVITY ORAL CAPSULE 40 MG ( <i>mobocertinib succinate</i> )	3	PA; SL (4 capsules per day.); SP; CM
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL ( <i>degarelix acetate</i> )	3	SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG ( <i>degarelix acetate</i> )	3	SP
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG ( <i>tivozanib hcl</i> )	3	PA; SL (0.75 capsules per day.); SP; CM
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG ( <i>fruquintinib</i> )	3	PA; SP; CM
GAVRETO ORAL CAPSULE 100 MG ( <i>pralsetinib</i> )	3	PA; SL (4 capsules per day.); SP; CM
<i>gefitinib oral tablet 250 mg</i>	1	PA; SL (2 tablets per day.); SP; CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG ( <i>afatinib dimaleate</i> )	3	PA; SL (1 tablet per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG ( <i>Iomustine</i> )	2	SP; CM
HYCAMTIN ORAL CAPSULE 0.25 MG ( <i>topotecan hcl</i> )	2	PA; SL (15 capsules per 15 days.); SP; CM
HYCAMTIN ORAL CAPSULE 1 MG ( <i>topotecan hcl</i> )	2	PA; SL (305 capsules per 15 days.); SP; CM
HYDREA ORAL CAPSULE 500 MG ( <i>hydroxyurea</i> )	3	CM
<i>hydroxyurea oral capsule 500 mg</i>	1	CM
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG ( <i>palbociclib</i> )	2	PA; SL (21 capsules per month.); SP; CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG ( <i>palbociclib</i> )	2	PA; SL (0.75 tablets per day.); SP; CM
ICLUSIG ORAL TABLET 10 MG ( <i>ponatinib hcl</i> )	3	PA; SL (1 tablet per day.); CM
ICLUSIG ORAL TABLET 15 MG, 45 MG ( <i>ponatinib hcl</i> )	3	PA; SL (1 tablet per day.); SP; CM
IDHIFA ORAL TABLET 100 MG, 50 MG ( <i>enasidenib mesylate</i> )	2	PA; SL (1 tablet per day); SP; CM
<i>imatinib mesylate oral tablet 100 mg</i>	1	PA; SL (6 tablets per day.); SP; CM
<i>imatinib mesylate oral tablet 400 mg</i>	1	PA; SL (1 tablet per day.); SP; CM
IMBRUVICA ORAL CAPSULE 140 MG ( <i>ibrutinib</i> )	2	PA; SL (4 capsules per day.); SP; CM
IMBRUVICA ORAL CAPSULE 70 MG ( <i>ibrutinib</i> )	2	PA; SL (1 capsule per day.); SP; CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML ( <i>ibrutinib</i> )	2	PA; SL (7.2 ml per day.); SP; CM
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG ( <i>ibrutinib</i> )	2	PA; SL (1 tablet per day.); SP; CM
INLYTA ORAL TABLET 1 MG ( <i>axitinib</i> )	3	PA; SL (6 tablets per day.); SP; CM
INLYTA ORAL TABLET 5 MG ( <i>axitinib</i> )	3	PA; SL (124 tablets per 30 days.); SP; CM
INQOVI ORAL TABLET 35-100 MG ( <i>decitabine-cedazuridine</i> )	3	PA; SL (5 tablets per month.); SP; CM
INREBIC ORAL CAPSULE 100 MG ( <i>fedratinib hcl</i> )	3	PA; ST; SL (4 capsules per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
IRESSA ORAL TABLET 250 MG ( <i>gefitinib</i> )	3	PA; SL (2 tablets per day.); SP; CM
IWILFIN ORAL TABLET 192 MG ( <i>eflornithine hcl</i> )	3	PA; CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG ( <i>ruxolitinib phosphate</i> )	2	PA; SL (2 tablets per day.); SP; CM
JAYPIRCA ORAL TABLET 100 MG ( <i>pirtobrutinib</i> )	3	PA; SL (3 tablets per day.); SP; CM
JAYPIRCA ORAL TABLET 50 MG ( <i>pirtobrutinib</i> )	3	PA; SL (1 tablet per day.); SP; CM
KISQALI FEMARA ORAL TABLET THERAPY PACK 200 & 2.5 MG ( <i>ribociclib-letrozole</i> )	3	PA; CM
KISQALI ORAL TABLET THERAPY PACK 200 MG ( <i>ribociclib succinate</i> )	3	PA; SL (21 tablets per month); SP; CM
KISQALI ORAL TABLET THERAPY PACK 200 MG ( <i>ribociclib succinate</i> )	3	PA; SL (42 tablets per month); SP; CM
KISQALI ORAL TABLET THERAPY PACK 200 MG ( <i>ribociclib succinate</i> )	3	PA; SL (63 tablets per month); SP; CM
KOSELUGO ORAL CAPSULE 10 MG ( <i>selumetinib sulfate</i> )	3	PA; SL (8 capsules per day.); SP; CM
KOSELUGO ORAL CAPSULE 25 MG ( <i>selumetinib sulfate</i> )	3	PA; SL (4 capsules per day.); SP; CM
KRAZATI ORAL TABLET 200 MG ( <i>adagrasib</i> )	3	PA; SL (6 tablets per day.); SP; CM
<i>lapatinib ditosylate oral tablet 250 mg</i>	1	PA; SP; CM
<i>lenalidomide oral capsule 10 mg, 2.5 mg, 5 mg</i>	1	PA; SL (28 capsules per 21 days.); SP; CM
<i>lenalidomide oral capsule 15 mg, 20 mg, 25 mg</i>	1	PA; SL (21 capsules per 21 days.); SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG ( <i>lenvatinib mesylate</i> )	3	PA; SL (2 capsules per day.); SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG ( <i>lenvatinib mesylate</i> )	3	PA; SL (3 capsules per day.); SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG ( <i>lenvatinib mesylate</i> )	3	PA; SL (1 capsule per day.); SP; CM
<i>letrozole oral tablet 2.5 mg</i>	1	H
LEUKERAN ORAL TABLET 2 MG ( <i>chlorambucil</i> )	2	CM
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA
LONSURF ORAL TABLET 15-6.14 MG ( <i>trifluridine-tipiracil</i> )	3	PA; SL (100 tablets per month.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LONSURF ORAL TABLET 20-8.19 MG ( <i>trifluridine-tipiracil</i> )	3	PA; SL (80 tablets per 21 days.); SP; CM
LORBRENA ORAL TABLET 100 MG, 25 MG ( <i>lorlatinib</i> )	3	PA; ST; SP; CM
LUMAKRAS ORAL TABLET 120 MG ( <i>sotorasib</i> )	3	PA; SL (4 tablets per day.); SP; CM
LUMAKRAS ORAL TABLET 320 MG ( <i>sotorasib</i> )	3	PA; SL (3 tablets per day.); SP; CM
LYNPARZA ORAL TABLET 100 MG, 150 MG ( <i>olaparib</i> )	2	PA; SL (4 tablets per day); SP; CM
LYSODREN ORAL TABLET 500 MG ( <i>mitotane</i> )	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG ( <i>futibatinib</i> )	3	PA; SL (84 tablets per month.); SP; CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG ( <i>futibatinib</i> )	3	PA; SL (112 tablets per month.); SP; CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG ( <i>futibatinib</i> )	3	PA; SL (140 tablets per month.); SP; CM
MATULANE ORAL CAPSULE 50 MG ( <i>procarbazine hcl</i> )	2	SP; CM
<i>megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml</i>	1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML ( <i>trametinib dimethyl sulfoxide</i> )	3	ST; SL (17.4 ml per day.); SP; CM
MEKINIST ORAL TABLET 0.5 MG ( <i>trametinib dimethyl sulfoxide</i> )	3	PA; ST; SL (2 tablets per day.); SP; CM
MEKINIST ORAL TABLET 2 MG ( <i>trametinib dimethyl sulfoxide</i> )	3	PA; ST; SL (1 tablet per day.); SP; CM
MEKTOVI ORAL TABLET 15 MG ( <i>binimetinib</i> )	3	PA; ST; SL (6 tablets per day); SP; CM
<i>melphalan oral tablet 2 mg</i>	1	CM
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
MYLERAN ORAL TABLET 2 MG ( <i>busulfan</i> )	2	CM
NERLYNX ORAL TABLET 40 MG ( <i>neratinib maleate</i> )	2	PA; SL (6 tablets per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG ( <i>ixazomib citrate</i> )	2	PA; SP; CM
NUBEQA ORAL TABLET 300 MG ( <i>darolutamide</i> )	2	PA; SL (4 tablets per day.); SP; CM
ODOMZO ORAL CAPSULE 200 MG ( <i>sonidegib phosphate</i> )	2	PA; SL (1 capsule per day.); SP; CM
OGSIVEO ORAL TABLET 50 MG ( <i>nirogacestat hydrobromide</i> )	3	PA; SL (6 tablets per day.); SP; CM
ONUREG ORAL TABLET 200 MG, 300 MG ( <i>azacitidine</i> )	2	PA; SL (14 tablets per 24 days.); SP; CM
ORGOVYX ORAL TABLET 120 MG ( <i>relugolix</i> )	3	PA; SL (1 tablet per day); SP; CM
ORSERDU ORAL TABLET 345 MG ( <i>elacestrant hydrochloride</i> )	2	PA; SL (1 tablet per day.); SP; CM
ORSERDU ORAL TABLET 86 MG ( <i>elacestrant hydrochloride</i> )	2	PA; SL (3 tablets per day.); SP; CM
<i>pazopanib hcl oral tablet 200 mg</i>	1	PA; SL (4 tablets per day.); SP; CM
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG ( <i>pemigatinib</i> )	3	PA; SL (1 tablet per day.); SP; CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG ( <i>alpelisib</i> )	2	PA; SL (2 tablets per day.); SP; CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG ( <i>alpelisib</i> )	2	PA; SL (1 tablet per day.); SP; CM
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG ( <i>pomalidomide</i> )	3	PA; SP; CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML ( <i>mercaptopurine</i> )	3	SP; CM
QINLOCK ORAL TABLET 50 MG ( <i>ripretinib</i> )	3	PA; SL (3 tablets per day.); SP; CM
RETEVMO ORAL CAPSULE 40 MG ( <i>selpercatinib</i> )	3	PA; SL (6 capsules per day.); SP; CM
RETEVMO ORAL CAPSULE 80 MG ( <i>selpercatinib</i> )	3	PA; SP; CM
REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG ( <i>lenalidomide</i> )	2	PA; SL (28 capsules per 21 days.); SP; CM
REVLIMID ORAL CAPSULE 15 MG, 20 MG, 25 MG ( <i>lenalidomide</i> )	2	PA; SL (21 capsules per 21 days.); SP; CM
REZLIDHIA ORAL CAPSULE 150 MG ( <i>olutasidenib</i> )	2	PA; SL (2 capsules per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG ( <i>entrectinib</i> )	2	PA; SL (3 capsules per day.); SP; CM
ROZLYTREK ORAL PACKET 50 MG ( <i>entrectinib</i> )	2	SL (3 pellet packets per day.); SP; CM
RUBRACA ORAL TABLET 200 MG ( <i>rucaparib camsylate</i> )	3	PA; ST; SL (2 tablets per day.); SP; CM
RUBRACA ORAL TABLET 250 MG, 300 MG ( <i>rucaparib camsylate</i> )	3	PA; ST; SL (4 tablets per day.); SP; CM
RYDAPT ORAL CAPSULE 25 MG ( <i>midostaurin</i> )	2	PA; SL (8 capsules per day.); SP; CM
SCEMBLIX ORAL TABLET 20 MG, 40 MG ( <i>asciminib hcl</i> )	3	PA; SL (2 tablets per day.); SP; CM
SOLTAMOX ORAL SOLUTION 10 MG/5ML ( <i>tamoxifen citrate</i> )	3	
<i>sorafenib tosylate oral tablet 200 mg</i>	1	PA; SL (4 tablets per day.); SP; CM
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG ( <i>dasatinib</i> )	3	PA; ST; SL (1 tablet per day.); SP; CM
SPRYCEL ORAL TABLET 20 MG ( <i>dasatinib</i> )	3	PA; ST; SL (2 tablets per day.); SP; CM
STIVARGA ORAL TABLET 40 MG ( <i>regorafenib</i> )	2	PA; SL (84 tablets per 21 days.); SP; CM
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	1	PA; SL (1 capsule per day.); SP; CM
TABLOID ORAL TABLET 40 MG ( <i>thioguanine</i> )	2	SP; CM
TABRECTA ORAL TABLET 150 MG, 200 MG ( <i>capmatinib hcl</i> )	3	PA; SL (4 tablets per day.); SP; CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG ( <i>dabrafenib mesylate</i> )	3	PA; ST; SL (4 capsules per day.); SP; CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG ( <i>dabrafenib mesylate</i> )	3	ST; SL (12 tablets per day.); SP; CM
TAGRISSE ORAL TABLET 40 MG, 80 MG ( <i>osimertinib mesylate</i> )	3	PA; SL (1 tablet per day.); SP; CM
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG ( <i>talazoparib tosylate</i> )	3	PA; ST; SL (1 capsule per day.); SP; CM
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG ( <i>nilotinib hcl</i> )	2	PA; ST; SL (4 capsules per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TAZVERIK ORAL TABLET 200 MG ( <i>tazemetostat hbr</i> )	3	PA; SL (8 tablets per day.); SP; CM
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	1	PA; SP; CM
TEPMETKO ORAL TABLET 225 MG ( <i>tepotinib hcl</i> )	3	PA; SL (2 tablets per day.); SP; CM
TIBSOVO ORAL TABLET 250 MG ( <i>ivosidenib</i> )	2	PA; SL (2 tablets per day.); SP; CM
<i>toremifene citrate oral tablet 60 mg</i>	1	CM
<i>tretinoin oral capsule 10 mg</i>	1	SP; CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG ( <i>methotrexate sodium</i> )	2	CM
TRUQAP ORAL TABLET 160 MG, 200 MG ( <i>capivasertib</i> )	3	PA; SL (64 tablets per month.); SP
TUKYSA ORAL TABLET 150 MG ( <i>tucatinib</i> )	2	PA; SL (4 tablets per day.); SP; CM
TUKYSA ORAL TABLET 50 MG ( <i>tucatinib</i> )	2	PA; SL (10 tablets per day.); SP; CM
TURALIO ORAL CAPSULE 125 MG ( <i>pexidartinib hcl</i> )	2	PA; SL (4 capsules per day.); SP; CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG ( <i>quizartinib dihydrochloride</i> )	3	PA; SL (2 tablets per day.); SP; CM
VENCLEXTA ORAL TABLET 10 MG, 100 MG ( <i>venetoclax</i> )	2	PA; SL (4 tablets per day.); SP; CM
VENCLEXTA ORAL TABLET 50 MG ( <i>venetoclax</i> )	2	PA; SL (1 tablet per day.); SP; CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG ( <i>venetoclax</i> )	2	PA; SL (42 tablets per year.); SP; CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>abemaciclib</i> )	2	PA; SL (2 tablets per day); SP; CM
VITRAKVI ORAL CAPSULE 100 MG ( <i>larotrectinib sulfate</i> )	2	PA; SL (2 capsules per day.); SP; CM
VITRAKVI ORAL CAPSULE 25 MG ( <i>larotrectinib sulfate</i> )	2	PA; SL (6 capsules per day.); SP; CM
VITRAKVI ORAL SOLUTION 20 MG/ML ( <i>larotrectinib sulfate</i> )	2	PA; SL (10 mL per day.); SP; CM
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG ( <i>dacomitinib</i> )	3	PA; SL (1 tablet per day.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VONJO ORAL CAPSULE 100 MG ( <i>pacritinib citrate</i> )	3	PA; SL (4 capsules per day.); SP; CM
WELIREG ORAL TABLET 40 MG ( <i>belzutifan</i> )	3	PA; SL (3 tablets day.); SP; CM
XATMEP ORAL SOLUTION 2.5 MG/ML ( <i>methotrexate</i> )	3	SL (4 ml per day); CM
XOSPATA ORAL TABLET 40 MG ( <i>gilteritinib fumarate</i> )	3	PA; SL (3 tablets per day.); SP; CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG ( <i>selinexor</i> )	3	PA; SL (0.26 tablet per day.); SP; CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG ( <i>selinexor</i> )	3	PA; SL (0.14 tablet per day.); SP; CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG ( <i>selinexor</i> )	3	PA; SL (0.29 tablet per day.); SP; CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG ( <i>selinexor</i> )	3	PA; SL (0.14 tablet per day.); SP; CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG ( <i>selinexor</i> )	3	PA; SL (0.86 tablets per day.); SP; CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG ( <i>selinexor</i> )	3	PA; SL (0.29 tablet per day.); SP; CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG ( <i>selinexor</i> )	3	PA; SL (1.15 tablets per day.); SP; CM
XTANDI ORAL CAPSULE 40 MG ( <i>enzalutamide</i> )	2	PA; SL (4 capsules per day.); SP; CM
XTANDI ORAL TABLET 40 MG ( <i>enzalutamide</i> )	2	PA; SL (4 tablets per day.); SP; CM
XTANDI ORAL TABLET 80 MG ( <i>enzalutamide</i> )	2	PA; SL (2 tablets per day.); SP; CM
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG ( <i>niraparib tosylate</i> )	2	PA; SL (1 tablet per day.); SP; CM
ZELBORAF ORAL TABLET 240 MG ( <i>vemurafenib</i> )	2	PA; SL (8 tablets per day.); SP; CM
ZOLINZA ORAL CAPSULE 100 MG ( <i>vorinostat</i> )	2	PA; SL (4 capsules per day.); SP; CM
ZYDELIG ORAL TABLET 100 MG, 150 MG ( <i>idelalisib</i> )	3	PA; SL (60 tablets per month.); SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM</b>		
<b>ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM</b>		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU ( <i>timothy grass pollen allergen</i> )	3	PA; SL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM ( <i>dust mite mixed allergen ext</i> )	3	PA; SL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR ( <i>grass mix pollens allergen ext</i> )	3	PA; SL (1 tablet per day.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR ( <i>grass mix pollens allergen ext</i> )	3	PA; SL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR ( <i>grass mix pollens allergen ext</i> )	3	PA; SL (1 tablet per day.)
PALFORZIA ORAL 0.5 & 1 & 1.5 & 3 & 6 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (13 capsules per year.); SP
PALFORZIA ORAL 2 X 1 MG & 10 MG, 3 X 1 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (45 capsules per 13 days.); SP
PALFORZIA ORAL 2 X 100 MG, 2 X 20 MG, 20 MG & 100 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (30 capsules per 13 days.); SP
PALFORZIA ORAL 2 X 20 MG & 2 X 100 MG, 4 X 20 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (60 capsules per 13 days.); SP
PALFORZIA ORAL 20 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (15 capsules per 13 days.); SP
PALFORZIA ORAL 3 X 20 MG & 100 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (60 capsule per 13 days.); SP
PALFORZIA ORAL 6 X 1 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (90 capsules per 13 days.); SP
PALFORZIA ORAL PACKET 300 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (1 capsule per day.); SP
PALFORZIA ORAL PACKET 300 MG ( <i>peanut powder-dnfp</i> )	3	PA; SL (15 capsules per 13 days.); SP
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U ( <i>short ragweed pollen ext</i> )	3	PA; SL (1 tablet per day.)
<b>TOXOIDS - Vaccines</b>		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	2	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 ( <i>diphth-acell pertussis-tetanus</i> )	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR ( <i>diphth-acell pertussis-tetanus</i> )	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR ( <i>diphth-acell pertussis-tetanus</i> )	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-hepatitis b recomb-ipv</i> )	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>dtap-ipv-hib vaccine</i> )	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv vaccine</i> )	3	H
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML ( <i>tetanus-diphtheria toxoids td</i> )	3	H
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU ( <i>tetanus-diphtheria toxoids td</i> )	3	H
VAXELIS INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv-hib-hepatitis b recmb</i> )	E	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-ipv-hib-hepatitis b recmb</i> )	E	H
<b>VACCINES - Vaccines</b>		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML ( <i>rsv pre-fusion f a&amp;b vac rcmb</i> )	3	H
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED ( <i>haemophilus b polysac conj vac</i> )	2	H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	3	H
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac split quad</i> )	3	H
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	3	H
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML ( <i>rsvpref3 vac recomb adjuvanted</i> )	3	H
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>meningococcal b recomb omv adj</i> )	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	2	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	2	H
COMIRNATY INTRAMUSCULAR SUSPENSION 30 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	3	H
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	3	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 ( <i>diphth-acell pertussis-tetanus</i> )	2	H
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>dengue virus vaccine live tetr</i> )	3	H
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	2	H
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	2	H
FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML ( <i>influenza vac a&amp;b sa adj quad</i> )	3	H
FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	3	H
FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac recomb ha quad</i> )	3	H
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac subunit quad</i> )	3	H
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac subunit quad</i> )	3	H
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	3	H
FLUMIST QUADRIVALENT NASAL SUSPENSION ( <i>influenza virus vac live quad</i> )	3	H
FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.7 ML ( <i>influenza vac high-dose quad</i> )	3	H
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac split quad</i> )	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION ( <i>hpv 9-valent recomb vaccine</i> )	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>hpv 9-valent recomb vaccine</i> )	3	H
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML ( <i>hepatitis a vaccine</i> )	3	H
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML ( <i>hepatitis b vac recomb adj</i> )	3	H
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG ( <i>haemophilus b polysac conj vac</i> )	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR ( <i>diphth-acell pertussis-tetanus</i> )	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR ( <i>diphth-acell pertussis-tetanus</i> )	3	H
IPOL INJECTION INJECTABLE ( <i>poliovirus vaccine inactivated</i> )	2	H
MENQUADFI INTRAMUSCULAR SOLUTION ( <i>mening acy&amp;w-135 tetanus conj</i> )	3	H
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED ( <i>meningococcal a c y&amp;w-135 olig</i> )	3	H
M-M-R II INJECTION SOLUTION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	2	H
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION 25 MCG/0.25ML ( <i>covid-19 mrna virus vaccine</i> )	3	H
NOVAVAX COVID-19 VACCINE INTRAMUSCULAR SUSPENSION 5 MCG/0.5ML	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-hepatitis b recomb-ipv</i> )	3	H
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML ( <i>haemophilus b polysac conj vac</i> )	2	H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>mening acyw(tet conj)-b(rcmb)</i> )	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>dtap-ipv-hib vaccine</i> )	3	H
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PFIZER COVID-19 VAC-TRIS 6M-4Y INTRAMUSCULAR SUSPENSION 3 MCG/0.3ML	3	H
PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML ( <i>pneumococcal vac polyvalent</i> )	2	H
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML ( <i>hepatitis b vac 3-antigen rcmb</i> )	3	H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 20-val conj vacc</i> )	3	H
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	3	H
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>measles-mumps-rubella-varicell</i> )	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv vaccine</i> )	3	H
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	2	H
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	2	H
ROTARIX ORAL SUSPENSION ( <i>rotavirus vaccine live oral</i> )	E	H
ROTATEQ ORAL SOLUTION ( <i>rotavirus vac live pentavalent</i> )	E	H
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML ( <i>zoster vac recomb adjuvanted</i> )	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION 50 MCG/0.5ML ( <i>covid-19 mrna virus vaccine</i> )	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML ( <i>covid-19 mrna virus vaccine</i> )	3	H
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>meningococcal b vac (recomb)</i> )	3	H
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML ( <i>hepatitis a-hep b recomb vac</i> )	3	H
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML ( <i>hepatitis a vaccine</i> )	2	H
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML ( <i>varicella virus vaccine live</i> )	3	H
VAXELIS INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv-hib-hepatitis b recmb</i> )	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-ipv-hib-hepatitis b recomb</i> )	E	H
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 15-val conj vacc</i> )	3	H
<b>AUTONOMIC DRUGS - Drugs for the Nervous System</b>		
<b>ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs</b>		
ADRENALIN NASAL SOLUTION 0.1 % ( <i>epinephrine hcl (nasal)</i> )	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML ( <i>epinephrine</i> )	2	
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML ( <i>pseudoeph-bromphen-dm</i> )	3	
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG ( <i>desloratadine-pseudoephedrine</i> )	3	
<i>droxidopa oral capsule 100 mg</i>	1	PA; SL (90 tablets per month.); SP
<i>droxidopa oral capsule 200 mg, 300 mg</i>	1	PA; SL (180 tablets per month.); SP
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	1	
LETS KIT	3	PA
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
<b>ALPHA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs</b>		
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	1	
LUCEMYRA ORAL TABLET 0.18 MG ( <i>lofexidine hcl</i> )	3	SL (192 tablets per year.)
METHYLDOPA ORAL TABLET 250 MG, 500 MG	3	PA
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml</i>	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson</b>		
ANASPAZ ORAL TABLET DISPERSIBLE 0.125 MG ( <i>hyoscyamine sulfate</i> )	2	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT ( <i>umeclidinium- vilanterol</i> )	3	SL (2 blisters per day.)
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT ( <i>ipratropium bromide hfa</i> )	2	SL (0.87 grams per day.)
<i>belladonna alkaloids-opium rectal suppository 16.2-60 mg</i>	1	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT ( <i>glycopyrrolate-formoterol</i> )	2	SL (0.36 grams per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <i>budeson-glycopyrrol-formoterol</i> )	3	SL (0.36 grams per day.)
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <i>ipratropium-albuterol</i> )	2	SL (0.28 grams per day.)
CUVPOSA ORAL SOLUTION 1 MG/5ML ( <i>glycopyrrolate</i> )	3	
<i>dicyclomine hcl oral capsule 10 mg</i>	1	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	1	
<i>dicyclomine hcl oral tablet 20 mg</i>	1	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	1	PA
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	1	PA
<i>hydromet oral solution 5-1.5 mg/5ml</i>	1	PA
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hyosyne oral solution 0.125 mg/ml</i>	1	
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG ( <i>hyoscyamine sulfate</i> )	3	
LEVSIN ORAL TABLET 0.125 MG ( <i>hyoscyamine sulfate</i> )	3	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG ( <i>hyoscyamine sulfate</i> )	3	
LOMOTIL ORAL TABLET 2.5-0.025 MG ( <i>diphenoxylate-atropine</i> )	3	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>methscopolamine bromide oral tablet 2.5 mg, 5 mg</i>	1	
MOTOFEN ORAL TABLET 1-0.025 MG ( <i>difenoxin-atropine</i> )	3	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG ( <i>hyoscyamine sulfate</i> )	3	
OSCIMIN ORAL TABLET 0.125 MG	3	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3	
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG ( <i>tiotropium bromide monohydrate</i> )	1	SL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT ( <i>tiotropium bromide monohydrate</i> )	2	SL (0.15 grams per day.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT ( <i>tiotropium bromide-olodaterol</i> )	2	SL (0.15 grams per day.)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day.)
URELLE ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
URIMAR-T ORAL CAPSULE 120 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<i>urin ds oral tablet 81.6 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
UROGESIC-BLUE ORAL TABLET 81.6 MG ( <i>methen-hyosc-meth blue-na phos</i> )	2	
VILEVEV MB ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
YUPELRI INHALATION SOLUTION 175 MCG/3ML ( <i>revefenacin</i> )	3	SL (3 ml per day.)
<b>ANTIPARKINSONIAN AGENTS - Drugs for Parkinson</b>		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	
<b>AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System</b>		
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	1	H
<i>habitrol transdermal patch 24 hour 21 mg/24hr</i>	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG ( <i>nicotine polacrilex</i> )	2	H
NICORETTE MOUTH/THROAT GUM 2 MG ( <i>nicotine polacrilex</i> )	3	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG ( <i>nicotine polacrilex</i> )	2	H
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	1	H
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	1	H
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	1	H
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	1	H
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	1	H
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	1	H
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	1	H
<i>nicotine transdermal patch 24 hour 21 mg/24hr</i>	1	H
NICOTROL INHALATION INHALER 10 MG ( <i>nicotine</i> )	3	H
NICOTROL NS NASAL SOLUTION 10 MG/ML ( <i>nicotine</i> )	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 &amp; 1 mg x 42</i>	1	H
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	1	H
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	1	H
<b>CENTRALLY ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles</b>		
<i>carisoprodol oral tablet 250 mg, 350 mg</i>	1	
<i>chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg</i>	1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	1	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
ENOVARX-CYCLOBENZAPRINE HCL TRANSDERMAL CREAM 20 MG/GM	3	PA
LORZONE ORAL TABLET 375 MG, 750 MG ( <i>chlorzoxazone</i> )	3	
<i>metaxalone oral tablet 400 mg, 800 mg</i>	1	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	1	
TABRADOL FUSEPAQ ORAL SUSPENSION 1 MG/ML ( <i>cyclobenzaprine hcl-msm</i> )	3	PA
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	1	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	
VP FC KIT EXTERNAL CREAM	3	PA
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG ( <i>tizanidine hcl</i> )	3	
ZANAFLEX ORAL TABLET 4 MG ( <i>tizanidine hcl</i> )	3	
<b>DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles</b>		
DANTRIUM ORAL CAPSULE 25 MG ( <i>dantrolene sodium</i> )	3	
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<b>GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles</b>		
BACLOFEN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML	3	
<i>baclofen oral suspension 25 mg/5ml</i>	1	
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	1	
ENOVARX-BACLOFEN EXTERNAL CREAM 1 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FLEQSUVY ORAL SUSPENSION 25 MG/5ML ( <i>baclofen</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	3	PA
OZOBAX DS ORAL SOLUTION 10 MG/5ML (baclofen)	3	
<b>INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles</b>		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
<b>NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart</b>		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
CORGARD ORAL TABLET 20 MG, 40 MG (nadolol)	3	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (propranolol hcl)	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (propranolol hcl)	3	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol hcl)	3	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
<b>NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart</b>		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	3	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (doxazosin mesylate)	3	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG ( <i>prazosin hcl</i> )	3	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<b>NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart</b>		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	1	
<i>ergoloid mesylates oral tablet 1 mg</i>	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG ( <i>ergotamine tartrate</i> )	3	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <i>ergotamine-caffeine</i> )	3	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	1	
<b>PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS) - Drugs for Bladder Incontinence</b>		
ADLARITY TRANSDERMAL PATCH WEEKLY 10 MG/DAY, 5 MG/DAY ( <i>donepezil hcl</i> )	3	
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
<i>cevimeline hcl oral capsule 30 mg</i>	1	
<i>donepezil hcl oral tablet 10 mg, 23 mg, 5 mg</i>	1	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	1	
FIRDAPSE ORAL TABLET 10 MG ( <i>amifampridine phosphate</i> )	2	PA; SL (8 tablets per day.); SP
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	1	
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	1	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	1	
MESTINON ORAL SOLUTION 60 MG/5ML ( <i>pyridostigmine bromide</i> )	3	
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG ( <i>memantine hcl-donepezil hcl</i> )	3	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG ( <i>memantine hcl-donepezil hcl</i> )	3	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	1	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG ( <i>pilocarpine hcl</i> )	3	
<b>SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart</b>		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	1	
<i>tamsulosin hcl oral capsule 0.4 mg</i>	1	
<b>SELECTIVE BETA-2-ADRENERGIC AGONISTS - Drugs for Heart and Lungs</b>		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT ( <i>fluticasone-salmeterol</i> )	2	SL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT ( <i>albuterol-budesonide</i> )	3	
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	1	
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1	
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT ( <i>umeclidinium-vilanterol</i> )	3	SL (2 blisters per day.)
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	1	SL (2 nebules per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT ( <i>glycopyrrolate-formoterol</i> )	2	SL (0.36 grams per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH ( <i>fluticasone furoate-vilanterol</i> )	2	SL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <i>budeson-glycopyrrol-formoterol</i> )	3	SL (0.36 grams per day.)
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML ( <i>arformoterol tartrate</i> )	3	SL (2 nebules per day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <i>ipratropium-albuterol</i> )	2	SL (0.28 grams per day.)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT ( <i>mometasone furo-formoterol fum</i> )	3	ST; SL (0.44 grams per day.)
DULERA INHALATION AEROSOL 50-5 MCG/ACT ( <i>mometasone furo-formoterol fum</i> )	3	ST; SL (0.44 mcg per day.)
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	2	SL (2 blisters per day.)
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	SL (0.4 grams per day.)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	SL (2 blisters per day)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	SL (0.04 mcg per day.)
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	1	SL (2 vials per day)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	1	
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML ( <i>formoterol fumarate</i> )	3	SL (2 vials per day)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>salmeterol xinafoate</i> )	2	SL (2 blisters per day.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT ( <i>tiotropium bromide-olodaterol</i> )	2	SL (0.15 grams per day.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT ( <i>olodaterol hcl</i> )	2	SL (0.14 grams per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT ( <i>budesonide-formoterol fumarate</i> )	1	SL (0.35 grams per day.)
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day.)
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	SL (2 blisters per day)
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT ( <i>levalbuterol tartrate</i> )	3	
<b>SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>atenolol</i> )	3	PA
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>metoprolol succinate</i> )	3	
LOPRESSOR ORAL TABLET 100 MG, 50 MG ( <i>metoprolol tartrate</i> )	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<b>SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles</b>		
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	
<b>BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood</b>		
<b>ANTIANEMIA DRUGS - Vitamins and Minerals</b>		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (2 syringes per month); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (4 syringes per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML ( <i>darbepoetin alfa</i> )	2	SL (1.6 ml per month.); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML ( <i>darbepoetin alfa</i> )	2	SL (1 prefill syringe per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML ( <i>darbepoetin alfa</i> )	2	SL (2 vials per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML ( <i>darbepoetin alfa</i> )	2	SL (4 vials per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML ( <i>darbepoetin alfa</i> )	2	SL (2 vials per prescription); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (2 syringes per month); SP
RETACRIT INJECTION SOLUTION 10000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (8 ml per 21 days.); SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (12 ml per 21 days.); SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (4 ml per 21 days.); SP
<b>ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots</b>		
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML ( <i>anticoagulant cit dext soln a</i> )	3	
ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML	3	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	1	
TRICITRASOL IN VITRO CONCENTRATE 46.7 % ( <i>anticoagulant sodium citrate</i> )	3	
<b>ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots</b>		
CABLIVI INJECTION KIT 11 MG ( <i>caplacizumab-yhdp</i> )	2	PA; SL (1 vial per day and 58 vials per 120 days.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding</b>		
OXBRYTA ORAL TABLET 300 MG, 500 MG ( <i>voxelotor</i> )	3	PA; SL (3 tablets per day.); SP
OXBRYTA ORAL TABLET SOLUBLE 300 MG ( <i>voxelotor</i> )	3	PA; SL (3 tablets per day.); SP
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG ( <i>mitapivat sulfate</i> )	3	PA; SL (56 tablets per 28 days.); SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG ( <i>mitapivat sulfate</i> )	3	PA; SL (7 tablets per 365 days.); SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG ( <i>mitapivat sulfate</i> )	3	PA; SL (14 tablets per 365 days.); SP; CM
TAVALISSE ORAL TABLET 100 MG, 150 MG ( <i>fostamatinib disodium</i> )	3	PA; SL (2 tablets per day); SP
<b>COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots</b>		
<i>jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
<b>DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots</b>		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG ( <i>apixaban</i> )	2	SL (2.5 tablets per day.)
ELIQUIS ORAL TABLET 2.5 MG ( <i>apixaban</i> )	2	SL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG ( <i>apixaban</i> )	2	SL (2.5 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG ( <i>edoxaban tosylate</i> )	3	ST; SL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML ( <i>rivaroxaban</i> )	2	SL (20 ml per day.)
XARELTO ORAL TABLET 10 MG ( <i>rivaroxaban</i> )	2	SL (1 tablet per day.)
XARELTO ORAL TABLET 15 MG ( <i>rivaroxaban</i> )	2	SL (52 tablets per month initial 1 tablet per day for maintenance.)
XARELTO ORAL TABLET 2.5 MG ( <i>rivaroxaban</i> )	2	SL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG ( <i>rivaroxaban</i> )	2	SL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG ( <i>rivaroxaban</i> )	2	SL (51 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots</b>		
<i>dabigatran etexilate mesylate oral capsule 110 mg</i>	1	SL (2 tablets per day.)
<i>dabigatran etexilate mesylate oral capsule 150 mg, 75 mg</i>	1	SL (62 capsules per 31 days.)
PRADAXA ORAL CAPSULE 110 MG ( <i>dabigatran etexilate mesylate</i> )	2	SL (2 tablets per day.)
PRADAXA ORAL CAPSULE 150 MG, 75 MG ( <i>dabigatran etexilate mesylate</i> )	2	SL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG ( <i>dabigatran etexilate mesylate</i> )	3	SL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG ( <i>dabigatran etexilate mesylate</i> )	3	SL (2 packets per day.)
<b>HEMATOPOIETIC AGENTS - Drugs for Anemia</b>		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (2 syringes per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (4 syringes per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML ( <i>darbepoetin alfa</i> )	2	SL (1.6 ml per month.); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML ( <i>darbepoetin alfa</i> )	2	SL (1 prefill syringe per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML ( <i>darbepoetin alfa</i> )	2	SL (2 vials per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML ( <i>darbepoetin alfa</i> )	2	SL (4 vials per month); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML ( <i>darbepoetin alfa</i> )	2	SL (2 vials per prescription); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML ( <i>darbepoetin alfa</i> )	2	SL (2 syringes per month); SP
DOPTELET ORAL TABLET 20 MG ( <i>avatrombopag maleate</i> )	3	PA; SL (15 tablets per month.); SP
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG ( <i>sargramostim</i> )	2	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML ( <i>plerixafor</i> )	3	SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MULPLETA ORAL TABLET 3 MG ( <i>lusutrombopag</i> )	2	PA; SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim</i> )	2	
<i>plerixafor subcutaneous solution 24 mg/1.2ml</i>	1	SP
PROMACTA ORAL PACKET 12.5 MG ( <i>eltrombopag olamine</i> )	3	PA; SL (6 packets per day.); SP
PROMACTA ORAL PACKET 25 MG ( <i>eltrombopag olamine</i> )	3	PA; SL (6 packets per day.)
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG ( <i>eltrombopag olamine</i> )	3	PA; SP
RETACRIT INJECTION SOLUTION 10000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (8 ml per 21 days.); SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (12 ml per 21 days.); SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	2	SL (4 ml per 21 days.); SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML ( <i>pegfilgrastim-cbqv</i> )	2	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim-cbqv</i> )	2	SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <i>filgrastim-sndz</i> )	2	SP
<b>HEMORRHOLOGIC AGENTS - Drugs for Blood Flow</b>		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	1	
<b>HEMOSTATICS - Drugs to Prevent Bleeding</b>		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT ( <i>antihemophil factor (rahf-pfm)</i> )	2	SP
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	3	PA; SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT ( <i>antihemophil fact single chain</i> )	3	PA; SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT ( <i>antihemophilic factor-vwf</i> )	2	SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT ( <i>coagulation factor ix</i> )	2	
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 500 UNIT ( <i>coagulation factor ix</i> )	2	SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT ( <i>coagulation factor ix (rfixfc)</i> )	3	SP
ALTUVIII INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT ( <i>antihem fact fc-vwf-xten-eh1</i> )	3	PA; SP
<i>aminocaproic acid oral solution 0.25 gm/ml</i>	1	
<i>aminocaproic acid oral tablet 1000 mg, 500 mg</i>	1	
ASTRINGYN EXTERNAL SOLUTION 259 MG/GM ( <i>ferric subsulfate</i> )	3	
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT ( <i>coagulation factor ix (recomb)</i> )	2	SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT ( <i>coagulation factor x (human)</i> )	2	SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT ( <i>factor xiii concentrate human</i> )	2	SP
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	1	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	1	
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT ( <i>antihem fact (bdd-rviiiifc)</i> )	3	PA; SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT ( <i>antiinhibitor coagulant cmplx</i> )	2	SP
GELFILM OPHTHALMIC FILM ( <i>gelatin adsorbable</i> )	2	
GEL-FLOW EXTERNAL KIT ( <i>gelatin absorb-thrombin</i> )	3	
GELFOAM-JMI POWDER EXTERNAL KIT ( <i>gelatin absorb-thrombin</i> )	3	
GELFOAM-JMI SPONGE EXTERNAL KIT ( <i>gelatin absorb-thrombin</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML ( <i>emicizumab-kxwh</i> )	2	PA; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT ( <i>antihemophilic factor</i> )	2	
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT ( <i>antihemophilic factor</i> )	2	SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT ( <i>antihemophilic factor-vwf</i> )	2	SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT ( <i>coagulation factor ix (rix-fp)</i> )	3	SP
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT ( <i>ahf (bdd-rfviii peg-aucf)</i> )	3	PA; SP
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT ( <i>antihemophilic factor</i> )	2	
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 500 UNIT ( <i>antihemophilic factor</i> )	2	
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT ( <i>antihem factor recomb (rfviii)</i> )	2	
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT ( <i>antihemophil factor (rahf-pfm)</i> )	2	SP
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG ( <i>desmopressin acetate</i> )	3	SL (1 tablet per day.)
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT ( <i>antihemophil fact bd truncated</i> )	2	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT ( <i>antihemophil fact bd truncated</i> )	2	SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG ( <i>coagulation factor viia recomb</i> )	2	SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT ( <i>antihem fact (bdd-rfviii,sim)</i> )	2	SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NUWIQ INTRAVENOUS KIT 1500 UNIT ( <i>antihem fact (bdd-rfviii,sim)</i> )	2	
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT ( <i>antihem fact (bdd-rfviii,sim)</i> )	2	SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT ( <i>antihem fact (bdd-rfviii,sim)</i> )	2	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT ( <i>factor ix complex</i> )	2	SP
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT ( <i>antihem factor recomb (rfviii)</i> )	2	SP
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 5000 UNIT ( <i>thrombin (recombinant)</i> )	3	
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT ( <i>thrombin (recombinant)</i> )	3	
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	2	
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 5 MG ( <i>coagulation factor viia-jncw</i> )	3	SP
THROMBIN-JMI EPISTAXIS EXTERNAL KIT 5000 UNIT ( <i>thrombin</i> )	3	
THROMBIN-JMI EXTERNAL KIT 20000 UNIT, 5000 UNIT ( <i>thrombin</i> )	3	
THROMBOGEN EXTERNAL KIT 10000 UNIT ( <i>thrombin</i> )	3	
THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED 1000 UNIT, 10000 UNIT ( <i>thrombin</i> )	3	
<i>tranexamic acid oral tablet 650 mg</i>	1	SL (30 tablets per 5 days.)
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT ( <i>coagulation factor xiii a-sub</i> )	3	SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT ( <i>von willebrand factor (recomb)</i> )	2	SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT ( <i>antihemophilic factor-vwf</i> )	2	SP
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT ( <i>antihem fact (bdd-rfviii,mor)</i> )	3	PA; ST
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT ( <i>antihem fact (bdd-rfviii,mor)</i> )	3	PA; ST

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XYNTHA SOLOFUSE INTRAVENOUS KIT 3000 UNIT ( <i>antihem fact (bdd-rfviii,mor)</i> )	3	PA; ST; SP
<b>HEPARINS - Drugs to Prevent Blood Clots</b>		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	1	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</i>	1	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML ( <i>dalteparin sodium</i> )	3	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML ( <i>dalteparin sodium</i> )	3	
<i>heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml</i>	1	
<i>heparin sodium (porcine) pf injection solution 5000 unit/0.5ml, 5000 unit/ml</i>	1	
<b>IRON PREPARATIONS - Vitamins and Minerals</b>		
ATABEX OB ORAL TABLET 29-1 MG ( <i>prenatal vit w/ fe bisg-fa</i> )	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG ( <i>prenat-fecb-fefum-fa-dha w/o a</i> )	3	
ELITE-OB ORAL TABLET 50-1.25 MG ( <i>prenatal vit-iron carbonyl-fa</i> )	3	
ENBRACE HR ORAL CAPSULE ( <i>prenat vit-fe gly cys-fa-omega</i> )	3	
<i>hematinic/folic acid oral tablet 324-1 mg</i>	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	1	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG, 29-1 MG	3	
NEONATAL FE ORAL TABLET 90-1 MG	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NEONATAL PLUS ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG ( <i>prenat-fe-methylfol-dha w/o a</i> )	3	
NESTABS ORAL TABLET 32-1 MG ( <i>prenat-fe bisgly-fa-w/o vit a</i> )	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML ( <i>ped multivitamins-fl-iron</i> )	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG ( <i>ped multivitamins-fl-iron</i> )	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
<i>prenatal oral tablet 27-1 mg</i>	1	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG ( <i>prenatal-feaspgly-methylfol-fa</i> )	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG ( <i>prenat-fecbn-feasp-meth-fa-dha</i> )	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATVITE COMPLETE ORAL TABLET 1 MG	3	
PRENATVITE PLUS ORAL TABLET 1 MG	3	
PRENATVITE RX ORAL TABLET 0.8 MG	3	
PRIMACARE ORAL CAPSULE 30-1-470 MG ( <i>pren-fe-meth-fa-omeg w/o a</i> )	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG ( <i>prenatal vit-fe psac cmplx-fa</i> )	3	
TRINATE ORAL TABLET ( <i>prenatal vit-fe fumarate-fa</i> )	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VINATE ONE ORAL TABLET 60-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG ( <i>prenat-fe poly-methfol-fa-dha</i> )	3	
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG ( <i>prenatal-fe fum-methf-fa w/o a</i> )	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG ( <i>prenat-fefum-fered-fa-dha w/oa</i> )	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<b>LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals</b>		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
<i>cyanocobalamin nasal solution 500 mcg/0.1ml</i>	1	
DODEX INJECTION SOLUTION 1000 MCG/ML ( <i>cyanocobalamin</i> )	3	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML ( <i>cyanocobalamin</i> )	3	
<b>PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots</b>		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
BRILINTA ORAL TABLET 60 MG, 90 MG ( <i>ticagrelor</i> )	2	SL (2 tablets per day.)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
<i>clopidogrel bisulfate oral tablet 300 mg, 75 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG ( <i>aspirin</i> )	E	H
ZONTIVITY ORAL TABLET 2.08 MG ( <i>vorapaxar sulfate</i> )	3	SL (1 tablet per day.)
<b>PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots</b>		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	1	
<b>THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots</b>		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG ( <i>aspirin</i> )	E	H
<b>CARDIOVASCULAR DRUGS - Drugs for the Heart</b>		
<b>ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for High Blood Pressure</b>		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG ( <i>doxazosin mesylate</i> )	3	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG ( <i>doxazosin mesylate</i> )	3	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG ( <i>prazosin hcl</i> )	3	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<b>ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure &amp; Angina</b>		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG ( <i>doxazosin mesylate</i> )	3	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG ( <i>doxazosin mesylate</i> )	3	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG ( <i>prazosin hcl</i> )	3	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<b>ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	
EDARBI ORAL TABLET 40 MG, 80 MG ( <i>azilsartan medoxomil</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	1	
VALSARTAN ORAL SOLUTION 4 MG/ML	3	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	1	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs for the Heart</b>		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	1	
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	1	
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	1	
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	1	
EDARBI ORAL TABLET 40 MG, 80 MG ( <i>azilsartan medoxomil</i> )	3	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG ( <i>azilsartan-chlorthalidone</i> )	3	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG ( <i>sacubitril-valsartan</i> )	3	PA; SL (2 tablets per day.)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	1	
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VALSARTAN ORAL SOLUTION 4 MG/ML	3	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	
<b>ANGIOTENSIN-CONVERT. ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	
<i>enalapril maleate oral solution 1 mg/ml</i>	1	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
EPANED ORAL SOLUTION 1 MG/ML ( <i>enalapril maleate</i> )	3	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG ( <i>benazepril hcl</i> )	3	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	1	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<b>ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart</b>		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG ( <i>quinapril-hydrochlorothiazide</i> )	3	
<i>amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1	
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	
<i>enalapril maleate oral solution 1 mg/ml</i>	1	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
EPANED ORAL SOLUTION 1 MG/ML ( <i>enalapril maleate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG ( <i>benazepril-hydrochlorothiazide</i> )	3	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG ( <i>benazepril hcl</i> )	3	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	1	
QBRELIS ORAL SOLUTION 1 MG/ML ( <i>lisinopril</i> )	3	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	1	
<b>ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina</b>		
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG ( <i>digoxin</i> )	3	
<b>ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol</b>		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG ( <i>lomitapide mesylate</i> )	3	PA; ST; SL (1 tablet per day.); SP
JUXTAPID ORAL CAPSULE 20 MG, 30 MG ( <i>lomitapide mesylate</i> )	3	PA; ST; SL (1 capsule per day.); SP
NEXLETOL ORAL TABLET 180 MG ( <i>bempedoic acid</i> )	2	SL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG ( <i>bempedoic acid-ezetimibe</i> )	2	SL (1 tablet per day.)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	1	
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>BETA-ADRENERGIC BLOCKING AGENTS - Drugs for Abnormal Heart Rhythms</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>atenolol</i> )	3	PA
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG ( <i>sotalol hcl af</i> )	3	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
CORGARD ORAL TABLET 20 MG, 40 MG ( <i>nadolol</i> )	3	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML ( <i>propranolol hcl</i> )	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG ( <i>propranolol hcl</i> )	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>metoprolol succinate</i> )	3	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG ( <i>metoprolol tartrate</i> )	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML ( <i>sotalol hcl</i> )	3	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<b>BETA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>atenolol</i> )	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG ( <i>sotalol hcl af</i> )	3	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
CORGARD ORAL TABLET 20 MG, 40 MG ( <i>nadolol</i> )	3	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML ( <i>propranolol hcl</i> )	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG ( <i>propranolol hcl</i> )	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>metoprolol succinate</i> )	3	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG ( <i>metoprolol tartrate</i> )	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML ( <i>sotalol hcl</i> )	3	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<b>BILE ACID SEQUESTRANTS - Drugs for Cholesterol</b>		
<i>cholestyramine light oral packet 4 gm</i>	1	
<i>cholestyramine light oral powder 4 gm/dose</i>	1	
<i>cholestyramine oral packet 4 gm</i>	1	
<i>cholestyramine oral powder 4 gm/dose</i>	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % ( <i>clindamycin-tretinoin-cholesty</i> )	3	PA
<i>colesevelam hcl oral packet 3.75 gm</i>	1	
<i>colesevelam hcl oral tablet 625 mg</i>	1	
COLESTID FLAVORED ORAL GRANULES 5 GM ( <i>colestipol hcl</i> )	3	
COLESTID FLAVORED ORAL PACKET 5 GM ( <i>colestipol hcl</i> )	3	
COLESTID ORAL GRANULES 5 GM ( <i>colestipol hcl</i> )	3	
COLESTID ORAL PACKET 5 GM ( <i>colestipol hcl</i> )	3	
COLESTID ORAL TABLET 1 GM ( <i>colestipol hcl</i> )	3	
<i>colestipol hcl oral granules 5 gm</i>	1	
<i>colestipol hcl oral packet 5 gm</i>	1	
<i>colestipol hcl oral tablet 1 gm</i>	1	
<i>prevalite oral packet 4 gm</i>	1	
<i>prevalite oral powder 4 gm/dose</i>	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE ( <i>cholestyramine light</i> )	3	
QUESTRAN ORAL PACKET 4 GM ( <i>cholestyramine</i> )	3	
QUESTRAN ORAL POWDER 4 GM/DOSE ( <i>cholestyramine</i> )	3	
<b>CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem hcl er beads)	3	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (verapamil hcl)	3	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (verapamil hcl)	3	
<b>CALCIUM-CHANNEL BLOCKING AGENTS, MISC. - Drugs for High Blood Pressure &amp; Angina</b>		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG ( <i>diltiazem hcl er beads</i> )	3	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	1	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG ( <i>verapamil hcl</i> )	3	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG ( <i>verapamil hcl</i> )	3	
<b>CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
<b>CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina</b>		
ASPRUZYO SPRINKLE ORAL PACKET 1000 MG, 500 MG ( <i>ranolazine</i> )	3	
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG ( <i>mavacamten</i> )	3	PA; SL (1 capsule per day.); SP
CORLANOR ORAL SOLUTION 5 MG/5ML ( <i>ivabradine hcl</i> )	3	PA; SL (20 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CORLANOR ORAL TABLET 5 MG, 7.5 MG ( <i>ivabradine hcl</i> )	3	PA; SL (2 tablets per day.)
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	1	
VYNDAMAX ORAL CAPSULE 61 MG ( <i>tafamidis</i> )	2	PA; SL (1 capsule per day.); SP
VYNDAQEL ORAL CAPSULE 20 MG ( <i>tafamidis meglumine (cardiac)</i> )	2	PA; SL (4 capsules per day.); SP
<b>CARDIOTONIC AGENTS - Drugs for Angina</b>		
<i>digoxin oral solution 0.05 mg/ml</i>	1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG, 62.5 MCG ( <i>digoxin</i> )	3	
<b>CENTRAL ALPHA-AGONISTS - Drugs for High Blood Pressure &amp; Angina</b>		
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
METHYLDOPA ORAL TABLET 250 MG, 500 MG	3	PA
<b>CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol</b>		
<i>ezetimibe oral tablet 10 mg</i>	1	
EZETIMIBE-ROSUVASTATIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG	3	SL (1 tablet per day.)
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	1	
NEXLIZET ORAL TABLET 180-10 MG ( <i>bempedoic acid-ezetimibe</i> )	2	SL (1 tablet per day.)
ROSZET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG ( <i>ezetimibe-rosuvastatin</i> )	3	SL (1 tablet per day.)
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG ( <i>ezetimibe-simvastatin</i> )	3	
<b>CLASS IA ANTIARRHYTHMICS - Drugs for Angina</b>		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG ( <i>disopyramide phosphate</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
NORPACE ORAL CAPSULE 100 MG, 150 MG ( <i>disopyramide phosphate</i> )	3	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	
<b>CLASS IB ANTIARRHYTHMICS - Drugs for Angina</b>		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG ( <i>phenytoin</i> )	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG ( <i>phenytoin sodium extended</i> )	3	
DILANTIN ORAL SUSPENSION 125 MG/5ML ( <i>phenytoin</i> )	3	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	1	
<i>phenytek oral capsule 200 mg, 300 mg</i>	1	
<i>phenytoin infatabs oral tablet chewable 50 mg</i>	1	
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin oral tablet chewable 50 mg</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	
<b>CLASS IC ANTIARRHYTHMICS - Drugs for Angina</b>		
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	1	
<b>CLASS II ANTIARRHYTHMICS - Drugs for Angina</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>atenolol</i> )	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG ( <i>sotalol hcl af</i> )	3	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML ( <i>propranolol hcl</i> )	3	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG ( <i>propranolol hcl</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>metoprolol succinate</i> )	3	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG ( <i>metoprolol tartrate</i> )	3	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML ( <i>sotalol hcl</i> )	3	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<b>CLASS III ANTIARRHYTHMICS - Drugs for Angina</b>		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG ( <i>sotalol hcl af</i> )	3	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	1	
MULTAQ ORAL TABLET 400 MG ( <i>dronedarone hcl</i> )	3	PA
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG ( <i>amiodarone hcl</i> )	3	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML ( <i>sotalol hcl</i> )	3	
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG ( <i>dofetilide</i> )	3	
<b>CLASS IV ANTIARRHYTHMICS - Drugs for Angina</b>		
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG ( <i>diltiazem hcl er beads</i> )	3	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG ( <i>verapamil hcl</i> )	3	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG ( <i>verapamil hcl</i> )	3	
<b>DIHYDROPYRIDINES - Drugs for High Blood Pressure &amp; Angina</b>		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>amlodipine besylate</i> )	3	PA
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>amlodipine besylate-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1	
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	1	
<i>amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg</i>	1	SL (1 tablet per day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	1	
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	1	
KATERZIA ORAL SUSPENSION 1 MG/ML ( <i>amlodipine benzoate</i> )	3	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	1	
NORLIQVA ORAL SOLUTION 1 MG/ML ( <i>amlodipine besylate</i> )	3	
NYMALIZE ORAL SOLUTION 6 MG/ML ( <i>nimodipine</i> )	2	
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG ( <i>nisoldipine</i> )	3	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	1	
<b>DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure &amp; Angina</b>		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>amlodipine besylate</i> )	3	PA
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KATERZIA ORAL SUSPENSION 1 MG/ML ( <i>amlodipine benzoate</i> )	3	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	1	
NORLIQVA ORAL SOLUTION 1 MG/ML ( <i>amlodipine besylate</i> )	3	
NYMALIZE ORAL SOLUTION 6 MG/ML ( <i>nimodipine</i> )	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG ( <i>nisoldipine</i> )	3	
<b>DIRECT VASODILATORS - Drugs for High Blood Pressure &amp; Angina</b>		
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg, 37.5-20 mg</i>	1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	1	
<b>DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
<b>FIBRIC ACID DERIVATIVES - Drugs for Cholesterol</b>		
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	1	
<i>fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg</i>	1	
<i>fenofibrate oral tablet 120 mg, 145 mg, 160 mg, 40 mg, 48 mg, 54 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	1	
<i>fenofibric acid oral tablet 105 mg, 35 mg</i>	1	
FIBRICOR ORAL TABLET 105 MG, 35 MG ( <i>fenofibric acid</i> )	3	
<i>gemfibrozil oral tablet 600 mg</i>	1	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG ( <i>fenofibrate</i> )	3	
LOPID ORAL TABLET 600 MG ( <i>gemfibrozil</i> )	3	
<b>HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol</b>		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG ( <i>lovastatin</i> )	3	
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	1	
<i>amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg</i>	1	SL (1 tablet per day)
ATORVALIQ ORAL SUSPENSION 20 MG/5ML ( <i>atorvastatin calcium</i> )	3	
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1	H
<i>atorvastatin calcium oral tablet 40 mg, 80 mg</i>	1	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG ( <i>rosuvastatin calcium</i> )	3	
EZETIMIBE-ROSUVASTATIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG	3	SL (1 tablet per day.)
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	1	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3	
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	1	
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	1	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG ( <i>pitavastatin calcium</i> )	3	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	1	H
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
ROSZET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG ( <i>ezetimibe-rosuvastatin</i> )	3	SL (1 tablet per day.)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>simvastatin oral tablet 80 mg</i>	1	
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG ( <i>ezetimibe-simvastatin</i> )	3	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG ( <i>pitavastatin magnesium</i> )	3	
<b>HYPOTENSIVE AGENTS, MISCELLANEOUS - Drugs for High Blood Pressure &amp; Angina</b>		
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	1	
VECAMYL ORAL TABLET 2.5 MG ( <i>mecamylamine hcl</i> )	3	
<b>LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG ( <i>bumetanide</i> )	3	
<i>ethacrynic acid oral tablet 25 mg</i>	1	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML ( <i>furosemide</i> )	3	PA
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG ( <i>furosemide</i> )	3	
SOAAZ ORAL TABLET 20 MG ( <i>torseamide</i> )	3	SL (1 tablet per day.)
SOAAZ ORAL TABLET 40 MG, 60 MG ( <i>torseamide</i> )	3	SL (2 tablets per day.)
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
<b>MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart</b>		
CAROSPIR ORAL SUSPENSION 25 MG/5ML ( <i>spironolactone</i> )	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
KERENDIA ORAL TABLET 10 MG, 20 MG ( <i>finerenone</i> )	3	PA; SL (1 tablet per day.)
<i>spironolactone oral suspension 25 mg/5ml</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<b>MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure &amp; Angina</b>		
CAROSPIR ORAL SUSPENSION 25 MG/5ML ( <i>spironolactone</i> )	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>NITRATES AND NITRITES - Drugs for the Heart</b>		
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg, 37.5-20 mg</i>	1	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	
NITRO-BID TRANSDERMAL OINTMENT 2 % ( <i>nitroglycerin</i> )	2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR ( <i>nitroglycerin</i> )	3	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	1	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG ( <i>nitroglycerin</i> )	3	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG ( <i>nitroglycerin</i> )	3	
<b>PCSK9 INHIBITORS - Drugs for Cholesterol</b>		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML ( <i>evolocumab</i> )	2	PA; ST; SL (3.5 ml (1 cartridge) per month.)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML ( <i>evolocumab</i> )	2	PA; ST; SL (2 syringes per 28 days.)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML ( <i>evolocumab</i> )	2	PA; ST; SL (2 ml per month.)
<b>PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart</b>		
<i>alyq oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
ENTADFI ORAL CAPSULE 5-5 MG ( <i>finasteride-tadalafil</i> )	3	SL (1 capsule per day.)
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; SL (186 ml per month.); SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	SL (6 tablets per month)
<i>sildenafil citrate oral tablet 20 mg</i>	1	SL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG ( <i>avanafil</i> )	2	SL (6 tablets per month)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	SL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML ( <i>tadalafil (pah)</i> )	3	PA; SL (10 ml per day.); SP
<i>varafenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	SL (6 tablets per month)
<i>varafenafil hcl oral tablet dispersible 10 mg</i>	1	SL (6 tablets per month)
<b>POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>amiloride hcl oral tablet 5 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML ( <i>spironolactone</i> )	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	1	
<b>RENIN INHIBITORS - Drugs for the Heart</b>		
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	1	
TEKTURNA ORAL TABLET 150 MG, 300 MG ( <i>aliskiren fumarate</i> )	3	
<b>RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart</b>		
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG ( <i>sacubitril-valsartan</i> )	3	PA; SL (2 tablets per day.)
<b>STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart</b>		
CAROSPIR ORAL SUSPENSION 25 MG/5ML ( <i>spironolactone</i> )	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<b>THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure &amp; Angina</b>		
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	2	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<b>THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure &amp; Angina</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
THALITONE ORAL TABLET 15 MG ( <i>chlorthalidone</i> )	3	
<b>VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart</b>		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; SL (1 tablet per day.); SP
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>amlodipine besylate</i> )	3	PA
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; SL (2 tablets per day.); SP
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG ( <i>alprostadil (vasodilator)</i> )	3	SL (6 units per month)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG ( <i>alprostadil (vasodilator)</i> )	3	SL (6 units per month)
CORLANOR ORAL SOLUTION 5 MG/5ML ( <i>ivabradine hcl</i> )	3	PA; SL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG ( <i>ivabradine hcl</i> )	3	PA; SL (2 tablets per day.)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG ( <i>alprostadil (vasodilator)</i> )	3	SL (6 units per month)
KATERZIA ORAL SUSPENSION 1 MG/ML ( <i>amlodipine benzoate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
MUSE URETHRAL PELLETT 1000 MCG, 250 MCG, 500 MCG ( <i>alprostadil (vasodilator)</i> )	3	SL (6 units per month)
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	1	
<i>nimodipine oral capsule 30 mg</i>	1	
NORLIQVA ORAL SOLUTION 1 MG/ML ( <i>amlodipine besylate</i> )	3	
NYMALIZE ORAL SOLUTION 6 MG/ML ( <i>nimodipine</i> )	2	
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	2	PA; SL (1 tablet per day.); SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (168 tablets per year.); SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (336 tablets per year.); SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (252 tablets per year.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day.); SP
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG ( <i>diltiazem hcl er beads</i> )	3	
TRACLEER ORAL TABLET 125 MG, 62.5 MG ( <i>bosentan</i> )	2	PA; SL (2 tablets per day.); SP
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	2	PA; SL (4 tablets per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG ( <i>treprostinil</i> )	2	PA; SL (112 cartridges per 23 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG ( <i>treprostinil</i> )	2	PA; SL (196 cartridges per 365 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG ( <i>treprostinil</i> )	2	PA; SL (252 cartridges per 365 days.); SP
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML ( <i>iloprost</i> )	2	PA; SP
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG ( <i>verapamil hcl</i> )	3	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG ( <i>verapamil hcl</i> )	3	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG ( <i>vericiguat</i> )	3	PA; SL (1 tablet per day.)
<b>CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System</b>		
<b>ADAMANTANES (CNS) - Drugs for Parkinson</b>		
<i>amantadine hcl oral capsule 100 mg</i>	1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
<b>AMPHETAMINE DERIVATIVES - Drugs for the Nervous System</b>		
ADIPEX-P ORAL TABLET 37.5 MG ( <i>phentermine hcl</i> )	3	PA
<i>diethylpropion hcl er oral tablet extended release 24 hour 75 mg</i>	1	PA
<i>diethylpropion hcl oral tablet 25 mg</i>	1	PA
LOMAIRA ORAL TABLET 8 MG ( <i>phentermine hcl</i> )	3	PA
<i>phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg</i>	1	PA
<i>phendimetrazine tartrate oral tablet 35 mg</i>	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg</i>	1	PA
<i>phentermine hcl oral tablet 37.5 mg</i>	1	PA
<b>AMPHETAMINES - Drugs for the Nervous System</b>		
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG ( <i>amphetamine-dextroamphetamine</i> )	3	SL (2 capsules per day.)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG ( <i>amphetamine</i> )	3	SL (1 tablet per day.)
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	1	
<i>amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	1	SL (2 capsules per day.)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	1	SL (1 capsule per day)
<i>benzphetamine hcl oral tablet 50 mg</i>	1	PA
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	1	SL (5 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	1	SL (4 capsules per day.)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	1	SL (10 capsules per day.)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	
<i>dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML ( <i>amphetamine</i> )	3	SL (15 mL per day.)
DYANAVEL XR ORAL TABLET CHEWABLE EXTENDED RELEASE 10 MG, 15 MG, 20 MG, 5 MG ( <i>amphetamine</i> )	3	SL (1 tablet per day.)
EVEKEO ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG ( <i>amphetamine sulfate</i> )	3	PA
EVEKEO ORAL TABLET 10 MG, 5 MG ( <i>amphetamine sulfate</i> )	3	
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	1	SL (2 capsules per day.)
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	1	SL (1 capsule per day)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	1	SL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	1	SL (1 tablet per day)
<i>methamphetamine hcl oral tablet 5 mg</i>	1	
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG ( <i>amphetamine-dextroamphetamine</i> )	3	SL (1 capsule per day)
PROCENTRA ORAL SOLUTION 5 MG/5ML ( <i>dextroamphetamine sulfate</i> )	3	
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG ( <i>lisdexamfetamine dimesylate</i> )	3	SL (2 capsules per day.)
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG ( <i>lisdexamfetamine dimesylate</i> )	3	SL (1 capsule per day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG ( <i>lisdexamfetamine dimesylate</i> )	3	SL (2 tablets per day.)
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG ( <i>lisdexamfetamine dimesylate</i> )	3	SL (1 tablet per day)
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR ( <i>dextroamphetamine</i> )	3	SL (1 patch per day.)
ZENZEDI ORAL TABLET 2.5 MG, 7.5 MG ( <i>dextroamphetamine sulfate</i> )	3	
<b>ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	
ALLZITAL ORAL TABLET 25-325 MG ( <i>butalbital-acetaminophen</i> )	3	
APADAZ ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG ( <i>benzhydrocodone-acetaminophen</i> )	3	
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	
<i>bac oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	SL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	
ESGIC ORAL CAPSULE 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 tablets per day)
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML ( <i>gabapentin</i> )	3	PA
FIORICET ORAL CAPSULE 50-300-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day.)
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	1	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	1	
NEURAPTINE EXTERNAL CREAM 10 % ( <i>gabapentin</i> )	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG ( <i>gabapentin</i> )	3	
NEURONTIN ORAL SOLUTION 250 MG/5ML ( <i>gabapentin</i> )	3	
NEURONTIN ORAL TABLET 600 MG, 800 MG ( <i>gabapentin</i> )	3	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	
OXYCODONE-ACETAMINOPHEN ORAL TABLET 5-300 MG, 7.5-300 MG	3	
<i>pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg</i>	1	SL (1 tablet per day.)
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG ( <i>oxycodone-acetaminophen</i> )	3	
TENCON ORAL TABLET 50-325 MG ( <i>butalbital-acetaminophen</i> )	3	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG ( <i>apap-caff-dihydrocodeine</i> )	1	
URELLE ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
URIMAR-T ORAL CAPSULE 120 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>urin ds oral tablet 81.6 mg</i>	1	
VILEVEV MB ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phosph sal</i> )	3	
<b>ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System</b>		
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG ( <i>phentermine-topiramate</i> )	3	PA
<b>ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System</b>		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG ( <i>naltrexone-bupropion hcl</i> )	3	PA
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML ( <i>setmelanotide acetate</i> )	3	PA; SP
<b>ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson</b>		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	
<b>ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG ( <i>eslicarbazepine acetate</i> )	3	PA
BANZEL ORAL SUSPENSION 40 MG/ML ( <i>rufinamide</i> )	3	
BANZEL ORAL TABLET 200 MG, 400 MG ( <i>rufinamide</i> )	3	PA
BRIVIACT ORAL SOLUTION 10 MG/ML ( <i>brivaracetam</i> )	3	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG ( <i>brivaracetam</i> )	3	PA
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	
<i>carbamazepine oral tablet 200 mg</i>	1	
<i>carbamazepine oral tablet chewable 100 mg</i>	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine</i> )	3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	3	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG ( <i>stiripentol</i> )	3	PA; SP
DIACOMIT ORAL PACKET 250 MG, 500 MG ( <i>stiripentol</i> )	3	PA; SP
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML ( <i>cannabidiol</i> )	3	PA; SP
<i>epitol oral tablet 200 mg</i>	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine (antipsychotic)</i> )	3	
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML ( <i>gabapentin</i> )	3	PA
<i>felbamate oral suspension 600 mg/5ml</i>	1	
<i>felbamate oral tablet 400 mg, 600 mg</i>	1	
FELBATOL ORAL TABLET 400 MG, 600 MG ( <i>felbamate</i> )	3	
FINTEPLA ORAL SOLUTION 2.2 MG/ML ( <i>fenfluramine hcl</i> )	3	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML ( <i>perampanel</i> )	3	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG ( <i>perampanel</i> )	3	PA
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
KEPPRA ORAL SOLUTION 100 MG/ML ( <i>levetiracetam</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG ( <i>levetiracetam</i> )	3	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG ( <i>levetiracetam</i> )	3	
<i>lacosamide oral solution 10 mg/ml</i>	1	PA
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	PA
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG ( <i>lamotrigine</i> )	3	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG ( <i>lamotrigine</i> )	3	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG ( <i>lamotrigine</i> )	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG ( <i>lamotrigine</i> )	3	
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	1	
<i>lamotrigine oral kit 21 x 25 mg &amp; 7 x 50 mg, 25 &amp; 50 &amp; 100 mg, 42 x 50 mg &amp; 14x100 mg</i>	1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	1	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	1	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	1	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	
<i>levetiracetam oral solution 100 mg/ml</i>	1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG ( <i>pregabalin</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LYRICA ORAL SOLUTION 20 MG/ML ( <i>pregabalin</i> )	3	
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG ( <i>gabapentin</i> )	3	
NEURONTIN ORAL SOLUTION 250 MG/5ML ( <i>gabapentin</i> )	3	
NEURONTIN ORAL TABLET 600 MG, 800 MG ( <i>gabapentin</i> )	3	
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	1	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	1	
<i>pregabalin oral solution 20 mg/ml</i>	1	
<i>roweepra oral tablet 500 mg</i>	1	
<i>rufinamide oral suspension 40 mg/ml</i>	1	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	1	PA
SABRIL ORAL TABLET 500 MG ( <i>vigabatrin</i> )	3	PA; SL (6 tablets per day.); SP
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG ( <i>levetiracetam</i> )	3	
<i>subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>subvenite starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>subvenite starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	1	
<i>subvenite starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML ( <i>carbamazepine</i> )	3	
TEGRETOL ORAL TABLET 200 MG ( <i>carbamazepine</i> )	3	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG ( <i>carbamazepine</i> )	3	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG ( <i>topiramate</i> )	3	
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG ( <i>topiramate</i> )	3	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
TRILEPTAL ORAL SUSPENSION 300 MG/5ML ( <i>oxcarbazepine</i> )	3	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG ( <i>oxcarbazepine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<i>vigabatrin oral packet 500 mg</i>	1	PA; SL (6 packets per day.)
<i>vigabatrin oral tablet 500 mg</i>	1	PA; SL (6 tablets per day.); SP
<i>vigadrone oral packet 500 mg</i>	1	PA; SL (6 packets per day.)
<i>vigadrone oral tablet 500 mg</i>	1	PA; SL (6 tablets per day.); SP
<i>vigpoder oral packet 500 mg</i>	1	PA; SL (6 packets per day.)
VIMPAT ORAL SOLUTION 10 MG/ML ( <i>lacosamide</i> )	3	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>lacosamide</i> )	3	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>cenobamate</i> )	3	PA
XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG ( <i>cenobamate</i> )	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG ( <i>zonisamide</i> )	3	
ZONISADE ORAL SUSPENSION 100 MG/5ML ( <i>zonisamide</i> )	3	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
ZTALMY ORAL SUSPENSION 50 MG/ML ( <i>ganaxolone</i> )	3	SP
<b>ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression &amp; Psychosis</b>		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG ( <i>dextromethorphan-bupropion</i> )	3	SL (2 tablets per day.)
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	1	H
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	1	
BUPROPION HCL ER (XL) ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG	3	SL (1 tablet per day.)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	1	
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG ( <i>bupropion hcl</i> )	3	SL (1 tablet per day.)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE ( <i>esketamine hcl</i> )	3	PA; SL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE ( <i>esketamine hcl</i> )	3	PA; SL (12 devices (4 kits) per month.)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG ( <i>zuranolone</i> )	3	PA; SL (28 capsules per year.); SP
ZURZUVAE ORAL CAPSULE 30 MG ( <i>zuranolone</i> )	3	PA; SL (14 capsules per year.); SP
<b>ANTIMANIC AGENTS - Drugs for Personality Disorder</b>		
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	1	SL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	1	SL (2 tablets per day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	1	SL (2 tablets per day.)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	
<i>carbamazepine oral tablet 200 mg</i>	1	
<i>carbamazepine oral tablet chewable 100 mg</i>	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine</i> )	3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	3	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
<i>epitol oral tablet 200 mg</i>	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine (antipsychotic)</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG ( <i>lamotrigine</i> )	3	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG ( <i>lamotrigine</i> )	3	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG ( <i>lamotrigine</i> )	3	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG ( <i>lamotrigine</i> )	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG ( <i>lamotrigine</i> )	3	
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	1	
<i>lamotrigine oral kit 21 x 25 mg &amp; 7 x 50 mg, 25 &amp; 50 &amp; 100 mg, 42 x 50 mg &amp; 14x100 mg</i>	1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	1	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	1	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	1	
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	1	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	
<i>lithium carbonate oral tablet 300 mg</i>	1	
<i>lithium oral solution 8 meq/5ml</i>	1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG ( <i>lithium carbonate</i> )	3	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	1	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	1	
<i>risperidone oral solution 1 mg/ml</i>	1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG ( <i>quetiapine fumarate</i> )	3	
<i>subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>subvenite starter kit-blue oral kit 35 x 25 mg</i>	1	
<i>subvenite starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	1	
<i>subvenite starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML ( <i>carbamazepine</i> )	3	
TEGRETOL ORAL TABLET 200 MG ( <i>carbamazepine</i> )	3	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG ( <i>carbamazepine</i> )	3	
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<b>ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment</b>		
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	1	
<i>caffeine citrate oral solution 20 mg/ml, 60 mg/3ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CAMBIA ORAL PACKET 50 MG ( <i>diclofenac potassium(migraine)</i> )	3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	3	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	3	
<i>diclofenac potassium(migraine) oral packet 50 mg</i>	1	
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	1	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG ( <i>naproxen</i> )	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG ( <i>ergotamine tartrate</i> )	3	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	1	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
HEMANGEOL ORAL SOLUTION 4.28 MG/ML ( <i>propranolol hcl</i> )	3	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG ( <i>propranolol hcl</i> )	3	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <i>ergotamine-caffeine</i> )	3	
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
NAPROSYN ORAL SUSPENSION 125 MG/5ML ( <i>naproxen</i> )	3	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG ( <i>aspirin</i> )	E	H
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG ( <i>topiramate</i> )	3	
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG ( <i>topiramate</i> )	3	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>valproic acid oral capsule 250 mg</i>	1	
<i>valproic acid oral solution 250 mg/5ml</i>	1	
<b>ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression &amp; Psychosis</b>		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG ( <i>loxapine</i> )	3	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	1	
<i>pimozide oral tablet 1 mg, 2 mg</i>	1	
<b>ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC - Drugs for Anxiety &amp; Sleep Disorder</b>		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG ( <i>suvorexant</i> )	3	SL (1 tablet per day.)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	
DAYVIGO ORAL TABLET 10 MG, 5 MG ( <i>lemborexant</i> )	3	SL (1 tablet per day.)
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG ( <i>zolpidem tartrate</i> )	3	SL (1 sublingual tablet per day)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML ( <i>tasimelteon</i> )	3	PA; SL (5.1 mL per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HETLIOZ ORAL CAPSULE 20 MG ( <i>tasimelteon</i> )	3	PA; SL (1 capsule per day.); SP
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethegan rectal suppository 12.5 mg, 25 mg, 50 mg</i>	1	
<i>ramelteon oral tablet 8 mg</i>	1	SL (1 tablet per day)
<i>tasimelteon oral capsule 20 mg</i>	1	PA; SL (1 capsule per day.); SP
VISTARIL ORAL CAPSULE 25 MG ( <i>hydroxyzine pamoate</i> )	3	
<i>zaleplon oral capsule 10 mg, 5 mg</i>	1	
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	1	
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	1	
<i>zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg</i>	1	SL (1 sublingual tablet per day)
<b>ATYPICAL ANTIPSYCHOTICS - Drugs for Depression &amp; Psychosis</b>		
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	1	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	1	SL (1 tablet per day.)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	1	SL (2 tablets per day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	1	SL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG ( <i>lumateperone tosylate</i> )	3	PA; SL (1 capsule per day.)
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	1	
CLOZARIL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG ( <i>clozapine</i> )	3	
FANAPT ORAL TABLET 1 MG ( <i>iloperidone</i> )	3	SL (86 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG ( <i>iloperidone</i> )	3	SL (2 tablets per day)
FANAPT ORAL TABLET 2 MG ( <i>iloperidone</i> )	3	SL (56 tablets per year.)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG ( <i>iloperidone</i> )	3	SL (8 tablets (1 pack) per 365 days.)
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg</i>	1	SL (1 tablet per day.)
<i>lurasidone hcl oral tablet 40 mg</i>	1	SL (1 tablet per day)
<i>lurasidone hcl oral tablet 80 mg</i>	1	SL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG ( <i>pimavanserin tartrate</i> )	3	PA
NUPLAZID ORAL TABLET 10 MG ( <i>pimavanserin tartrate</i> )	3	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	1	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	1	SL (1 capsule per day)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	1	SL (1 tablet per day)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	1	SL (2 tablets per day)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	1	
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	1	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG ( <i>brexpiprazole</i> )	3	ST; SL (1 tablet per day.)
<i>risperidone oral solution 1 mg/ml</i>	1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG ( <i>quetiapine fumarate</i> )	3	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG ( <i>olanzapine-fluoxetine hcl</i> )	3	SL (1 capsule per day)
VERSACLOZ ORAL SUSPENSION 50 MG/ML ( <i>clozapine</i> )	3	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG ( <i>cariprazine hcl</i> )	3	SL (1 capsule per day.)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG ( <i>cariprazine hcl</i> )	3	SL (7 capsules per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<b>BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures</b>		
MYSOLINE ORAL TABLET 250 MG, 50 MG ( <i>primidone</i> )	2	
<i>phenobarbital oral elixir 20 mg/5ml</i>	1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1	
<i>primidone oral tablet 125 mg</i>	1	PA
<i>primidone oral tablet 250 mg, 50 mg</i>	1	
<b>BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety &amp; Sleep Disorder</b>		
ALLZITAL ORAL TABLET 25-325 MG ( <i>butalbital-acetaminophen</i> )	3	
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>bac oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1	
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	SL (6 capsules per day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
ESGIC ORAL CAPSULE 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 tablets per day)
FIORICET ORAL CAPSULE 50-300-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day.)
<i>phenobarbital oral elixir 20 mg/5ml</i>	1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1	
TENCON ORAL TABLET 50-325 MG ( <i>butalbital-acetaminophen</i> )	3	
<b>BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures</b>		
<i>clobazam oral suspension 2.5 mg/ml</i>	1	
<i>clobazam oral tablet 10 mg, 20 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	1	
<i>diazepam intensol oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	1	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	1	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG ( <i>lorazepam</i> )	3	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML ( <i>midazolam (anticonvulsant)</i> )	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML ( <i>clobazam</i> )	3	PA
ONFI ORAL TABLET 10 MG, 20 MG ( <i>clobazam</i> )	3	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG ( <i>clobazam</i> )	3	PA
VALTOCO NASAL LIQUID 10 MG/0.1ML, 5 MG/0.1ML ( <i>diazepam</i> )	3	PA
VALTOCO NASAL LIQUID THERAPY PACK 10 MG/0.1ML, 7.5 MG/0.1ML ( <i>diazepam</i> )	3	PA
<b>BENZODIAZEPINES (ANXIOLYTIC, SEDATIV/HYP) - Drugs for Anxiety &amp; Sleep Disorder</b>		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	
<i>alprazolam intensol oral concentrate 1 mg/ml</i>	1	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	1	
<i>clobazam oral suspension 2.5 mg/ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>clobazam oral tablet 10 mg, 20 mg</i>	1	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	1	
<i>diazepam intensol oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral concentrate 5 mg/ml</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	1	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	1	
<i>estazolam oral tablet 1 mg, 2 mg</i>	1	
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	1	
HALCION ORAL TABLET 0.25 MG ( <i>triazolam</i> )	3	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral concentrate 2 mg/ml</i>	1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG ( <i>lorazepam</i> )	3	
<i>midazolam hcl oral syrup 2 mg/ml</i>	1	
MIDAZOLAM+SYRSPEND SF ORAL SUSPENSION 1 MG/ML ( <i>midazolam</i> )	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML ( <i>clobazam</i> )	3	PA
ONFI ORAL TABLET 10 MG, 20 MG ( <i>clobazam</i> )	3	PA
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG ( <i>temazepam</i> )	3	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG ( <i>clobazam</i> )	3	PA
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	1	
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	1	
<b>BUTYROPHENONES - Drugs for Depression &amp; Psychosis</b>		
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	1	
<b>CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment</b>		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML ( <i>erenumab-aooe</i> )	2	PA; SL (1 ml per 21 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML ( <i>erenumab-aooe</i> )	2	PA
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML ( <i>galcanezumab-gnlm</i> )	2	PA; SL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>galcanezumab-gnlm</i> )	2	PA; SL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML ( <i>galcanezumab-gnlm</i> )	2	PA; SL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG ( <i>rimegepant sulfate</i> )	2	PA; ST; SL (0.27 tablets per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG ( <i>ubrogepant</i> )	2	PA; ST; SL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT ( <i>zavegepant hcl</i> )	3	PA; ST
<b>CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson</b>		
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	1	
COMTAN ORAL TABLET 200 MG ( <i>entacapone</i> )	3	
<i>entacapone oral tablet 200 mg</i>	1	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG ( <i>opicapone</i> )	3	SL (1 capsule per day.)
STALEVO 100 ORAL TABLET 25-100-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 125 ORAL TABLET 31.25-125-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 150 ORAL TABLET 37.5-150-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 200 ORAL TABLET 50-200-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 50 ORAL TABLET 12.5-50-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 75 ORAL TABLET 18.75-75-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
<i>tolcapone oral tablet 100 mg</i>	1	PA
<b>CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder</b>		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	1	
ADDYI ORAL TABLET 100 MG ( <i>flibanserin</i> )	3	SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>atomoxetine hcl oral capsule 10 mg, 25 mg</i>	1	SL (3 capsules per day.)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	1	SL (1 capsule per day)
<i>atomoxetine hcl oral capsule 18 mg</i>	1	SL (5 capsules per day.)
<i>atomoxetine hcl oral capsule 40 mg</i>	1	SL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML ( <i>trofinetide</i> )	2	PA; SL (120 ml per day.); SP
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM ( <i>sodium oxybate</i> )	3	PA; SL (1 packet per day.); SP
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg &amp; 21 x 10 mg, 5 mg</i>	1	
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG ( <i>memantine hcl-donepezil hcl</i> )	3	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG ( <i>memantine hcl-donepezil hcl</i> )	3	
NOURIANZ ORAL TABLET 20 MG, 40 MG ( <i>istradefylline</i> )	3	SL (1 tablet per day.)
NUEDEXTA ORAL CAPSULE 20-10 MG ( <i>dextromethorphan-quinidine</i> )	2	PA; SL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML ( <i>edaravone</i> )	3	PA; SL (150 ml per 84 days.); SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML ( <i>edaravone</i> )	3	PA; SL (70 ml per 365 days.); SP
RELYVRIO ORAL PACKET 3-1 GM ( <i>phenylbutyrate-taurursodio</i> l)	3	PA; SL (2 packets per day.); SP
<i>riluzole oral tablet 50 mg</i>	1	
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	3	PA; SL (18 ml per day.); SP
STRATTERA ORAL CAPSULE 10 MG, 25 MG ( <i>atomoxetine hcl</i> )	3	SL (3 capsules per day.)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG ( <i>atomoxetine hcl</i> )	3	SL (1 capsule per day)
STRATTERA ORAL CAPSULE 18 MG ( <i>atomoxetine hcl</i> )	3	SL (5 capsules per day.)
STRATTERA ORAL CAPSULE 40 MG ( <i>atomoxetine hcl</i> )	3	SL (2 capsules per day)
TEGLUTIK ORAL SUSPENSION 50 MG/10ML ( <i>riluzole</i> )	3	PA; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VEOZAH ORAL TABLET 45 MG ( <i>fezolinetant</i> )	3	SL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML ( <i>bremelanotide acetate</i> )	3	SL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG ( <i>tafamidis</i> )	2	PA; SL (1 capsule per day.); SP
XYWAV ORAL SOLUTION 500 MG/ML ( <i>ca, mg, k, and na oxybates</i> )	3	PA; SL (18 mL per day.); SP
<b>CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain</b>		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	1	SL (2 capsules per day)
<i>celecoxib oral capsule 400 mg</i>	1	SL (31 capsules per 31 days.)
<b>DOPAMINE PRECURSORS - Drugs for Parkinson</b>		
<i>carbidopa oral tablet 25 mg</i>	1	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	1	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML ( <i>carbidopa-levodopa</i> )	3	
INBRIJA INHALATION CAPSULE 42 MG ( <i>levodopa</i> )	3	PA; SL (10 tablets per day.); SP
SINEMET ORAL TABLET 10-100 MG, 25-100 MG ( <i>carbidopa-levodopa</i> )	3	
STALEVO 100 ORAL TABLET 25-100-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 125 ORAL TABLET 31.25-125-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 150 ORAL TABLET 37.5-150-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 200 ORAL TABLET 50-200-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
STALEVO 50 ORAL TABLET 12.5-50-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
STALEVO 75 ORAL TABLET 18.75-75-200 MG ( <i>carbidopa-levodopa-entacapone</i> )	3	
<b>ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson</b>		
<i>bromocriptine mesylate oral capsule 5 mg</i>	1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	1	
<i>cabergoline oral tablet 0.5 mg</i>	1	
<b>FIBROMYALGIA AGENTS - Drugs for Nerve Pain</b>		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg</i>	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG ( <i>pregabalin</i> )	3	
LYRICA ORAL SOLUTION 20 MG/ML ( <i>pregabalin</i> )	3	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	1	
<i>pregabalin oral solution 20 mg/ml</i>	1	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG ( <i>milnacipran hcl</i> )	3	SL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG ( <i>milnacipran hcl</i> )	3	SL (1 pack per 365 days.)
<b>HYDANTOINS - Drugs for Seizures</b>		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG ( <i>phenytoin</i> )	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG ( <i>phenytoin sodium extended</i> )	3	
DILANTIN ORAL SUSPENSION 125 MG/5ML ( <i>phenytoin</i> )	3	
<i>phenytek oral capsule 200 mg, 300 mg</i>	1	
<i>phenytoin infatabs oral tablet chewable 50 mg</i>	1	
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin oral tablet chewable 50 mg</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	
<b>INHALATION ANESTHETICS - Anesthetics</b>		
FORANE INHALATION SOLUTION ( <i>isoflurane</i> )	2	
<i>isoflurane inhalation solution</i>	1	
<i>sevoflurane inhalation solution</i>	1	
<i>terrell inhalation solution</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ULTANE INHALATION SOLUTION ( <i>sevoflurane</i> )	3	
<b>MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson</b>		
AZILECT ORAL TABLET 0.5 MG, 1 MG ( <i>rasagiline mesylate</i> )	3	
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR ( <i>selegiline</i> )	3	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	1	
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG ( <i>selegiline hcl</i> )	3	
<b>MONOAMINE OXIDASE INHIBITORS - Drugs for Depression &amp; Psychosis</b>		
AZILECT ORAL TABLET 0.5 MG, 1 MG ( <i>rasagiline mesylate</i> )	3	
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR ( <i>selegiline</i> )	3	
MARPLAN ORAL TABLET 10 MG ( <i>isocarboxazid</i> )	3	
NARDIL ORAL TABLET 15 MG ( <i>phenelzine sulfate</i> )	3	
PARNATE ORAL TABLET 10 MG ( <i>tranylcypromine sulfate</i> )	3	
<i>phenelzine sulfate oral tablet 15 mg</i>	1	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	1	
<i>selegiline hcl oral capsule 5 mg</i>	1	
<i>selegiline hcl oral tablet 5 mg</i>	1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG ( <i>selegiline hcl</i> )	3	
<b>NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson</b>		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML ( <i>apomorphine hcl</i> )	3	PA; SL (3 ml per day.); SP
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	1	PA; SL (3 ml per day.); SP
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR ( <i>rotigotine</i> )	3	
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	
<b>OPIATE AGONISTS - Drugs for Pain</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	
APADAZ ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG ( <i>benzhydrocodone-acetaminophen</i> )	3	
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>belladonna alkaloids-opium rectal suppository 16.2-60 mg</i>	1	
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>codeine sulfate oral tablet 30 mg, 60 mg</i>	1	
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG ( <i>tramadol hcl</i> )	3	SL (1 capsule per day)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	1	PA; SL (4 lozenges per day)
FENTANYL CITRATE BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	3	PA; SL (4 buccal tablets per day)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr</i>	1	PA; SL (0.34 patches per day)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	1	PA; SL (15 patches per 31 days)
FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG ( <i>fentanyl citrate</i> )	3	PA; SL (4 buccal tablets per day)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	1	PA; SL (2 capsules per day)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg</i>	1	PA; SL (0 tablet per 0 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	1	PA; SL (1 tablet per day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	1	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	1	
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg</i>	1	PA; SL (2 tablets per day)
<i>hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg</i>	1	PA; SL (1 tablet per day)
<i>hydromorphone hcl er oral tablet extended release 24 hour 32 mg</i>	1	PA; SL (0 tablet per 0 days)
<i>hydromorphone hcl oral liquid 1 mg/ml</i>	1	
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	1	
<i>hydromorphone hcl rectal suppository 3 mg</i>	1	
<i>levorphanol tartrate oral tablet 2 mg</i>	1	ST; SL (4 tablets per day)
<i>levorphanol tartrate oral tablet 3 mg</i>	1	ST; SL (4 tablets per day.)
<i>meperidine hcl oral solution 50 mg/5ml</i>	1	
<i>meperidine hcl oral tablet 50 mg</i>	1	
<i>methadone hcl intensol oral concentrate 10 mg/ml</i>	1	SL (6 ml per day.)
<i>methadone hcl oral concentrate 10 mg/ml</i>	1	SL (6 ml per day.)
<i>methadone hcl oral solution 10 mg/5ml</i>	1	PA; SL (11.3 mL per day)
<i>methadone hcl oral solution 5 mg/5ml</i>	1	PA; SL (22.6 mL per day)
<i>methadone hcl oral tablet 10 mg</i>	1	PA; SL (2 tablets per day)
<i>methadone hcl oral tablet 5 mg</i>	1	PA; SL (4 tablets per day)
<i>methadone hcl oral tablet soluble 40 mg</i>	1	SL (1.5 tablets per day.)
METHADOSE ORAL CONCENTRATE 10 MG/ML ( <i>methadone hcl</i> )	3	SL (6 ml per day.)
<i>methadose oral tablet soluble 40 mg</i>	1	SL (1.5 tablets per day.)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML ( <i>methadone hcl</i> )	3	SL (6 ml per day.)
<i>morphine sulfate (concentrate) oral solution 10 mg/0.5ml, 100 mg/5ml, 20 mg/ml</i>	1	
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg</i>	1	PA; SL (0 capsule per 100 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	1	PA; SL (1 capsule per day)
<i>morphine sulfate er oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg</i>	1	PA; SL (62 capsules per 31 days)
<i>morphine sulfate er oral capsule extended release 24 hour 100 mg</i>	1	PA; SL (0 capsule per 100 days)
<i>morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg, 80 mg</i>	1	PA; SL (1 capsule per day)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg</i>	1	PA; SL (0 capsule per 100 days)
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg</i>	1	PA; SL (93 tablets per 31 days)
<i>morphine sulfate oral solution 10 mg/5ml</i>	1	
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	1	
<i>morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i>	1	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG ( <i>tapentadol hcl</i> )	3	PA; SL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG ( <i>tapentadol hcl</i> )	3	PA; SL (0 capsule per 100 days)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG ( <i>tapentadol hcl</i> )	2	SL (6 tablets per day)
<i>oxycodone hcl oral capsule 5 mg</i>	1	
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	1	
<i>oxycodone hcl oral solution 5 mg/5ml</i>	1	
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	
<i>oxycodone hcl oral tablet 5 mg</i>	1	SL (12 tablets per day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	
OXYCODONE-ACETAMINOPHEN ORAL TABLET 5-300 MG, 7.5-300 MG	3	
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg</i>	1	PA; SL (2 tablets per day.)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg</i>	1	PA; SL (0 tablet per 100 days.)
<i>oxymorphone hcl er oral tablet extended release 12 hour 30 mg, 40 mg</i>	1	PA; SL (0 capsule per 100 days)
<i>oxymorphone hcl oral tablet 10 mg, 5 mg</i>	1	SL (6 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROLATE ORAL TABLET 5-300 MG, 7.5-300 MG ( <i>oxycodone-acetaminophen</i> )	3	
SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML ( <i>tramadol hcl</i> )	3	PA
TRAMADOL HCL (ER BIPHASIC) ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG	3	SL (1 capsule per day)
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	1	SL (1 tablet per day)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	1	SL (1 tablet per day)
<i>tramadol hcl oral tablet 50 mg</i>	1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG ( <i>apap-caff-dihydrocodeine</i> )	1	
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG ( <i>oxycodone</i> )	3	PA; SL (2 tablets per day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG ( <i>oxycodone</i> )	3	PA; SL (0 capsule per 100 days)
<b>OPIATE ANTAGONISTS - Drugs for Overdose or Poisoning</b>		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1	SL (2 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	1	SL (1 film per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	1	SL (1 sublingual film per day)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1	SL (3 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1	SL (3 sublingual tablets per day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1	SL (3 tablets per day.)
KLOXXADO NASAL LIQUID 8 MG/0.1ML ( <i>naloxone hcl</i> )	2	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	1	
<i>naltrexone hcl oral tablet 50 mg</i>	1	
NARCAN NASAL LIQUID 4 MG/0.1ML ( <i>naloxone hcl</i> )	2	
OPVEE NASAL SOLUTION 2.7 MG/0.1ML ( <i>nalmefene hcl</i> )	2	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML ( <i>methylnaltrexone bromide</i> )	3	SL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	3	SL (0.4 ml per day.)
SUBOXONE SUBLINGUAL FILM 12-3 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 4-1 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (1 sublingual film per day)
SUBOXONE SUBLINGUAL FILM 8-2 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (3 films per day.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML ( <i>naloxone hcl</i> )	2	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (2 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (1 tablet per day)
<b>OPIATE PARTIAL AGONISTS - Drugs for Pain</b>		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG ( <i>buprenorphine hcl</i> )	3	PA; SL (2 films per day)
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	1	SL (3 sublingual tablets per day)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1	SL (3 tablets per day)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1	SL (2 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	1	SL (1 film per day.)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	1	SL (1 sublingual film per day)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1	SL (3 films per day.)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1	SL (3 sublingual tablets per day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1	SL (3 tablets per day.)
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr</i>	1	PA; SL (4 patches per 28 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr</i>	1	PA; SL (4 patches per month)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	1	
SUBOXONE SUBLINGUAL FILM 12-3 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 4-1 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (1 sublingual film per day)
SUBOXONE SUBLINGUAL FILM 8-2 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	3	PA; ST; SL (3 films per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (2 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG ( <i>buprenorphine hcl-naloxone hcl</i> )	1	SL (1 tablet per day)
<b>OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety &amp; Sleep Disorder</b>		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG ( <i>suvorexant</i> )	3	SL (1 tablet per day.)
DAYVIGO ORAL TABLET 10 MG, 5 MG ( <i>lemborexant</i> )	3	SL (1 tablet per day.)
<b>OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Pain</b>		
CAMBIA ORAL PACKET 50 MG ( <i>diclofenac potassium(migraine)</i> )	3	
DAYPRO ORAL TABLET 600 MG ( <i>oxaprozin</i> )	3	
<i>diclofenac potassium oral capsule 25 mg</i>	1	
<i>diclofenac potassium oral tablet 50 mg</i>	1	
<i>diclofenac potassium(migraine) oral packet 50 mg</i>	1	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	1	
<i>diflunisal oral tablet 500 mg</i>	1	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG ( <i>naproxen</i> )	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	1	
FELDENE ORAL CAPSULE 10 MG, 20 MG ( <i>piroxicam</i> )	3	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	1	
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
INDOCIN ORAL SUSPENSION 25 MG/5ML ( <i>indomethacin</i> )	3	
INDOCIN RECTAL SUPPOSITORY 50 MG ( <i>indomethacin</i> )	3	
<i>indomethacin er oral capsule extended release 75 mg</i>	1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	1	
<i>indomethacin rectal suppository 50 mg</i>	1	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % ( <i>ketoprofen-baclofen-gabap-lido</i> )	3	PA
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	1	
<i>mefenamic acid oral capsule 250 mg</i>	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
NAPROSYN ORAL SUSPENSION 125 MG/5ML ( <i>naproxen</i> )	3	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>oxaprozin oral tablet 600 mg</i>	1	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY ( <i>ketorolac tromethamine</i> )	3	ST
<i>sulindac oral tablet 150 mg, 200 mg</i>	1	
ZIPSOR ORAL CAPSULE 25 MG ( <i>diclofenac potassium</i> )	3	
<b>PHENOTHIAZINES - Drugs for Depression &amp; Psychosis</b>		
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	1	
<i>chlorpromazine hcl oral tablet 10 mg, 25 mg</i>	1	SL (6 tablets per day.)
<i>chlorpromazine hcl oral tablet 100 mg, 50 mg</i>	1	SL (4 tablets per day.)
<i>chlorpromazine hcl oral tablet 200 mg</i>	1	SL (2 tablets per day.)
<i>compro rectal suppository 25 mg</i>	1	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	1	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	1	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<b>RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System</b>		
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	1	
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG ( <i>methylphenidate hcl</i> )	3	SL (1 capsule per day.)
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG ( <i>serdexmethylphen-dexmethylphen</i> )	2	SL (1 capsule per day.)
<i>bac oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	1	SL (6 capsules per day.)
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	1	SL (6 capsules per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	1	SL (6 tablets per day)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
<i>caffeine citrate oral solution 20 mg/ml, 60 mg/3ml</i>	1	
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG ( <i>methylphenidate</i> )	3	SL (1 tablet per day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg</i>	1	SL (2 capsules per day.)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg</i>	1	SL (31 capsules per 31 days.)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	1	
ESGIC ORAL CAPSULE 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 tablets per day)
FIORICET ORAL CAPSULE 50-300-40 MG ( <i>butalbital-apap-caffeine</i> )	3	SL (6 capsules per day.)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG ( <i>dexmethylphenidate hcl</i> )	3	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG ( <i>methylphenidate hcl</i> )	2	SL (1 capsule per day.)
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML ( <i>methylphenidate hcl</i> )	3	
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	1	SL (2 tablets per day.)
<i>methylphenidate hcl er (cd) oral capsule extended release 60 mg</i>	1	SL (31 capsules per 31 days.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg</i>	1	SL (5 capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg</i>	1	SL (5capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg</i>	1	SL (3 capsules per day.)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg</i>	1	SL (2 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg</i>	1	
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 36 mg, 54 mg</i>	1	SL (2 tablets per day.)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	1	SL (1 capsule per day.)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	1	SL (10 tablets per day.)
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	1	SL (5 tablets per day.)
<i>methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	1	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	1	
<i>methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr</i>	1	SL (1 patch per day)
<i>methylphenidate transdermal patch 30 mg/9hr</i>	1	SL (1 patch per day.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <i>ergotamine-caffeine</i> )	3	
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG ( <i>methylphenidate hcl</i> )	3	SL (1 tablet per day.)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML ( <i>methylphenidate hcl</i> )	3	SL (360 mL per month.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG ( <i>apap-caff-dihydrocodeine</i> )	1	
<b>SALICYLATES - Drugs for Pain</b>		
<i>ascomp-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin childrens oral tablet chewable 81 mg</i>	E	H
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	E	H
<i>aspirin low dose oral tablet chewable 81 mg</i>	E	H
<i>aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>aspirin oral tablet chewable 81 mg</i>	E	H
<i>aspirin oral tablet delayed release 81 mg</i>	E	H
<i>aspirin regimen oral tablet delayed release 81 mg</i>	E	H
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	1	
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	1	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	E	H
<i>mm aspirin oral tablet delayed release 81 mg</i>	E	H
<i>salsalate oral tablet 500 mg, 750 mg</i>	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (aspirin)	E	H
<b>SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression &amp; Psychosis</b>		
DESVENLAFAXINE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG	3	
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 50 mg</i>	1	SL (1 tablet per day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg</i>	1	SL (1 tablet per day.)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg</i>	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG ( <i>levomilnacipran hcl</i> )	3	ST; SL (1 capsule per day.)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ( <i>levomilnacipran hcl</i> )	3	ST; SL (28 capsules per year.)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG ( <i>milnacipran hcl</i> )	3	SL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG ( <i>milnacipran hcl</i> )	3	SL (1 pack per 365 days.)
VENLAFAXINE BESYLATE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 112.5 MG	3	
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg</i>	1	SL (2 tablets per day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg</i>	1	SL (1 tablet per day)
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<b>SELECTIVE SEROTONIN AGONISTS - Migraine Treatment</b>		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	1	
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	1	
<i>frovatriptan succinate oral tablet 2.5 mg</i>	1	
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	1	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC ( <i>sumatriptan succinate</i> )	3	
REYVOW ORAL TABLET 100 MG ( <i>lasmiditan succinate</i> )	3	PA; ST; SL (0.27 tablets per day. 8 tablets per prescription.)
REYVOW ORAL TABLET 50 MG ( <i>lasmiditan succinate</i> )	3	PA; ST; SL (0.14 tablets per day. Benefit maximum quantity 4 tablets per prescription.)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	1	
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	1	
<i>sumatriptan nasal solution 20 mg/act, 5 mg/act</i>	1	
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>sumatriptan succinate refill subcutaneous solution cartridge subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</i>	1	
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	1	
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml</i>	1	
TOSYMRA NASAL SOLUTION 10 MG/ACT ( <i>sumatriptan</i> )	3	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML ( <i>sumatriptan succinate</i> )	3	
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	1	
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	1	
ZOMIG NASAL SOLUTION 2.5 MG ( <i>zolmitriptan</i> )	2	
ZOMIG NASAL SOLUTION 5 MG ( <i>zolmitriptan</i> )	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression &amp; Psychosis</b>		
CITALOPRAM HYDROBROMIDE ORAL CAPSULE 30 MG	3	
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	1	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg</i>	1	
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	1	
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	1	SL (4 capsules per 28 days.)
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	1	
<i>fluoxetine hcl oral tablet 10 mg</i>	1	SL (1 tablet per day.)
<i>fluoxetine hcl oral tablet 20 mg, 60 mg</i>	1	
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	1	SL (2 capsules per day)
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	1	SL (1 capsule per day)
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg</i>	1	SL (1 tablet per day)
<i>paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg</i>	1	SL (2 tablets per day)
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>paroxetine mesylate oral capsule 7.5 mg</i>	1	SL (1 capsule per day.)
PAXIL ORAL SUSPENSION 10 MG/5ML ( <i>paroxetine hcl</i> )	3	
SERTRALINE HCL ORAL CAPSULE 150 MG, 200 MG	3	SL (1 capsule per day.)
<i>sertraline hcl oral concentrate 20 mg/ml</i>	1	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	1	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG ( <i>olanzapine-fluoxetine hcl</i> )	3	SL (1 capsule per day)
<b>SEROTONIN MODULATORS - Drugs for Depression &amp; Psychosis</b>		
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	1	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG ( <i>vortioxetine hbr</i> )	3	ST; SL (1 tablet per day.)
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	SL (1 tablet per day)
<b>SUCCINIMIDES - Drugs for Seizures</b>		
CELONTIN ORAL CAPSULE 300 MG ( <i>methsuximide</i> )	3	
<i>ethosuximide oral capsule 250 mg</i>	1	
<i>ethosuximide oral solution 250 mg/5ml</i>	1	
<i>methsuximide oral capsule 300 mg</i>	1	
ZARONTIN ORAL CAPSULE 250 MG ( <i>ethosuximide</i> )	3	
ZARONTIN ORAL SOLUTION 250 MG/5ML ( <i>ethosuximide</i> )	3	
<b>THIOXANTHENES - Drugs for Depression &amp; Psychosis</b>		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<b>TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression &amp; Psychosis</b>		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	1	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	1	SL (1 tablet per day)
ENOVARX-AMITRIPTYLINE EXTERNAL KIT 2 %	3	PA
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG ( <i>desipramine hcl</i> )	3	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	1	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	1	
SILENOR ORAL TABLET 3 MG, 6 MG ( <i>doxepin hcl</i> )	3	SL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<b>VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System</b>		
AUSTEDO ORAL TABLET 12 MG, 9 MG ( <i>deutetrabenazine</i> )	2	PA; SL (4 tablets per day); SP
AUSTEDO ORAL TABLET 6 MG ( <i>deutetrabenazine</i> )	2	PA; SL (2 tablets per day); SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 6 MG ( <i>deutetrabenazine</i> )	2	SL (2 tablets per day.); SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG ( <i>deutetrabenazine</i> )	2	SL (42 tablets per 365 days.); SP
<i>tetrabenazine oral tablet 12.5 mg</i>	1	PA
<i>tetrabenazine oral tablet 25 mg</i>	1	PA; SP
<b>WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System</b>		
<i>armodafinil oral tablet 150 mg, 250 mg</i>	1	SL (1 tablet per day)
<i>armodafinil oral tablet 200 mg, 50 mg</i>	1	SL (1 tablet per day.)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	1	
<i>modafinil oral tablet 100 mg, 200 mg</i>	1	SL (1 tablet per day)
SUNOSI ORAL TABLET 150 MG, 75 MG ( <i>solriamfetol hcl</i> )	2	PA; SL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG ( <i>pitolisant hcl</i> )	3	PA; SL (2 tablets per day.); SP
<b>DENTAL AGENTS - Oral Care</b>		
<b>DENTAL AGENTS - Oral Care</b>		
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	
FLUORIMAX 5000 SENSITIVE DENTAL PASTE 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>DEVICES - Medical Supplies and Durable Medical Equipment</b>		
<b>DEVICES - Medical Supplies and Durable Medical Equipment</b>		
ACCU-CHEK AVIVA IN VITRO SOLUTION ( <i>blood glucose calibration</i> )	1	
ACCU-CHEK FASTCLIX LANCET KIT KIT ( <i>lancets misc.</i> )	1	
ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID ( <i>blood glucose calibration</i> )	3	
ACCU-CHEK GUIDE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	3	
ACCU-CHEK GUIDE ME KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	3	
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID ( <i>blood glucose calibration</i> )	1	
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT ( <i>lancets misc.</i> )	1	
AEROCHAMBER HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
AEROCHAMBER PLUS FLO-VU INTERM DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
AEROCHAMBER PLUS FLO-VU LARGE DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
AEROCHAMBER PLUS FLO-VU SMALL DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
ALCOHOL PREP PADS SHEET 70 %	3	
AQ INSULIN SYRINGE 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	2	SL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	SL (10 pen needles per day.)
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM	2	SL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	SL (10 pen needles per day.)
AUM PEN NEEDLE 32G X 4 MM , 32G X 5 MM , 32G X 6 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	SL (10 pen needles per day.)
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
AUTOLET LANCING DEVICE ( <i>lancet devices</i> )	3	
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" ( <i>needle (disp)</i> )	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" ( <i>needle (disp)</i> )	2	
BD SHARPS COLLECTOR ( <i>sharps container</i> )	3	
BD ULTRA-FINE INSULIN SYRINGES 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	2	SL (10 syringes per day.)
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML ( <i>insulin syringe/needle u-500</i> )	2	SL (10 syringes per day.)
BD ULTRA-FINE PEN NEEDLES 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
BREATHE COMFORT CHAMBER/ADULT DEVICE	2	
BREATHE COMFORT CHAMBER/CHILD DEVICE	2	
CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 25G X 5/8"	2	
CAREPOINT POLY HUB NEEDLE 21G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 22G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 27G X 1/2"	2	
CAREPOINT SAFETY 1ST NEEDLE 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8"	2	
CARESENS CONTROL SOLUTION A/B IN VITRO SOLUTION ( <i>blood glucose calibration</i> )	2	
CARESENS LANCETS 30G ( <i>lancets</i> )	3	
CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID ( <i>blood glucose calibration</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" ( <i>needle (disp)</i> )	2	
CARETOUCH LANCING/EJECTOR ( <i>lancet devices</i> )	3	
CEQUR SIMPLICITY 2U DEVICE ( <i>injection device for insulin</i> )	3	
CHEMSTRIP BG LOG BOOK ( <i>blood glucose monitoring suppl</i> )	1	
CLEVER CHOICE COMFORT EZ ( <i>lancets</i> )	3	
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
CONTOUR CONTROL IN VITRO LIQUID HIGH ( <i>blood glucose calibration</i> )	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL ( <i>blood glucose calibration</i> )	2	
CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL ( <i>blood glucose calibration</i> )	2	
CONTOUR NEXT MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	2	
CONTOUR NEXT ONE KIT ( <i>blood glucose monitoring suppl</i> )	2	
DEXCOM G6 RECEIVER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA; SL (1 kit per 999 days.)
DEXCOM G6 SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA; SL (3 sensors per month.)
DEXCOM G6 TRANSMITTER ( <i>continuous blood gluc transmit</i> )	3	PA; SL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.)
DEXCOM G7 RECEIVER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA; SL (1 kit per 999 days.)
DEXCOM G7 SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA; SL (3 sensors per month.)
DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	2	SL (10 syringes per day.)
EASIVENT ( <i>spacer/aero-holding chambers</i> )	2	
EASY COMFORT SHARPS CONTAINER	3	
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID ( <i>blood glucose calibration</i> )	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL ( <i>blood glucose calibration</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID ( <i>blood glucose calibration</i> )	3	
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
ENLITE GLUCOSE SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA
FLEXICHAMBER ADULT MASK/SMALL ( <i>spacer/aero-hold chamber mask</i> )	2	
FLEXICHAMBER CHILD MASK/LARGE ( <i>spacer/aero-hold chamber mask</i> )	2	
FLEXICHAMBER CHILD MASK/SMALL ( <i>spacer/aero-hold chamber mask</i> )	2	
FLEXICHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
FORTISCARE CONTROL IN VITRO SOLUTION HIGH , LOW , NORMAL ( <i>blood glucose calibration</i> )	2	
FREESTYLE LIBRE 14 DAY READER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA; SL (1 receiver per 999 days.)
FREESTYLE LIBRE 14 DAY SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA; SL (2 sensors per 21 days.)
FREESTYLE LIBRE 2 READER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA; SL (1 receiver per 999 days.)
FREESTYLE LIBRE 2 SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA; SL (2 sensors per 21 days.)
FREESTYLE LIBRE 3 READER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA
FREESTYLE LIBRE 3 SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA; SL (2 sensors per 21 days.)
FREESTYLE LIBRE READER DEVICE ( <i>continuous blood gluc receiver</i> )	3	PA; SL (1 kit per 999 days.)
GUARDIAN 4 GLUCOSE SENSOR ( <i>continuous blood gluc sensor</i> )	3	PA
GUARDIAN 4 TRANSMITTER ( <i>continuous blood gluc transmit</i> )	3	PA
GUARDIAN CONNECT TRANSMITTER ( <i>continuous blood gluc transmit</i> )	3	PA; SL (1 transmitter per 365 days.)
GUARDIAN LINK 3 TRANSMITTER ( <i>continuous blood gluc transmit</i> )	3	PA; SL (1 transmitter kit per 365 days.)
GUARDIAN SENSOR (3) ( <i>continuous blood gluc sensor</i> )	3	PA; SL (5 sensors per 24 days.)
GUARDIAN SENSOR 3	3	PA; SL (5 sensors per 24 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INPEN 100-BLUE-LILLY-HUMALOG DEVICE ( <i>injection device for insulin</i> )	3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE ( <i>injection device for insulin</i> )	3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE ( <i>injection device for insulin</i> )	3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE ( <i>injection device for insulin</i> )	3	
INPEN 100-PINK-LILLY-HUMALOG DEVICE ( <i>injection device for insulin</i> )	3	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE ( <i>injection device for insulin</i> )	3	
INSPIREASE RESERVOIR BAGS ( <i>spacer/aero-hold chamber bags</i> )	2	
INSULIN PEN NEEDLES 29G X 12.7MM , 29G X 12MM , 29G X 5MM , 29G X 8MM , 31G X 4 MM , 32G X 5 MM , 32G X 6 MM , 32G X 8 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
INSULIN PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM	2	SL (10 pen needles per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 32G X 5/16" 1 ML	2	SL (10 syringes per day.)
INSULIN SYRINGES 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	2	SL (10 syringes per day.)
LANCETS ( <i>lancets</i> )	1	
LANCETS ( <i>lancets</i> )	3	
MICROLET NEXT LANCING DEVICE ( <i>lancet devices</i> )	3	
NORDIPEN 5 INJECTION DEVICE ( <i>injection device</i> )	3	
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
NOVOFINE PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
NOVOPEN ECHO DEVICE ( <i>injection device for insulin</i> )	3	
OMNIPOD 5 G6 INTRO (GEN 5) KIT ( <i>insulin disposable pump</i> )	2	PA; SL (1 kit per 180 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OMNIPOD 5 G6 PODS (GEN 5) ( <i>insulin disposable pump</i> )	2	PA
ONETOUCH DELICA PLUS LANCING ( <i>lancet devices</i> )	1	
ONETOUCH DELICA SAFETY LANCING ( <i>lancet devices</i> )	1	
ONETOUCH ULTRA 2 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	1	
ONETOUCH ULTRA IN VITRO LIQUID ( <i>blood glucose calibration</i> )	1	
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH ( <i>blood glucose calibration</i> )	1	
ONETOUCH VERIO REFLECT KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	1	
PARI VORTEX ADULT MASK ( <i>spacer/aero-hold chamber mask</i> )	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID ( <i>blood glucose calibration</i> )	3	
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	SL (10 pen needles per day.)
RAYA SURE PEN NEEDLE 29G X 12MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM	2	SL (10 pen needles per day.)
SAFETY PEN NEEDLES 30G X 5 MM , 30G X 8 MM	2	SL (10 pen needles per day.)
SHARPS COLLECTOR	3	
SHARPS CONTAINER	3	
TECHLITE LANCETS 26G ( <i>lancets</i> )	3	
TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW ( <i>blood glucose calibration</i> )	2	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL ( <i>blood glucose calibration</i> )	2	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH ( <i>blood glucose calibration</i> )	2	
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
UNISTRIP CONTROL IN VITRO SOLUTION LOW ( <i>blood glucose calibration</i> )	3	
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	2	SL (10 syringes per day.)
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM ( <i>insulin pen needle</i> )	2	SL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G ( <i>lancets</i> )	3	
VERIFINE SAFE LANCET MINI 23G ( <i>lancets</i> )	3	
VERIFINE SAFE LANCET MINI 28G ( <i>lancets</i> )	3	
VERIFINE SAFE LANCET MINI 30G ( <i>lancets</i> )	3	
VERIFINE SHARPS CONTAINER ( <i>sharps container</i> )	3	
VORTEX VALVED HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	2	
<b>DIAGNOSTIC AGENTS</b>		
<b>ADRENOCORTICAL INSUFFICIENCY</b>		
ACTHAR INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	3	PA; ST; SL (20 ml per 24 days.); SP
CORTROPHIN INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	3	PA; ST; SL (20 ml per 24 days.); SP
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG ( <i>cosyntropin</i> )	3	
<i>cosyntropin injection solution reconstituted 0.25 mg</i>	1	
<b>CARDIAC FUNCTION</b>		
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
<b>DIABETES MELLITUS</b>		
ACCU-CHEK GUIDE IN VITRO STRIP ( <i>glucose blood</i> )	3	SL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR NEXT TEST IN VITRO STRIP ( <i>glucose blood</i> )	2	SL (51 strips per prescription without history 204 strips per prescription with history.)
FORA TEST N'GO ADV-VOICE-6 CON IN VITRO STRIP ( <i>ketone blood test</i> )	3	
ONETOUCH ULTRA IN VITRO STRIP ( <i>glucose blood</i> )	1	SL (51 strips per prescription without history 204 strips per prescription with history.)
ONETOUCH VERIO IN VITRO STRIP ( <i>glucose blood</i> )	1	SL (51 strips per prescription without history 204 strips per prescription with history.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>DIAGNOSTIC AGENTS</b>		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
CARESTART COVID-19 HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
CLEARDETECT COVID-19 AG HOME IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
CLINITEST RAPID COVID-19 TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
COVID-19 AT HOME ANTIGEN TEST IN VITRO KIT	3	SM
COVID-19 AT-HOME TEST IN VITRO KIT	3	SM
DIATRUST COVID-19 HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
ELLUME COVID-19 HOME TEST IN VITRO KIT	3	SM
FASTEP COVID-19 ANTIGEN TEST IN VITRO KIT	3	SM
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
IHEALTH COVID-19 RAPID TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
INDICAID COVID-19 RAPID TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
ON/GO COVID-19 ANTIGEN TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
ON/GO ONE COVID-19 HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
PILOT COVID-19 AT-HOME TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
SPEEDY SWAB COVID-19 ANTIGEN IN VITRO KIT ( <i>covid-19 at home test</i> )	3	SM
<b>KETONES</b>		
CHEMSTRIP K IN VITRO STRIP ( <i>acetone (urine) test</i> )	2	
KETONE TEST IN VITRO STRIP	2	
KETOSTIX IN VITRO STRIP ( <i>acetone (urine) test</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>PHEOCHROMOCYTOMA</b>		
DEMSEER ORAL CAPSULE 250 MG ( <i>metyrosine</i> )	3	
<i>metyrosine oral capsule 250 mg</i>	1	
<b>URINE AND FECES CONTENTS</b>		
CHEMSTRIP UGK IN VITRO STRIP ( <i>urine glucose-ketones test</i> )	3	
CVS KETONE CARE IN VITRO STRIP ( <i>urine glucose-ketones test</i> )	2	
KETO-DIASTIX IN VITRO STRIP ( <i>urine glucose-ketones test</i> )	3	
<b>DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants</b>		
<b>DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants</b>		
<i>formaldehyde external solution 10 %, 37 %</i>	1	
<i>glutaraldehyde external solution 25 %</i>	1	
<b>ELECTROLYTIC, CALORIC, AND WATER BALANCE</b>		
<b>ACIDIFYING AGENTS</b>		
K-PHOS NO 2 ORAL TABLET 305-700 MG ( <i>pot &amp; sod ac phosphates</i> )	2	
<b>ALKALINIZING AGENTS</b>		
<i>cytra k crystals oral packet 3300-1002 mg</i>	1	
ORACIT ORAL SOLUTION 490-640 MG/5ML ( <i>sod citrate-citric acid</i> )	2	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	1	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	1	
<i>sod citrate-citric acid oral solution 500-334 mg/5ml</i>	1	
<i>tricitrates oral solution 550-500-334 mg/5ml</i>	1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) ( <i>potassium citrate</i> )	3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) ( <i>potassium citrate</i> )	3	
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE 5 MEQ (540 MG) ( <i>potassium citrate</i> )	3	
<b>AMMONIA DETOXICANTS</b>		
<i>carglumic acid oral tablet soluble 200 mg</i>	1	PA; SP
<i>constulose oral solution 10 gm/15ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>enulose oral solution 10 gm/15ml</i>	1	
<i>generlac oral solution 10 gm/15ml</i>	1	
KRISTALOSE ORAL PACKET 10 GM, 20 GM ( <i>lactulose</i> )	3	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	1	
LITHOSTAT ORAL TABLET 250 MG ( <i>acetohydroxamic acid</i> )	3	
RAVICTI ORAL LIQUID 1.1 GM/ML ( <i>glycerol phenylbutyrate</i> )	3	PA; ST; SL (17.5 ml per day.); SP
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	1	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	1	PA
<b>CALORIC AGENTS - Drugs for Nutrition</b>		
<i>aminoamrms oral capsule</i>	1	
<i>aminoreliefrms oral capsule</i>	1	
DOJOLVI ORAL LIQUID 100 % ( <i>triheptanoin</i> )	3	PA; SP
L-CYSTINE POWDER	3	
L-ISOLEUCINE POWDER	3	PA
<b>CARBONIC ANHYDRASE INHIBITORS - Drugs for Water Balance</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<b>DIURETICS, MISCELLANEOUS - Drugs for Water Balance</b>		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
<b>LOOP DIURETICS - Drugs for Water Balance</b>		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
BUMEX ORAL TABLET 0.5 MG ( <i>bumetanide</i> )	3	
<i>ethacrynic acid oral tablet 25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML ( <i>furosemide</i> )	3	PA
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG ( <i>furosemide</i> )	3	
SOAANZ ORAL TABLET 20 MG ( <i>torseamide</i> )	3	SL (1 tablet per day.)
SOAANZ ORAL TABLET 40 MG, 60 MG ( <i>torseamide</i> )	3	SL (2 tablets per day.)
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
<b>OTHER ION-REMOVING AGENTS</b>		
RADIOGARDASE ORAL CAPSULE 0.5 GM ( <i>prussian blue insoluble</i> )	3	
<b>PHOSPHATE-REMOVING AGENTS</b>		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	1	
<i>calcium acetate oral tablet 667 mg</i>	1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG ( <i>lanthanum carbonate</i> )	3	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	1	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	1	
<i>sevelamer carbonate oral tablet 800 mg</i>	1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	1	
VELPHORO ORAL TABLET CHEWABLE 500 MG ( <i>sucroferric oxyhydroxide</i> )	2	
XPHOZAH ORAL TABLET 20 MG, 30 MG ( <i>tenapanor hcl (ckd)</i> )	3	PA; SL (2 tablets per day.); SP
<b>POTASSIUM-REMOVING AGENTS</b>		
LOKELMA ORAL PACKET 10 GM ( <i>sodium zirconium cyclosilicate</i> )	3	SL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM ( <i>sodium zirconium cyclosilicate</i> )	3	SL (3 packets per day.)
<i>sodium polystyrene sulfonate oral powder</i>	1	
SPS ORAL SUSPENSION 15 GM/60ML ( <i>sodium polystyrene sulfonate</i> )	3	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM ( <i>patiromer sorbitex calcium</i> )	3	SL (1 Packet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XPHOZAH ORAL TABLET 30 MG ( <i>tenapanor hcl (ckd)</i> )	3	PA; SL (2 tablets per day.); SP
<b>POTASSIUM-SPARING DIURETICS - Drugs for Water Balance</b>		
<i>amiloride hcl oral tablet 5 mg</i>	1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML ( <i>spironolactone</i> )	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	1	
MAXZIDE ORAL TABLET 75-50 MG ( <i>triamterene-hctz</i> )	3	
MAXZIDE-25 ORAL TABLET 37.5-25 MG ( <i>triamterene-hctz</i> )	3	
<i>spironolactone oral suspension 25 mg/5ml</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	
<b>REPLACEMENT PREPARATIONS</b>		
CALCIFOL ORAL WAFER 1342-1.6 MG ( <i>ca carb-fa-d-b6-b12-boron-mg</i> )	3	
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	1	
<i>calcium acetate oral tablet 667 mg</i>	1	
EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ ( <i>potassium bicarb-citric acid</i> )	2	
<i>effe-r-k oral tablet effervescent 25 meq</i>	1	
GALZIN ORAL CAPSULE 25 MG, 50 MG ( <i>zinc acetate (oral)</i> )	3	
<i>klor-con 10 oral tablet extended release 10 meq</i>	1	
<i>klor-con m10 oral tablet extended release 10 meq</i>	1	
<i>klor-con m15 oral tablet extended release 15 meq</i>	1	
<i>klor-con m20 oral tablet extended release 20 meq</i>	1	
<i>klor-con oral packet 20 meq</i>	1	
<i>klor-con oral tablet extended release 8 meq</i>	1	
<i>klor-con/ef oral tablet effervescent 25 meq</i>	1	
K-PHOS ORAL TABLET 500 MG ( <i>potassium phosphate monobasic</i> )	2	
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG ( <i>k phos mono-sod phos di &amp; mono</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>k-prime oral tablet effervescent 25 meq</i>	1	
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ ( <i>potassium chloride</i> )	3	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML- % ( <i>insulin regular(human) in nacl</i> )	3	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG ( <i>k phos mono-sod phos di &amp; mono</i> )	2	
<i>phosphorous oral tablet 155-852-130 mg</i>	1	
<i>phospho-trin 250 neutral oral tablet 155-852-130 mg</i>	1	
PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION 22-4-1 MEQ-MMOL/L	3	
PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION 32-4- 2.5-1 MEQ-MMOL/L	3	
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq</i>	1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	1	
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq</i>	1	
<i>potassium chloride oral packet 20 meq</i>	1	
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	1	
PREMESISRX ORAL TABLET 1 MG ( <i>prenatal ca-b6-b12-fa- ginger</i> )	3	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat- feasp-meth-fa-dha w/o a</i> )	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG ( <i>prenat- fecbn-feasp-meth-fa-dha</i> )	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG ( <i>prenat mv- min-methylfolate-fa</i> )	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG ( <i>prenat- feasp-meth-fa-dha w/o a</i> )	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PRENATVITE COMPLETE ORAL TABLET 1 MG	3	
PRENATVITE PLUS ORAL TABLET 1 MG	3	
PRENATVITE RX ORAL TABLET 0.8 MG	3	
PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION 22-4 MEQ/L ( <i>bicarb-dextrose-k (crrt)</i> )	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION 32-2.5 MEQ/L ( <i>bicarb-dextrose-ca (crrt)</i> )	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION 32-2 MEQ/L ( <i>bicarb-dextrose-k (crrt)</i> )	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION 32-2-3.5 MEQ/L ( <i>bicarb-dextrose-k-ca (crrt)</i> )	3	
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION 32-4-1.2 MEQ/L ( <i>bicarb-dextrose-k-mg (crrt)</i> )	3	
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5 MEQ/L ( <i>bicarb-dextrose-k-ca (crrt)</i> )	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION 32-1.2 MEQ/L ( <i>bicarb-mg (crrt)</i> )	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG ( <i>prenat-fe poly-methfol-fa-dha</i> )	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	1	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<b>THIAZIDE DIURETICS - Drugs for Water Balance</b>		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG ( <i>quinapril-hydrochlorothiazide</i> )	3	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	2	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG ( <i>azilsartan-chlorthalidone</i> )	3	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG ( <i>benazepril-hydrochlorothiazide</i> )	3	
MAXZIDE ORAL TABLET 75-50 MG ( <i>triamterene-hctz</i> )	3	
MAXZIDE-25 ORAL TABLET 37.5-25 MG ( <i>triamterene-hctz</i> )	3	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	1	
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	
<b>THIAZIDE-LIKE DIURETICS - Drugs for Water Balance</b>		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
THALITONE ORAL TABLET 15 MG ( <i>chlorthalidone</i> )	3	
<b>URICOSURIC AGENTS</b>		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
<i>probenecid oral tablet 500 mg</i>	1	
<b>VASOPRESSIN ANTAGONISTS - Drugs for Water Balance</b>		
JYNARQUE ORAL TABLET 15 MG, 30 MG ( <i>tolvaptan</i> )	2	PA; SL (2 tablets per day.); SP
JYNARQUE ORAL TABLET THERAPY PACK 15 MG ( <i>tolvaptan</i> )	2	PA; SL (2 tablets per day.); SP
JYNARQUE ORAL TABLET THERAPY PACK 30 & 15 MG ( <i>tolvaptan</i> )	2	PA; SL (2 tablets per day.)
JYNARQUE ORAL TABLET THERAPY PACK 45 & 15 MG, 60 & 30 MG, 90 & 30 MG ( <i>tolvaptan</i> )	2	PA; SL (2 tablets per day); SP
SAMSCA ORAL TABLET 15 MG ( <i>tolvaptan</i> )	3	PA; SL (90 tablets per 365 days.); SP
SAMSCA ORAL TABLET 30 MG ( <i>tolvaptan</i> )	3	PA; SL (60 tablets per 365 days.); SP
<i>tolvaptan oral tablet 15 mg</i>	1	PA; SP
<i>tolvaptan oral tablet 30 mg</i>	1	PA; SL (2 tablets per day.); SP
<b>ENZYMES</b>		
<b>ENZYMES</b>		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	2	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML ( <i>pegvaliase-pqpz</i> )	3	PA; ST; SL (7 mL per year.); SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML ( <i>pegvaliase-pqpz</i> )	3	PA; ST; SL (6 syringes per 365 days.); SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML ( <i>pegvaliase-pqpz</i> )	3	PA; ST; SL (1 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML ( <i>dornase alfa</i> )	2	PA; SL (5 ml per day.); SP
SANTYL EXTERNAL OINTMENT 250 UNIT/GM ( <i>collagenase</i> )	3	
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML ( <i>asfotase alfa</i> )	2	PA; SL (5.4 ml per month.); SP
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML ( <i>asfotase alfa</i> )	2	PA; SL (8.4 ml per month.); SP
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML ( <i>asfotase alfa</i> )	2	PA; SL (12 ml tablets per month.); SP
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML ( <i>asfotase alfa</i> )	2	PA; SL (9.6 ml (12 vials) per month.); SP
SUCRAID ORAL SOLUTION 8500 UNIT/ML ( <i>sacrosidase</i> )	2	PA; SP
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	2	
<b>EYE, EAR, NOSE AND THROAT (EENT) PREPS.</b>		
<b>ALPHA-ADRENERGIC AGONISTS (EENT) - Drugs for the Eye</b>		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % ( <i>brimonidine tartrate</i> )	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % ( <i>brimonidine tartrate</i> )	3	
<i>brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %</i>	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % ( <i>brimonidine tartrate-timolol</i> )	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % ( <i>brinzolamide-brimonidine</i> )	3	
<b>ANTIALLERGIC AGENTS - Drugs for Allergy</b>		
ALOCRILOPHTHALMIC SOLUTION 2 % ( <i>nedocromil sodium</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ALOMIDE OPHTHALMIC SOLUTION 0.1 % ( <i>Iodoxamide tromethamine</i> )	3	
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	
<i>bepotastine besilate ophthalmic solution 1.5 %</i>	1	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	1	
<i>olopatadine hcl nasal solution 0.6 %</i>	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT ( <i>olopatadine-mometasone</i> )	3	
<b>ANTIBACTERIALS (EENT) - Drugs for Infections</b>		
AZASITE OPHTHALMIC SOLUTION 1 % ( <i>azithromycin</i> )	3	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % ( <i>besifloxacin hcl</i> )	3	
CETRAXAL OTIC SOLUTION 0.2 % ( <i>ciprofloxacin hcl</i> )	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 % ( <i>ciprofloxacin hcl</i> )	3	
CIPRO HC OTIC SUSPENSION 0.2-1 % ( <i>ciprofloxacin-hydrocortisone</i> )	3	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	1	
<i>ciprofloxacin hcl otic solution 0.2 %</i>	1	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML ( <i>neomycin-colist-hc-thonzonium</i> )	3	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	1	H
<i>gatifloxacin ophthalmic solution 0.5 %</i>	1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	
<i>levofloxacin ophthalmic solution 1.5 %</i>	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 ( <i>neomycin-polymyxin-dexameth</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MAXITROL OPHTHALMIC SUSPENSION 0.1 % ( <i>neomycin-polymyxin-dexameth</i> )	3	
MITOSOL OPHTHALMIC KIT 0.2 MG ( <i>mitomycin</i> )	3	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	1	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	1	
<i>neo-polycin hc ophthalmic ointment 1 %</i>	1	
<i>neo-polycin ophthalmic ointment 3.5-400-10000</i>	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % ( <i>ofloxacin</i> )	3	
<i>ofloxacin ophthalmic solution 0.3 %</i>	1	
<i>ofloxacin otic solution 0.3 %</i>	1	
<i>polycin ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	1	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % ( <i>tobramycin-dexamethasone</i> )	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % ( <i>tobramycin-dexamethasone</i> )	3	
<i>tobramycin ophthalmic solution 0.3 %</i>	1	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % ( <i>tobramycin</i> )	3	
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
VIGAMOX OPHTHALMIC SOLUTION 0.5 % ( <i>moxifloxacin hcl</i> )	3	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % ( <i>loteprednol-tobramycin</i> )	3	
<b>ANTIFUNGALS (EENT) - Drugs for Infections</b>		
NATACYN OPHTHALMIC SUSPENSION 5 % ( <i>natamycin</i> )	3	
<b>ANTIVIRALS (EENT) - Drugs for Infections</b>		
<i>trifluridine ophthalmic solution 1 %</i>	1	
ZIRGAN OPHTHALMIC GEL 0.15 % ( <i>ganciclovir</i> )	3	
<b>BETA-ADRENERGIC BLOCKING AGENTS (EENT) - Drugs for the Eye</b>		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % ( <i>timolol hemihydrate</i> )	2	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % ( <i>betaxolol hcl</i> )	3	
<i>carteolol hcl ophthalmic solution 1 %</i>	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % ( <i>brimonidine tartrate-timolol</i> )	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % ( <i>dorzolamide hcl-timolol mal</i> )	3	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	
<i>dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %</i>	1	
ISTALOL OPHTHALMIC SOLUTION 0.5 % ( <i>timolol maleate</i> )	3	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	1	
TIMOPTIC OCULOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % ( <i>timolol maleate</i> )	3	
<b>CARBONIC ANHYDRASE INHIBITORS (EENT) - Drugs for the Eye</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>brinzolamide ophthalmic suspension 1 %</i>	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % ( <i>dorzolamide hcl-timolol mal</i> )	3	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	3	
<i>dorzolamide hcl solution 2 % ophthalmic</i>	1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	
<i>dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %</i>	1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % ( <i>brinzolamide-brimonidine</i> )	3	
<b>CORTICOSTEROIDS (EENT) - Drugs for Inflammation</b>		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT ( <i>albuterol-budesonide</i> )	3	
ALREX OPHTHALMIC SUSPENSION 0.2 % ( <i>loteprednol etabonate</i> )	3	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	1	
CIPRO HC OTIC SUSPENSION 0.2-1 % ( <i>ciprofloxacin-hydrocortisone</i> )	3	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML ( <i>neomycin-colist-hc-thonzonium</i> )	3	
DERMOTIC OTIC OIL 0.01 % ( <i>fluocinolone acetonide</i> )	3	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	1	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	1	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
DUREZOL OPHTHALMIC EMULSION 0.05 % ( <i>difluprednate</i> )	3	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % ( <i>loteprednol etabonate</i> )	2	
<i>flac otic oil 0.01 %</i>	1	
FLAREX OPHTHALMIC SUSPENSION 0.1 % ( <i>fluorometholone acetate</i> )	2	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluocinolone acetonide otic oil 0.01 %</i>	1	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (fluorometholone)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (fluorometholone)	3	
hydrocortisone-acetic acid otic solution 1-2 %	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (loteprednol etabonate)	3	
LOTEMAX OPHTHALMIC GEL 0.5 % (loteprednol etabonate)	3	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (loteprednol etabonate)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (loteprednol etabonate)	3	
loteprednol etabonate ophthalmic gel 0.5 %	1	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (dexamethasone)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (neomycin-polymyxin-dexameth)	3	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (neomycin-polymyxin-dexameth)	3	
mometasone furoate nasal suspension 50 mcg/act	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
neo-polycin hc ophthalmic ointment 1 %	1	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (ciclesonide)	3	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (prednisolone acetate)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (beclomethasone diprop (nasal))	3	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (beclomethasone diprop (nasal))	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT ( <i>olopatadine-mometasone</i> )	3	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % ( <i>tobramycin-dexamethasone</i> )	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % ( <i>tobramycin-dexamethasone</i> )	3	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	1	
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT ( <i>ciclesonide</i> )	3	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % ( <i>loteprednol-tobramycin</i> )	3	
<b>EENT ANTI-INFECTIVES, MISCELLANEOUS - Drugs for Infections</b>		
ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % ( <i>silver nitrate-pot nitrate</i> )	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % ( <i>povidone-iodine</i> )	3	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % ( <i>chlorhexidine gluconate</i> )	3	
<i>periogard mouth/throat solution 0.12 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % ( <i>pramoxine-chloroxylonol</i> )	3	
<i>silver nitrate external solution 0.5 %</i>	1	
<b>EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation</b>		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % ( <i>cyclosporine</i> )	3	PA; SL (5.5 mL (1 bottle) per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % ( <i>cyclosporine</i> )	1	PA
XIIDRA OPHTHALMIC SOLUTION 5 % ( <i>lifitegrast</i> )	2	PA
<b>EENT DRUGS, MISCELLANEOUS</b>		
<i>acetic acid otic solution 2 %</i>	1	
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	1	
AQUORAL MOUTH/THROAT SOLUTION ( <i>artificial saliva</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % ( <i>cysteamine hcl</i> )	3	PA; SL (20 mL per 21 days)
CYSTARAN OPHTHALMIC SOLUTION 0.44 % ( <i>cysteamine hcl</i> )	2	PA; SL (60 ml (4 bottles) per month.); SP
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % ( <i>sulfuric acid-sulf phenolics</i> )	2	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % ( <i>apraclonidine hcl</i> )	3	
LACRISERT OPHTHALMIC INSERT 5 MG ( <i>artificial tear insert</i> )	2	
MUCOSITISRX MOUTH/THROAT PACKET ( <i>artificial saliva</i> )	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % ( <i>cenegermin-bkbj</i> )	3	PA; SL (1 ml per day and 56 ml per 365 days.); SP
SALIVAMAX MOUTH/THROAT PACKET ( <i>artificial saliva</i> )	3	
TYRVAYA NASAL SOLUTION 0.03 MG/ACT ( <i>varenicline tartrate</i> )	3	PA; SL (0.28 ml per day.)
<b>EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation</b>		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % ( <i>ketorolac tromethamine</i> )	3	
ACULAR OPHTHALMIC SOLUTION 0.5 % ( <i>ketorolac tromethamine</i> )	3	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % ( <i>ketorolac tromethamine</i> )	3	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	1	
<i>bromfenac sodium ophthalmic solution 0.07 %, 0.075 %</i>	1	
BROMSITE OPHTHALMIC SOLUTION 0.075 % ( <i>bromfenac sodium</i> )	3	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	1	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % ( <i>nepafenac</i> )	3	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	1	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % ( <i>nepafenac</i> )	3	
PROLENSA OPHTHALMIC SOLUTION 0.07 % ( <i>bromfenac sodium</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
<b>LOCAL ANESTHETICS (EENT) - Drugs for Numbing</b>		
AKTEN OPHTHALMIC GEL 3.5 % ( <i>lidocaine hcl</i> )	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % ( <i>proparacaine hcl</i> )	3	
ALTACAIN OPHTHALMIC SOLUTION 0.5 % ( <i>tetracaine hcl</i> )	3	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
<i>lidocaine hcl mouth/throat solution 4 %</i>	1	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	1	
PRAMOTIC OTIC LIQUID 1-0.1 % ( <i>pramoxine-chloroxylonol</i> )	3	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	1	
<b>MIOTICS - Drugs for the Eye</b>		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % ( <i>echothiophate iodide</i> )	2	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
<b>MYDRIATICS - Drugs for the Eye</b>		
<i>altafrin ophthalmic solution 10 %, 2.5 %</i>	1	
<i>atropine sulfate ophthalmic ointment 1 %</i>	1	
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % ( <i>cyclopentolate hcl</i> )	3	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % ( <i>cyclopentolate-phenylephrine</i> )	3	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
<b>PROSTAGLANDIN ANALOGS - Drugs for the Eye</b>		
<i>bimatoprost ophthalmic solution 0.03 %</i>	1	
LATANOPROST OIL	3	PA
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
LATANOPROST POWDER	3	PA
LUMIGAN OPHTHALMIC SOLUTION 0.01 % ( <i>bimatoprost</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % ( <i>netarsudil-latanoprost</i> )	3	
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	1	ST
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	1	
XELPROS OPHTHALMIC EMULSION 0.005 % ( <i>latanoprost</i> )	3	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % ( <i>tafluprost</i> )	3	ST
<b>RHO KINASE INHIBITORS - Drugs for the Eye</b>		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % ( <i>netarsudil dimesylate</i> )	3	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % ( <i>netarsudil-latanoprost</i> )	3	
<b>VASOCONSTRICTORS</b>		
ADRENALIN NASAL SOLUTION 0.1 % ( <i>epinephrine hcl (nasal)</i> )	2	
<i>altafrin ophthalmic solution 10 %, 2.5 %</i>	1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % ( <i>cyclopentolate-phenylephrine</i> )	3	
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
UPNEEQ OPHTHALMIC SOLUTION 0.1 % ( <i>oxymetazoline hcl</i> )	3	PA
<b>GASTROINTESTINAL DRUGS</b>		
<b>ANTACIDS AND ADSORBENTS</b>		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
<b>GASTROINTESTINAL DRUGS - Drugs for the Stomach</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea</b>		
AKYNZEO ORAL CAPSULE 300-0.5 MG ( <i>netupitant-palonosetron</i> )	3	
ANZEMET ORAL TABLET 50 MG ( <i>dolasetron mesylate</i> )	3	
<i>granisetron hcl oral tablet 1 mg</i>	1	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	1	
<i>ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg</i>	1	
<i>ondansetron odt oral tablet dispersible 4 mg, 8 mg</i>	1	
<b>ANTIDIARRHEA AGENTS - Drugs for Diarrhea</b>		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	
LOMOTIL ORAL TABLET 2.5-0.025 MG ( <i>diphenoxylate-atropine</i> )	3	
MOTOFEN ORAL TABLET 1-0.025 MG ( <i>difenoxin-atropine</i> )	3	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG ( <i>crofelemer</i> )	3	PA; SL (2 tablets per day.)
<i>opium oral tincture 10 mg/ml (1%)</i>	1	
PYLERA ORAL CAPSULE 140-125-125 MG ( <i>bis subcit-metronid-tetracyc</i> )	3	SL (120 capsules per 180 days.)
XERMELO ORAL TABLET 250 MG ( <i>telotristat etiprate</i> )	3	PA; SL (3 tablets per day); SP
<b>ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea</b>		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	1	
MARINOL ORAL CAPSULE 2.5 MG ( <i>dronabinol</i> )	3	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethegan rectal suppository 12.5 mg, 25 mg, 50 mg</i>	1	
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	1	
SYNDROS ORAL SOLUTION 5 MG/ML ( <i>dronabinol</i> )	3	SL (4 ml per day)
<b>ANTIFLATULENTS - Drugs for Gas</b>		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
<b>ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea</b>		
<i>compro rectal suppository 25 mg</i>	1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	
<i>prochlorperazine rectal suppository 25 mg</i>	1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	1	
<b>ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation</b>		
<i>alose tron hcl oral tablet 0.5 mg, 1 mg</i>	1	PA; SL (2 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM ( <i>mesalamine</i> )	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG ( <i>sulfasalazine</i> )	3	
AZULFIDINE ORAL TABLET 500 MG ( <i>sulfasalazine</i> )	3	
<i>balsalazide disodium oral capsule 750 mg</i>	1	
DIPENTUM ORAL CAPSULE 250 MG ( <i>olsalazine sodium</i> )	3	
<i>mesalamine oral capsule delayed release 400 mg</i>	1	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	1	
<i>mesalamine rectal enema 4 gm</i>	1	
<i>mesalamine rectal suppository 1000 mg</i>	1	SL (1 suppository per day.)
<i>mesalamine-cleanser rectal kit 4 gm</i>	1	SL (4 grams per month.)
ROWASA RECTAL KIT 4 GM ( <i>mesalamine-cleanser</i> )	3	SL (4 grams per month.)
SFROWASA RECTAL ENEMA 4 GM/60ML ( <i>mesalamine</i> )	3	
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<b>ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid</b>		
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	1	SL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG ( <i>bis subcit-metronid-tetracyc</i> )	3	SL (120 capsules per 180 days.)
<b>ANTIULCER AGENTS AND ACID SUPPRESSANTS - Drugs for Ulcers and Stomach Acid</b>		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLAGYL ORAL CAPSULE 375 MG ( <i>metronidazole</i> )	3	
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML ( <i>metronidazole benzoate</i> )	3	PA
<i>metronidazole oral capsule 375 mg</i>	1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	1	
<b>CATHARTICS AND LAXATIVES - Drugs for Constipation</b>		
<i>bisacodyl ec oral tablet delayed release 5 mg</i>	E	H
<i>bisacodyl oral tablet delayed release 5 mg</i>	E	H
<i>citroma oral solution 1.745 gm/30ml</i>	E	H
<i>clearlax oral powder 17 gm/scoop</i>	E	H
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML ( <i>sod picosulfate-mag ox-cit acd</i> )	2	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
<i>ft clearlax oral powder 17 gm/scoop</i>	E	H
<i>ft laxative oral tablet delayed release 5 mg</i>	E	H
<i>ft magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
<i>gavilax oral powder 17 gm/scoop</i>	E	H
<i>gavilyte-c oral solution reconstituted 240 gm</i>	1	H
<i>gavilyte-g oral solution reconstituted 236 gm</i>	1	H
<i>gentle laxative oral tablet delayed release 5 mg</i>	E	H
<i>gentlelax oral powder 17 gm/scoop</i>	E	H
<i>glycolax oral powder 17 gm/scoop</i>	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM ( <i>peg 3350-kcl-nabcb-nacl-nasulf</i> )	3	
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
<i>mineral oil heavy oral oil</i>	1	
<i>mm clearlax oral powder 17 gm/scoop</i>	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM ( <i>peg-kcl-nacl-nasulf-na asc-c</i> )	2	
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml</i>	1	
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	1	H
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	1	
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	1	
PEG-PREP ORAL KIT 5-210 MG-GM ( <i>bisacodyl-peg-kcl-nabicar-nacl</i> )	3	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM ( <i>peg-kcl-nacl-nasulf-na asc-c</i> )	2	
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	E	H
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
<i>qc magnesium citrate oral solution 1.745 gm/30ml</i>	E	H
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM ( <i>peg 3350-kcl-nacl-nasulf-mgsul</i> )	3	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML ( <i>na sulfate-k sulfate-mg sulf</i> )	3	
SUTAB ORAL TABLET 1479-225-188 MG ( <i>sodium sulfate-mag sulfate-kcl</i> )	2	H
<b>CHOLELITHOLYTIC AGENTS - Drugs for the Stomach</b>		
CHENODAL ORAL TABLET 250 MG ( <i>chenodiol</i> )	3	ST; SP
<i>ursodiol oral capsule 300 mg</i>	1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	1	
URSODIOL+SYRSPEND SF ORAL SUSPENSION 30 MG/ML ( <i>ursodiol</i> )	3	PA
<b>DIGESTANTS - Drugs for the Stomach</b>		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	2	
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	3	ST

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	2	
<b>GI DRUGS, MISCELLANEOUS - Drugs for the Stomach</b>		
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
<i>alvimopan oral capsule 12 mg</i>	1	
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.4 ml per day.); SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG ( <i>odevixibat</i> )	3	PA; SL (2 capsules per day.); SP
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG ( <i>odevixibat</i> )	3	PA; SL (1 capsule per day.); SP
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG ( <i>odevixibat</i> )	3	PA; SL (2 capsules per day.); SP
CHOLBAM ORAL CAPSULE 250 MG ( <i>cholic acid</i> )	2	PA; SL (4 capsules per day.); SP
CHOLBAM ORAL CAPSULE 50 MG ( <i>cholic acid</i> )	2	PA; SP
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (6 mL per 365 days.); SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (1 kit per 21 days.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (0.08 syringe per day.); SP
ENTEREG ORAL CAPSULE 12 MG ( <i>alvimopan</i> )	3	
GATTEX SUBCUTANEOUS KIT 5 MG ( <i>teduglutide (rdna)</i> )	2	PA; SL (1 vial per day.); SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (6 pens (1 kit) per year.); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 kits per year); SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (3 syringes per year); SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG ( <i>linaclotide</i> )	2	PA; SL (1 capsule per day.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML ( <i>maralixibat chloride</i> )	3	PA; SL (3 mL per day.); SP
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	1	PA; SL (2 capsules per day.)
MOTEGRITY ORAL TABLET 1 MG, 2 MG ( <i>prucalopride succinate</i> )	3	PA; SL (1 tablet per day.)
OCALIVA ORAL TABLET 10 MG, 5 MG ( <i>obeticholic acid</i> )	3	PA; ST; SL (1 tablet per day.); SP
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
ORLISTAT ORAL CAPSULE 120 MG	3	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML ( <i>methylnaltrexone bromide</i> )	3	SL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	3	SL (0.4 ml per day.)
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML ( <i>octreotide acetate</i> )	3	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (1.2 ml per 42 days.); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (2.4 mL per 42 days.); SP
SYMPROIC ORAL TABLET 0.2 MG ( <i>naldemedine tosylate</i> )	2	PA; SL (1 tablet per day)
TRULANCE ORAL TABLET 3 MG ( <i>plecanatide</i> )	3	PA; ST; SL (1 tablet per day)
VIBERZI ORAL TABLET 100 MG, 75 MG ( <i>eluxadoline</i> )	3	SL (2 tablets per day.)
XENICAL ORAL CAPSULE 120 MG ( <i>orlistat</i> )	3	PA
XPHOZAH ORAL TABLET 30 MG ( <i>tenapanor hcl (ckd)</i> )	3	PA; SL (2 tablets per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid</b>		
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
<b>NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea</b>		
AKYNZEO ORAL CAPSULE 300-0.5 MG ( <i>netupitant-palonosetron</i> )	3	
<i>aprepitant oral 80 &amp; 125 mg</i>	1	
<i>aprepitant oral capsule 125 mg, 40 mg, 80 &amp; 125 mg, 80 mg</i>	1	
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML ( <i>aprepitant</i> )	2	
<b>PROKINETIC AGENTS - Drugs for the Stomach</b>		
<i>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</i>	1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
<i>metoclopramide hcl oral tablet dispersible 5 mg</i>	1	
REGLAN ORAL TABLET 10 MG, 5 MG ( <i>metoclopramide hcl</i> )	3	
<b>PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid</b>		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG ( <i>misoprostol</i> )	3	SM
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	1	
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	1	SM
<b>PROTECTANTS - Drugs for Ulcers and Stomach Acid</b>		
<i>sucralfate oral suspension 1 gm/10ml</i>	1	
<i>sucralfate oral tablet 1 gm</i>	1	
<b>PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid</b>		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	1	SL (112 capsules and tablets (1 Package) per 180 days.)
<i>esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg</i>	1	SL (1 packet per day)
FIRST PANTOPRAZOLE ORAL SUSPENSION 4 MG/ML ( <i>pantoprazole sodium</i> )	3	
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML ( <i>lansoprazole</i> )	3	PA
FIRST-OMEPRAZOLE ORAL SUSPENSION 2 MG/ML ( <i>omeprazole</i> )	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	1	SL (1 tablet per day.)
NEXIUM ORAL PACKET 10 MG, 20 MG, 40 MG ( <i>esomeprazole magnesium</i> )	3	SL (1 packet per day)
NEXIUM ORAL PACKET 2.5 MG, 5 MG ( <i>esomeprazole magnesium</i> )	3	SL (1 packet per day.)
OMECLAMOX-PAK ORAL 500-500-20 MG ( <i>amoxicill-clarithro-omeprazole</i> )	3	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	
OMEPRAZOLE+SYRSPEND SF ALKA ORAL SUSPENSION 2 MG/ML ( <i>omeprazole</i> )	3	PA
<i>pantoprazole sodium oral packet 40 mg</i>	1	
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG ( <i>omeprazole magnesium</i> )	3	
PROTONIX ORAL PACKET 40 MG ( <i>pantoprazole sodium</i> )	3	
RABEPRAZOLE SODIUM ORAL CAPSULE SPRINKLE 10 MG	3	SL (1 capsule per day.)
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	1	SL (1 tablet per day)
<b>GOLD COMPOUNDS</b>		
<b>GOLD COMPOUNDS</b>		
RIDAURA ORAL CAPSULE 3 MG ( <i>auranofin</i> )	3	SP
<b>HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron</b>		
<b>HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron</b>		
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	2	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	1	SP
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	1	SP
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	1	PA; SP
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	1	PA; SP
<i>deferiprone oral tablet 1000 mg</i>	1	PA
<i>deferiprone oral tablet 500 mg</i>	1	PA; SP
DEPEN TITRATABS ORAL TABLET 250 MG ( <i>penicillamine</i> )	2	SP
FERRIPROX ORAL SOLUTION 100 MG/ML ( <i>deferiprone</i> )	2	PA; SP
FERRIPROX ORAL TABLET 1000 MG ( <i>deferiprone</i> )	3	PA
FERRIPROX ORAL TABLET 500 MG ( <i>deferiprone</i> )	3	PA; SP
<i>penicillamine oral tablet 250 mg</i>	1	SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>trientine hcl oral capsule 250 mg</i>	1	PA; SP
<i>trientine hcl oral capsule 500 mg</i>	1	PA
<b>HORMONES AND SYNTHETIC SUBSTITUTES</b>		
<b>MELANOCORTIN RECEPTOR ANTAGONISTS</b>		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML ( <i>setmelanotide acetate</i> )	3	PA; SP
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML ( <i>bremelanotide acetate</i> )	3	SL (4 autoinjector pens (1.2mls) per month.)
<b>HORMONES AND SYNTHETIC SUBSTITUTES - Hormones</b>		
<b>ADRENALS - Hormones</b>		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230- 21 MCG/ACT, 45-21 MCG/ACT ( <i>fluticasone-salmeterol</i> )	2	SL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT ( <i>albuterol-budesonide</i> )	3	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT ( <i>fluticasone furoate</i> )	1	SL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>fluticasone furoate</i> )	1	SL (1 packet per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH ( <i>fluticasone furoate-vilanterol</i> )	2	SL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <i>budeson-glycopyrrol-formoterol</i> )	3	SL (0.36 grams per day.)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1	SL (120 ml (2 boxes) per 30 days.)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1	SL (60 ml (1 box) per 30 days.)
<i>budesonide oral capsule delayed release particles 3 mg</i>	1	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG ( <i>hydrocortisone</i> )	3	
CORTISONE ACETATE ORAL TABLET 25 MG	3	
<i>dexamethasone intensol oral concentrate 1 mg/ml</i>	1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)</i>	1	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT ( <i>mometasone furo-formoterol fum</i> )	3	ST; SL (0.44 grams per day.)
DULERA INHALATION AEROSOL 50-5 MCG/ACT ( <i>mometasone furo-formoterol fum</i> )	3	ST; SL (0.44 mcg per day.)
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT	2	SL (2 blisters per day.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3	SL (1 inhaler per month)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3	SL (2 inhalers per month)
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	SL (0.4 grams per day.)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	SL (2 blisters per day)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	SL (0.04 mcg per day.)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	1	
INTRAROSA VAGINAL INSERT 6.5 MG ( <i>prasterone</i> )	3	PA; SL (1 insert per day)
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG ( <i>methylprednisolone</i> )	3	
MEDROL ORAL TABLET 2 MG ( <i>methylprednisolone</i> )	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG ( <i>methylprednisolone</i> )	3	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	1	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG ( <i>prednisolone sodium phosphate</i> )	3	
PEDIAPRED ORAL SOLUTION 6.7 (5 BASE) MG/5ML ( <i>prednisolone sodium phosphate</i> )	2	
<i>prednisolone oral solution 15 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>prednisolone oral tablet 5 mg</i>	1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml</i>	1	
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg</i>	1	
<i>prednisone intensol oral concentrate 5 mg/ml</i>	1	
<i>prednisone oral solution 5 mg/5ml</i>	1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	1	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	1	SL (10.6 grams per month.)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	1	SL (42.4 grams per month.)
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT ( <i>olopatadine-mometasone</i> )	3	
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT ( <i>budesonide-formoterol fumarate</i> )	1	SL (0.35 grams per day.)
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) ( <i>dexamethasone</i> )	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21) ( <i>dexamethasone</i> )	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) ( <i>dexamethasone</i> )	3	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG ( <i>budesonide</i> )	3	PA; SL (4 capsules per day.); SP
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	3	SL (2 blisters per day.)
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG ( <i>budesonide</i> )	1	
<i>wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1	SL (2 blisters per day)
<b>ALPHA-GLUCOSIDASE INHIBITORS - Drugs for Diabetes</b>		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>migliitol oral tablet 100 mg, 25 mg, 50 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>AMYLINOMIMETICS - Drugs for Diabetes</b>		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML ( <i>pramlintide acetate</i> )	3	SL (4 pens (10.8 ml) per month.)
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML ( <i>pramlintide acetate</i> )	3	SL (4 pens (6 ml) per month.)
<b>ANDROGENS - Hormones</b>		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR ( <i>testosterone</i> )	2	SL (1 patch per day)
COVARYX HS ORAL TABLET 0.625-1.25 MG ( <i>est estrogens-methyltest</i> )	3	
COVARYX ORAL TABLET 1.25-2.5 MG ( <i>est estrogens-methyltest</i> )	2	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML, 200 MG/ML ( <i>testosterone cypionate</i> )	3	
EC-RX TESTOSTERONE TRANSDERMAL CREAM 0.2 %, 0.4 %, 10 %, 20 %	3	PA
EEMT HS ORAL TABLET 0.625-1.25 MG ( <i>est estrogens-methyltest</i> )	3	
EEMT ORAL TABLET 1.25-2.5 MG ( <i>est estrogens-methyltest</i> )	2	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	1	
KYZATREX ORAL CAPSULE 100 MG ( <i>testosterone undecanoate</i> )	3	SL (2 capsules per day.)
KYZATREX ORAL CAPSULE 150 MG, 200 MG ( <i>testosterone undecanoate</i> )	3	SL (4 capsules per day.)
METHITEST ORAL TABLET 10 MG	2	
<i>methyltestosterone oral capsule 10 mg</i>	1	
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) ( <i>testosterone</i> )	1	SL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day)
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)</i>	1	SL (31 packets per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes</b>		
<i>colesevelam hcl oral packet 3.75 gm</i>	1	
<i>colesevelam hcl oral tablet 625 mg</i>	1	
CYCLOSET ORAL TABLET 0.8 MG ( <i>bromocriptine mesylate</i> )	3	
KORLYM ORAL TABLET 300 MG ( <i>mifepristone</i> )	3	PA; SL (4 tablets per day.); SP
<i>mifepristone oral tablet 300 mg</i>	1	PA; SL (4 tablets per day.); SP
<b>ANTIESTROGENS - Drugs for Women</b>		
<i>anastrozole oral tablet 1 mg</i>	1	H
<i>exemestane oral tablet 25 mg</i>	1	H
KISQALI FEMARA ORAL TABLET THERAPY PACK 200 & 2.5 MG ( <i>ribociclib-letrozole</i> )	3	PA; CM
<i>letrozole oral tablet 2.5 mg</i>	1	H
<b>ANTIGONADTROPINS - Hormones</b>		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL ( <i>degarelix acetate</i> )	3	SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG ( <i>degarelix acetate</i> )	3	SP
MYFEMBREE ORAL TABLET 40-1-0.5 MG ( <i>relugolix-estradiol-norethind</i> )	2	SL (1 tablet day.)
ORGOVYX ORAL TABLET 120 MG ( <i>relugolix</i> )	3	PA; SL (1 tablet per day); SP; CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG ( <i>elagolix-estradiol-norethind</i> )	2	PA; SL (2 capsules per day.)
ORLISSA ORAL TABLET 150 MG ( <i>elagolix sodium</i> )	2	SL (1 tablet per day.)
ORLISSA ORAL TABLET 200 MG ( <i>elagolix sodium</i> )	2	SL (2 tablets per day.)
<b>ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones</b>		
<i>diazoxide oral suspension 50 mg/ml</i>	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML ( <i>diazoxide</i> )	3	
<b>ANTIPARATHYROID AGENTS - Drugs for Bones</b>		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	1	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg</i>	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MIACALCIN INJECTION SOLUTION 200 UNIT/ML ( <i>calcitonin (salmon)</i> )	3	
<b>ANTITHYROID AGENTS - Drugs for the Thyroid</b>		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	1	
<b>BIGUANIDES - Drugs for Diabetes</b>		
ACTOPLUS MET ORAL TABLET 15-850 MG ( <i>pioglitazone hcl-metformin hcl</i> )	3	SL (3 tablets per day)
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (1 tablet per day.)
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	
<i>metformin hcl oral solution 500 mg/5ml</i>	1	
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	1	
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	SL (3 tablets per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	1	SL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	1	SL (31 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (1 tablet per day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (2 tablets per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG ( <i>empagliflozin-linagliptin-metformin</i> )	2	SL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG ( <i>empagliflozin-linagliptin-metformin</i> )	2	SL (2 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>CONTRACEPTIVES - Drugs for Women</b>		
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aftera oral tablet 1.5 mg</i>	1	H
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amethia oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <i>segesterone-ethinyl estradiol</i> )	3	SL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) ( <i>levonorgest-eth estrad-fe bisg</i> )	3	H
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	1	H
<i>camila oral tablet 0.35 mg</i>	1	H
<i>camrese lo oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>camrese oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>chateal eq oral tablet 0.15-30 mg-mcg</i>	1	H
<i>cryselle-28 oral tablet 0.3-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>curae oral tablet 1.5 mg</i>	1	H
<i>cyred eq oral tablet 0.15-30 mg-mcg</i>	1	H
<i>dasetta 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>daysee oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>deblitane oral tablet 0.35 mg</i>	1	H
<i>delyla oral tablet 0.1-20 mg-mcg</i>	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML ( <i>medroxyprogesterone acetate</i> )	3	SL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML ( <i>medroxyprogesterone acetate</i> )	3	SL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML ( <i>medroxyprogesterone acetate</i> )	2	SL (3.25 ml per year.); H
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>dolishale oral tablet 90-20 mcg</i>	1	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	1	H
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	1	H
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
ELLA ORAL TABLET 30 MG ( <i>ulipristal acetate</i> )	1	SL (1 tablet per 21 days.); H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H
<i>errin oral tablet 0.35 mg</i>	1	H
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	1	H
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>haloette vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>heather oral tablet 0.35 mg</i>	1	H
<i>her style oral tablet 1.5 mg</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 &amp;0.01 mg</i>	1	H
<i>jasmiel oral tablet 3-0.02 mg</i>	1	H
<i>jencycla oral tablet 0.35 mg</i>	1	H
<i>jolessa oral tablet 0.15-0.03 mg</i>	1	H
<i>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kelnor 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>layolis fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>leena oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i>	1	H
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>levonorgestrel oral tablet 1.5 mg</i>	1	H
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	1	H
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg</i>	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	1	H
<i>lojaimiess oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>lutera oral tablet 0.1-20 mg-mcg</i>	1	H
<i>lyleq oral tablet 0.35 mg</i>	1	H
<i>lyza oral tablet 0.35 mg</i>	1	H
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	1	SL (5 ml per year.); H
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	SL (5 mL per 365 days.); H
<i>merzee oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin 24 fe oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
<i>my choice oral tablet 1.5 mg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>my way oral tablet 1.5 mg</i>	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <i>estradiol valerate-dienogest</i> )	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>new day oral tablet 1.5 mg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <i>drospirenone-estetrol</i> )	3	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>nora-be oral tablet 0.35 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethindrone oral tablet 0.35 mg</i>	1	H
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>norlyroc oral tablet 0.35 mg</i>	1	H
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nylia 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nymyo oral tablet 0.25-35 mg-mcg</i>	1	H
<i>ocella oral tablet 3-0.03 mg</i>	1	H
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
<i>option 2 oral tablet 1.5 mg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>philith oral tablet 0.4-35 mg-mcg</i>	1	H
<i>pimtree oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	1	H
<i>portia-28 oral tablet 0.15-30 mg-mcg</i>	1	H
<i>react oral tablet 1.5 mg</i>	1	H
<i>reclipsen oral tablet 0.15-30 mg-mcg</i>	1	H
<i>rivelsa oral tablet 42-21-21-7 days</i>	1	H
<i>setlakin oral tablet 0.15-0.03 mg</i>	1	H
<i>sharobel oral tablet 0.35 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG ( <i>drospirenone</i> )	3	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	1	H
<i>take action oral tablet 1.5 mg</i>	1	H
<i>tarina 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	1	H
<i>taysofy oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>trivora (28) oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <i>levonorgestrel-eth estradiol</i> )	3	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <i>levonorgestrel-ethinyl estrad</i> )	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	1	H
<i>wera oral tablet 0.5-35 mg-mcg</i>	1	H
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
YAZ ORAL TABLET 3-0.02 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	1	H
<b>DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes</b>		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG ( <i>empagliflozin-linagliptin</i> )	2	ST; SL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	SL (1 tablet per day.)
<i>saxagliptin hcl oral tablet 2.5 mg, 5 mg</i>	1	SL (1 tablet per day)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg</i>	1	SL (62 tablets per month.)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg</i>	1	SL (31 tablets per month.)
TRADJENTA ORAL TABLET 5 MG ( <i>linagliptin</i> )	2	SL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG ( <i>empagliflozin-linagliptin-metform</i> )	2	SL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG ( <i>empagliflozin-linagliptin-metform</i> )	2	SL (2 tablets per day.)
<b>ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women</b>		
DUAVEE ORAL TABLET 0.45-20 MG ( <i>conj estrogens-bazedoxifene</i> )	3	SL (1 tablet per day)
OSPHEA ORAL TABLET 60 MG ( <i>ospemifene</i> )	2	PA; SL (1 tablet per day.)
<i>raloxifene hcl oral tablet 60 mg</i>	1	H
SOLTAMOX ORAL SOLUTION 10 MG/5ML ( <i>tamoxifen citrate</i> )	3	
<i>tamoxifen citrate oral tablet 10 mg</i>	1	
<i>tamoxifen citrate oral tablet 20 mg</i>	1	H
<i>toremifene citrate oral tablet 60 mg</i>	1	CM
<b>ESTROGENS - Drugs for Women</b>		
ACTIVELLA ORAL TABLET 1-0.5 MG ( <i>estradiol-norethindrone acet</i> )	3	
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR ( <i>estradiol</i> )	3	SL (8 patches (1 box) per 28 days.)
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amabelz oral tablet 0.5-0.1 mg</i>	1	
<i>amethia oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG ( <i>drospirenone-estradiol</i> )	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <i>segesterone-ethinyl estradiol</i> )	3	SL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) ( <i>levonorgest-eth estrad-fe bisg</i> )	3	H
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG ( <i>estradiol-progesterone</i> )	3	
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	1	H
<i>camrese lo oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>camrese oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>chateal eq oral tablet 0.15-30 mg-mcg</i>	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY ( <i>estradiol-levonorgestrel</i> )	2	SL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY ( <i>estradiol-norethindrone acet</i> )	2	SL (8 patches per 28 days.)
COVARYX HS ORAL TABLET 0.625-1.25 MG ( <i>est estrogens-methyltest</i> )	3	
COVARYX ORAL TABLET 1.25-2.5 MG ( <i>est estrogens-methyltest</i> )	2	
<i>cryselle-28 oral tablet 0.3-30 mg-mcg</i>	1	H
<i>cyred eq oral tablet 0.15-30 mg-mcg</i>	1	H
<i>dasetta 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>daysee oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML ( <i>estradiol valerate</i> )	3	
<i>delyla oral tablet 0.1-20 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML ( <i>estradiol cypionate</i> )	3	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 1 MG/GM, 1.25 MG/1.25GM ( <i>estradiol</i> )	3	
DIVIGEL TRANSDERMAL GEL 0.75 MG/0.75GM ( <i>estradiol</i> )	2	
<i>dolishale oral tablet 90-20 mcg</i>	1	H
<i>dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (8 patches (1 box) per 28 days.)
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	1	H
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	1	H
DUAVEE ORAL TABLET 0.45-20 MG ( <i>conj estrogens-bazedoxifene</i> )	3	SL (1 tablet per day)
EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %	3	PA
EEMT HS ORAL TABLET 0.625-1.25 MG ( <i>est estrogens-methyltest</i> )	3	
EEMT ORAL TABLET 1.25-2.5 MG ( <i>est estrogens-methyltest</i> )	2	
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) ( <i>estradiol</i> )	3	
<i>elimest oral tablet 0.3-30 mg-mcg</i>	1	H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	1	
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm</i>	1	
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (4 patches (1 carton) per 28 days.)
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
<i>estradiol vaginal tablet 10 mcg</i>	1	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	1	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	1	
ESTRING VAGINAL RING 7.5 MCG/24HR ( <i>estradiol</i> )	2	SL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) ( <i>estradiol</i> )	3	SL (50 grams (1 box) per month.)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	1	H
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY ( <i>estradiol</i> )	2	
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR ( <i>estradiol acetate</i> )	3	SL (1 ring per 3 months.)
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>haloette vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG ( <i>estradiol</i> )	2	SL (0.29 vaginal insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG ( <i>estradiol</i> )	2	SL (18 inserts per year.)
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>jasmiel oral tablet 3-0.02 mg</i>	1	H
<i>jinteli oral tablet 1-5 mg-mcg</i>	1	
<i>jolessa oral tablet 0.15-0.03 mg</i>	1	H
<i>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kelnor 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>layolis fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>leena oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i>	1	H
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	1	H
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg</i>	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	1	H
<i>lojaimiess oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>lutra oral tablet 0.1-20 mg-mcg</i>	1	H
<i>lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (8 patches (1 box) per 28 days.)
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (esterified estrogens)	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (estradiol)	3	SL (4 patches (1 carton) per 28 days.)
<i>merzee oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin 24 fe oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
MYFEMBREE ORAL TABLET 40-1-0.5 MG ( <i>relugolix-estradiol-norethind</i> )	2	SL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <i>estradiol valerate-dienogest</i> )	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <i>drospirenone-estetrol</i> )	3	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nylia 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nymyo oral tablet 0.25-35 mg-mcg</i>	1	H
<i>ocella oral tablet 3-0.03 mg</i>	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG ( <i>elagolix-estradiol-norethind</i> )	2	PA; SL (2 capsules per day.)
<i>philith oral tablet 0.4-35 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>pimtre</i> a oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
<i>portia</i> -28 oral tablet 0.15-30 mg-mcg	1	H
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG ( <i>estrogens conjugated</i> )	2	
PREMARIN VAGINAL CREAM 0.625 MG/GM ( <i>estrogens, conjugated</i> )	3	
PREMPHASE ORAL TABLET 0.625-5 MG ( <i>conj estrog-medroxyprogest ace</i> )	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG ( <i>conj estrog-medroxyprogest ace</i> )	2	
<i>reclipsen</i> oral tablet 0.15-30 mg-mcg	1	H
<i>rivelsa</i> oral tablet 42-21-21-7 days	1	H
<i>setlakin</i> oral tablet 0.15-0.03 mg	1	H
<i>simliya</i> oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
<i>simpesse</i> oral tablet 0.15-0.03 & 0.01 mg	1	H
<i>sprintec 28</i> oral tablet 0.25-35 mg-mcg	1	H
<i>sronyx</i> oral tablet 0.1-20 mg-mcg	1	H
<i>syeda</i> oral tablet 3-0.03 mg	1	H
<i>tarina 24 fe</i> oral tablet 1-20 mg-mcg(24)	1	H
<i>tarina fe 1/20 eq</i> oral tablet 1-20 mg-mcg	1	H
<i>taysofy</i> oral capsule 1-20 mg-mcg(24)	1	H
<i>tilia fe</i> oral tablet 1-20/1-30/1-35 mg-mcg	1	H
<i>tri-estarylla</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
<i>tri-legest fe</i> oral tablet 1-20/1-30/1-35 mg-mcg	1	H
<i>tri-linyah</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
<i>tri-lo-estarylla</i> oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
<i>tri-lo-marzia</i> oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
<i>tri-lo-mili</i> oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
<i>tri-lo-sprintec</i> oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
<i>tri-mili</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
<i>tri-nymyo</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
<i>tri-sprintec</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
<i>trivora (28)</i> oral tablet 50-30/75-40/ 125-30 mcg	1	H
<i>tri-vylibra lo</i> oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
<i>tri-vylibra</i> oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <i>levonorgestrel-eth estradiol</i> )	3	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <i>levonorgestrel-ethinyl estrad</i> )	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	1	H
<i>wera oral tablet 0.5-35 mg-mcg</i>	1	H
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
YAZ ORAL TABLET 3-0.02 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
<i>yuvafer vaginal tablet 10 mcg</i>	1	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	1	H
<b>GLYCOGENOLYTIC AGENTS - Hormones</b>		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	2	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG ( <i>glucagon hcl (rdna)</i> )	3	
<i>glucagon emergency kit injection kit 1 mg</i>	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML ( <i>glucagon</i> )	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML ( <i>glucagon</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML ( <i>glucagon</i> )	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML ( <i>glucagon</i> )	2	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML ( <i>dasiglucagon hcl</i> )	2	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML ( <i>dasiglucagon hcl</i> )	2	
<b>GONADOTROPINS - Hormones</b>		
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	1	PA
SYNAREL NASAL SOLUTION 2 MG/ML ( <i>nafarelin acetate</i> )	2	
<b>INCRETIN MIMETICS - Drugs for Diabetes</b>		
BYDUREON BCISE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML ( <i>exenatide</i> )	2	PA; ST; SL (3.4 mL per month)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML ( <i>exenatide</i> )	2	PA; ST; SL (2.4 mL (one pen) per prescription)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML ( <i>exenatide</i> )	2	PA; ST; SL (1.2 mL (one pen) per prescription)
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML ( <i>tirzepatide</i> )	2	PA; ST; SL (0.08 ml per day.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML ( <i>semaglutide</i> )	2	PA; ST; SL (6 ml per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML ( <i>semaglutide</i> )	2	PA; ST; SL (9 ml per 3 months.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML ( <i>semaglutide</i> )	2	PA; ST; SL (3 ml per 21 days.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG ( <i>semaglutide</i> )	2	PA; ST; SL (1 tablet per day.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML ( <i>liraglutide -weight management</i> )	3	PA; SL (0.5 ml per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML ( <i>insulin glargine-lixisenatide</i> )	2	SL (18 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML ( <i>dulaglutide</i> )	2	PA; ST; SL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML ( <i>dulaglutide</i> )	2	PA; ST; SL (2 mL per 21 days)
VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS ( <i>liraglutide</i> )	2	PA; ST; SL (6 ml (2 pens) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS ( <i>liraglutide</i> )	3	PA; ST; SL (6 ml (2 pens) per month.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML ( <i>semaglutide-weight management</i> )	3	PA
<b>INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes</b>		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	2	
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	1	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML ( <i>insulin nph human (isophane)</i> )	2	
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML ( <i>insulin nph human (isophane)</i> )	1	
<b>LEPTINS - Hormones</b>		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG ( <i>metreleptin</i> )	3	PA; SL (0.9 vial per day.); SP
<b>LONG-ACTING INSULINS - Drugs for Diabetes</b>		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin glargine</i> )	1	
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin glargine</i> )	1	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML ( <i>insulin glargine-lixisenatide</i> )	2	SL (18 ml per month.)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML ( <i>insulin glargine</i> )	2	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML ( <i>insulin glargine</i> )	2	
<b>MEGLITINIDES - Drugs for Diabetes</b>		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	1	SL (3 tablets per day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	1	SL (4 tablets per day)
<i>repaglinide oral tablet 2 mg</i>	1	SL (8 tablets per day)
<b>PARATHYROID AGENTS - Drugs for Bones</b>		
TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	3	PA; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML ( <i>abaloparatide</i> )	3	PA; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>PITUITARY - Hormones</b>		
ACTHAR INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	3	PA; ST; SL (20 ml per 24 days.); SP
CORTROPHIN INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	3	PA; ST; SL (20 ml per 24 days.); SP
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	1	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	1	
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML ( <i>somatrogon-ghla</i> )	3	PA; SL (0.172 ml per day.); SP
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG ( <i>desmopressin acetate</i> )	3	SL (1 tablet per day.)
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML ( <i>somatropin</i> )	2	PA; SL (13.5 mL per month.)
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML ( <i>somatropin</i> )	2	PA; SL (9 mL per month.); SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML ( <i>somatropin</i> )	2	PA; SL (27 mL per month.)
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML ( <i>somatropin</i> )	2	PA; SL (18 ml per month.); SP
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML ( <i>somatropin</i> )	2	PA; SL (10 ml (5 cartridges) per month.); SP
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML ( <i>somatropin</i> )	2	PA; SL (36 ml per month.); SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG ( <i>somatropin (non-refrigerated)</i> )	3	PA; SL (1 tablet per day); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG ( <i>lonapegsomatropin-tcgd</i> )	3	PA; SL (0.143 cartridge per day.); SP
<b>PROGESTINS - Drugs for Women</b>		
ACTIVELLA ORAL TABLET 1-0.5 MG ( <i>estradiol-norethindrone acet</i> )	3	
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aftera oral tablet 1.5 mg</i>	1	H
<i>altavera oral tablet 0.15-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>amabelz oral tablet 0.5-0.1 mg</i>	1	
<i>amethia oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>amethyst oral tablet 90-20 mcg</i>	1	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG ( <i>drospirenone-estradiol</i> )	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <i>segesterone-ethinyl estradiol</i> )	3	SL (1 vaginal ring per 327 days); H
<i>apri oral tablet 0.15-30 mg-mcg</i>	1	H
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>ashlyna oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	1	H
<i>aurovela 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aurovela 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>aviane oral tablet 0.1-20 mg-mcg</i>	1	H
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	1	H
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) ( <i>levonorgest-eth estrad-fe bisg</i> )	3	H
<i>balziva oral tablet 0.4-35 mg-mcg</i>	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG ( <i>estradiol-progesterone</i> )	3	
<i>blisovi 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>blisovi fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	1	H
<i>camila oral tablet 0.35 mg</i>	1	H
<i>camrese lo oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>camrese oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>chateal eq oral tablet 0.15-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY ( <i>estradiol-levonorgestrel</i> )	2	SL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY ( <i>estradiol-norethindrone acet</i> )	2	SL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % ( <i>progesterone</i> )	3	ST
<i>cryselle-28 oral tablet 0.3-30 mg-mcg</i>	1	H
<i>curae oral tablet 1.5 mg</i>	1	H
<i>cyred eq oral tablet 0.15-30 mg-mcg</i>	1	H
<i>dasetta 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>daysee oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>deblitane oral tablet 0.35 mg</i>	1	H
<i>delyla oral tablet 0.1-20 mg-mcg</i>	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML ( <i>medroxyprogesterone acetate</i> )	3	SL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML ( <i>medroxyprogesterone acetate</i> )	3	SL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML ( <i>medroxyprogesterone acetate</i> )	2	SL (3.25 ml per year.); H
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>dolishale oral tablet 90-20 mcg</i>	1	H
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	1	H
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	1	H
<i>econtra one-step oral tablet 1.5 mg</i>	1	H
EC-RX PROGESTERONE TRANSDERMAL CREAM 10 %, 20 %	3	PA
<i>elinest oral tablet 0.3-30 mg-mcg</i>	1	H
ELLA ORAL TABLET 30 MG ( <i>ulipristal acetate</i> )	1	SL (1 tablet per 21 days.); H
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	1	H
ENDOMETRIN VAGINAL INSERT 100 MG ( <i>progesterone</i> )	2	
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>errin oral tablet 0.35 mg</i>	1	H
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	1	H
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	1	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	1	H
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>falmina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>finzala oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
FIRST-PROGESTERONE VGS VAGINAL SUPPOSITORY 100 MG, 200 MG (progesterone)	3	PA
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>gemmily oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>hailey fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>haloette vaginal ring 0.12-0.015 mg/24hr</i>	1	H
<i>heather oral tablet 0.35 mg</i>	1	H
<i>her style oral tablet 1.5 mg</i>	1	H
<i>iclevia oral tablet 0.15-0.03 mg</i>	1	H
<i>incassia oral tablet 0.35 mg</i>	1	H
<i>introvale oral tablet 0.15-0.03 mg</i>	1	H
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	1	H
<i>jaimiess oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
<i>jasmiel oral tablet 3-0.02 mg</i>	1	H
<i>jencycla oral tablet 0.35 mg</i>	1	H
<i>jinteli oral tablet 1-5 mg-mcg</i>	1	
<i>jolessa oral tablet 0.15-0.03 mg</i>	1	H
<i>joyeaux oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>juleber oral tablet 0.15-30 mg-mcg</i>	1	H
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>junel fe 24 oral tablet 1-20 mg-mcg(24)</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>kalliga oral tablet 0.15-30 mg-mcg</i>	1	H
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>kelnor 1/50 oral tablet 1-50 mg-mcg</i>	1	H
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	1	H
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>larin 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>layolis fe oral tablet chewable 0.8-25 mg-mcg</i>	1	H
<i>leena oral tablet 0.5/1/0.5-35 mg-mcg</i>	1	H
<i>lessina oral tablet 0.1-20 mg-mcg</i>	1	H
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i>	1	H
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i>	1	H
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	1	H
<i>levonorgestrel oral tablet 1.5 mg</i>	1	H
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	1	H
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg</i>	1	H
<b>LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphase)</b>	1	H
<i>lojaimiess oral tablet 0.1-0.02 &amp; 0.01 mg</i>	1	H
<i>loryna oral tablet 3-0.02 mg</i>	1	H
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	1	H
<i>lo-zumandimine oral tablet 3-0.02 mg</i>	1	H
<i>lutra oral tablet 0.1-20 mg-mcg</i>	1	H
<i>lyleq oral tablet 0.35 mg</i>	1	H
<i>lyza oral tablet 0.35 mg</i>	1	H
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	1	SL (5 ml per year.); H
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	SL (5 mL per 365 days.); H
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml</i>	1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
<i>merzee oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin 24 fe oral tablet 1-20 mg-mcg</i>	1	H
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	1	H
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	1	H
<i>mili oral tablet 0.25-35 mg-mcg</i>	1	H
<i>mimvey oral tablet 1-0.5 mg</i>	1	
<i>mono-lynyah oral tablet 0.25-35 mg-mcg</i>	1	H
<i>my choice oral tablet 1.5 mg</i>	1	H
<i>my way oral tablet 1.5 mg</i>	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG ( <i>relugolix-estradiol-norethind</i> )	2	SL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <i>estradiol valerate-dienogest</i> )	1	H
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>new day oral tablet 1.5 mg</i>	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <i>drospirenone-estetrol</i> )	3	H
<i>nikki oral tablet 3-0.02 mg</i>	1	H
<i>nora-be oral tablet 0.35 mg</i>	1	H
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>norethindrone acetate oral tablet 5 mg</i>	1	
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	H
<i>norethindrone oral tablet 0.35 mg</i>	1	H
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	H
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	H
<i>norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>norlyroc oral tablet 0.35 mg</i>	1	H
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nylia 1/35 oral tablet 1-35 mg-mcg</i>	1	H
<i>nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	H
<i>nymyo oral tablet 0.25-35 mg-mcg</i>	1	H
<i>ocella oral tablet 3-0.03 mg</i>	1	H
<i>opcicon one-step oral tablet 1.5 mg</i>	1	H
<i>option 2 oral tablet 1.5 mg</i>	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG ( <i>elagolix-estradiol-norethind</i> )	2	PA; SL (2 capsules per day.)
<i>philith oral tablet 0.4-35 mg-mcg</i>	1	H
<i>pimtreea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	1	H
<i>portia-28 oral tablet 0.15-30 mg-mcg</i>	1	H
PREMPHASE ORAL TABLET 0.625-5 MG ( <i>conj estrog-medroxyprogest ace</i> )	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG ( <i>conj estrog-medroxyprogest ace</i> )	2	
<i>progesterone intramuscular oil 50 mg/ml</i>	1	
PROGESTERONE MICRONIZED TRANSDERMAL CREAM 10 %	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>progesterone oral capsule 100 mg, 200 mg</i>	1	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG ( <i>medroxyprogesterone acetate</i> )	3	
<i>react oral tablet 1.5 mg</i>	1	H
<i>reclipsen oral tablet 0.15-30 mg-mcg</i>	1	H
<i>rivelsa oral tablet 42-21-21-7 days</i>	1	H
<i>setlakin oral tablet 0.15-0.03 mg</i>	1	H
<i>sharobel oral tablet 0.35 mg</i>	1	H
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>simpesse oral tablet 0.15-0.03 &amp; 0.01 mg</i>	1	H
SLYND ORAL TABLET 4 MG ( <i>drospirenone</i> )	3	H
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	1	H
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	1	H
<i>syeda oral tablet 3-0.03 mg</i>	1	H
<i>take action oral tablet 1.5 mg</i>	1	H
<i>tarina 24 fe oral tablet 1-20 mg-mcg(24)</i>	1	H
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	1	H
<i>taysofy oral capsule 1-20 mg-mcg(24)</i>	1	H
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	1	H
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>trivora (28) oral tablet 50-30/75-40/ 125-30 mcg</i>	1	H
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	H
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	H
<i>turqoz oral tablet 0.3-30 mg-mcg</i>	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <i>levonorgestrel-eth estradiol</i> )	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <i>levonorgestrel-ethinyl estrad</i> )	1	
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	1	H
<i>vestura oral tablet 3-0.02 mg</i>	1	H
<i>vienva oral tablet 0.1-20 mg-mcg</i>	1	H
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>volnea oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	H
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	1	H
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	1	H
<i>wera oral tablet 0.5-35 mg-mcg</i>	1	H
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	H
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
YAZ ORAL TABLET 3-0.02 MG ( <i>drospirenone-ethinyl estradiol</i> )	3	
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	1	H
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	1	H
<i>zumandimine oral tablet 3-0.03 mg</i>	1	H
<b>RAPID-ACTING INSULINS - Drugs for Diabetes</b>		
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 & 60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT ( <i>insulin regular human</i> )	3	
HUMALOG INJECTION SOLUTION 100 UNIT/ML ( <i>insulin lispro</i> )	3	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML ( <i>insulin lispro</i> )	2	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML ( <i>insulin lispro prot &amp; lispro</i> )	2	
HUMALOG MIX 50/50 VIAL SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML ( <i>insulin lispro prot &amp; lispro</i> )	1	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML ( <i>insulin lispro prot &amp; lispro</i> )	2	
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML ( <i>insulin lispro prot &amp; lispro</i> )	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML ( <i>insulin lispro</i> )	2	
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin lispro</i> )	2	
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML ( <i>insulin lispro-aabc</i> )	2	
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML ( <i>insulin lispro-aabc</i> )	1	
<b>SHORT-ACTING INSULINS - Drugs for Diabetes</b>		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	2	
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	1	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML ( <i>insulin regular human</i> )	2	
HUMULIN R U-500 VIAL SUBCUTANEOUS SOLUTION 500 UNIT/ML ( <i>insulin regular human</i> )	1	
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML ( <i>insulin regular human</i> )	1	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% ( <i>insulin regular(human) in nacl</i> )	3	
<b>SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes</b>		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG ( <i>empagliflozin-linagliptin</i> )	2	ST; SL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG ( <i>empagliflozin</i> )	2	SL (30 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (1 tablet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	SL (2 tablets per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG ( <i>empagliflozin-linagliptin-metformin</i> )	2	SL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG ( <i>empagliflozin-linagliptin-metformin</i> )	2	SL (2 tablets per day.)
<b>SOMATOSTATIN AGONISTS - Hormones</b>		
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	1	PA
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML ( <i>octreotide acetate</i> )	3	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML ( <i>pasireotide diaspertate</i> )	3	PA; SL (2 ampules per day.); SP
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML ( <i>lanreotide acetate</i> )	3	SP
<b>SOMATOTROPIN AGONISTS - Hormones</b>		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG ( <i>tesamorelin acetate</i> )	3	PA; SL (1 vial per day.)
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML ( <i>mecasermin</i> )	2	PA; SL (52 vials per month.); SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML ( <i>somatropin</i> )	2	PA; SL (13.5 mL per month.)
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML ( <i>somatropin</i> )	2	PA; SL (9 mL per month.); SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML ( <i>somatropin</i> )	2	PA; SL (27 mL per month.)
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML ( <i>somatropin</i> )	2	PA; SL (18 ml per month.); SP
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML ( <i>somatropin</i> )	2	PA; SL (10 ml (5 cartridges) per month.); SP
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML ( <i>somatropin</i> )	2	PA; SL (36 ml per month.); SP
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG ( <i>somatropin (non-refrigerated)</i> )	3	PA; SL (1 tablet per day); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>SOMATOTROPIN ANTAGONISTS - Hormones</b>		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG ( <i>pegvisomant</i> )	3	PA; SL (1 vial per day.); SP
<b>SULFONYLUREAS - Drugs for Diabetes</b>		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG ( <i>pioglitazone hcl-glimepiride</i> )	3	SL (1 tablet per day)
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 2.5 MG, 5 MG ( <i>glipizide</i> )	3	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	SL (1 tablet per day)
<b>THIAZOLIDINEDIONES - Drugs for Diabetes</b>		
ACTOPLUS MET ORAL TABLET 15-850 MG ( <i>pioglitazone hcl-metformin hcl</i> )	3	SL (3 tablets per day)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG ( <i>pioglitazone hcl-glimepiride</i> )	3	SL (1 tablet per day)
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	1	SL (1 tablet per day)
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	SL (1 tablet per day)
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	SL (3 tablets per day)
<b>THYROID AGENTS - Drugs for the Thyroid</b>		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG ( <i>thyroid</i> )	2	
ERMEZA ORAL SOLUTION 150 MCG/5ML ( <i>levothyroxine sodium</i> )	2	PA
<i>euthyrox oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>levo-t oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
LEVOTHYROXINE SODIUM ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	3	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	1	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
<i>np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	1	
THYQUIDITY ORAL SOLUTION 100 MCG/5ML ( <i>levothyroxine sodium</i> )	3	
<i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	1	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG ( <i>levothyroxine sodium</i> )	3	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML ( <i>levothyroxine sodium</i> )	2	
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<b>LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing</b>		
<b>LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing</b>		
LETS KIT	3	PA
ZTLIDO EXTERNAL PATCH 1.8 % ( <i>lidocaine</i> )	3	PA; SL (3 patches per day.)
<b>MISCELLANEOUS THERAPEUTIC AGENTS</b>		
<b>5-ALPHA-REDUCTASE INHIBITORS</b>		
<i>dutasteride oral capsule 0.5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	1	
ENTADFI ORAL CAPSULE 5-5 MG ( <i>finasteride-tadalafil</i> )	3	SL (1 capsule per day.)
<i>finasteride oral tablet 5 mg</i>	1	
<b>ALCOHOL DETERRENTS - Drugs for Alcohol Dependence</b>		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	1	
<i>naltrexone hcl oral tablet 50 mg</i>	1	
<b>ANTIDOTES - Drugs for Overdose or Poisoning</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	2	
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG ( <i>lanthanum carbonate</i> )	3	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG ( <i>glucagon hcl (rdna)</i> )	3	
<i>glucagon emergency kit injection kit 1 mg</i>	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML ( <i>glucagon</i> )	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML ( <i>glucagon</i> )	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML ( <i>glucagon</i> )	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML ( <i>glucagon</i> )	2	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	1	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1	
<i>naltrexone hcl oral tablet 50 mg</i>	1	
<i>phytonadione oral tablet 5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RADIOGARDASE ORAL CAPSULE 0.5 GM ( <i>prussian blue insoluble</i> )	3	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	1	
<i>sevelamer carbonate oral tablet 800 mg</i>	1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	1	
<i>sodium polystyrene sulfonate oral powder</i>	1	
SPS ORAL SUSPENSION 15 GM/60ML ( <i>sodium polystyrene sulfonate</i> )	3	
VISTOGARD ORAL PACKET 10 GM ( <i>uridine triacetate</i> )	2	PA
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML ( <i>dasiglucagon hcl</i> )	2	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML ( <i>dasiglucagon hcl</i> )	2	
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML ( <i>naloxone hcl</i> )	2	
<b>ANTIGOUT AGENTS - Drugs for Gout</b>		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	
ALLOPURINOL ORAL TABLET 200 MG	3	
<i>colchicine oral capsule 0.6 mg</i>	1	
<i>colchicine oral tablet 0.6 mg</i>	1	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG, 500 MG ( <i>naproxen</i> )	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	1	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML ( <i>colchicine</i> )	3	
INDOCIN ORAL SUSPENSION 25 MG/5ML ( <i>indomethacin</i> )	3	
INDOCIN RECTAL SUPPOSITORY 50 MG ( <i>indomethacin</i> )	3	
<i>indomethacin er oral capsule extended release 75 mg</i>	1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>indomethacin oral suspension 25 mg/5ml</i>	1	
<i>indomethacin rectal suppository 50 mg</i>	1	
MITIGARE ORAL CAPSULE 0.6 MG ( <i>colchicine</i> )	2	
NAPROSYN ORAL SUSPENSION 125 MG/5ML ( <i>naproxen</i> )	3	
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>probenecid oral tablet 500 mg</i>	1	
<b>ANTISENSE OLIGONUCLEOTIDES</b>		
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML ( <i>inotersen sodium</i> )	2	PA; SL (0.22 ml per day.); SP
<b>BONE ANABOLIC AGENTS</b>		
TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	3	PA; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML ( <i>abaloparatide</i> )	3	PA; SP
<b>BONE RESORPTION INHIBITORS - Drugs for Bone Loss</b>		
<i>alendronate sodium oral solution 70 mg/75ml</i>	1	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	1	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR ( <i>estradiol</i> )	3	SL (8 patches (1 box) per 28 days.)
BINOSTO ORAL TABLET EFFERVESCENT 70 MG ( <i>alendronate sodium</i> )	3	SL (4 tablets per month.)
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML ( <i>estradiol valerate</i> )	3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML ( <i>estradiol cypionate</i> )	3	
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 1 MG/GM, 1.25 MG/1.25GM ( <i>estradiol</i> )	3	
DIVIGEL TRANSDERMAL GEL 0.75 MG/0.75GM ( <i>estradiol</i> )	2	
<i>dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (8 patches (1 box) per 28 days.)
EC-RX ESTRADIOL TRANSDERMAL CREAM 0.4 %, 0.6 %	3	PA
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) ( <i>estradiol</i> )	3	
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	1	SL (8 patches (1 box) per 28 days.)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	3	SL (8 patches (1 box) per 28 days.)
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm</i>	1	
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (4 patches (1 carton) per 28 days.)
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
<i>estradiol vaginal tablet 10 mcg</i>	1	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	1	
ESTRING VAGINAL RING 7.5 MCG/24HR ( <i>estradiol</i> )	2	SL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) ( <i>estradiol</i> )	3	SL (50 grams (1 box) per month.)
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY ( <i>estradiol</i> )	2	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR ( <i>estradiol acetate</i> )	3	SL (1 ring per 3 months.)
FOSAMAX ORAL TABLET 70 MG ( <i>alendronate sodium</i> )	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT ( <i>alendronate-cholecalciferol</i> )	3	
<i>ibandronate sodium oral tablet 150 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	SL (8 patches (1 box) per 28 days.)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (esterified estrogens)	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (estradiol)	3	SL (4 patches (1 carton) per 28 days.)
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (calcitonin (salmon))	3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens conjugated)	2	
PREMARIN VAGINAL CREAM 0.625 MG/GM (estrogens, conjugated)	3	
<i>raloxifene hcl oral tablet 60 mg</i>	1	H
<i>risedronate sodium oral tablet 150 mg</i>	1	SL (1 tablet per month)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1	
<i>risedronate sodium oral tablet 35 mg</i>	1	SL (4 tablets per 28 days.)
<i>risedronate sodium oral tablet delayed release 35 mg</i>	1	SL (4 tablets per month)
<i>yuvaferm vaginal tablet 10 mcg</i>	1	
<b>BRADYKININ RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; SL (0.6 ml per day.); SP
<i>sajazir subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; SL (0.6 ml per day.); SP
<b>CARBONIC ANHYDRASE INHIBITORS (MISC.)</b>		
<i>dichlorphenamide oral tablet 50 mg</i>	1	PA; SL (4 tablets per day.); SP
KEVEYIS ORAL TABLET 50 MG (dichlorphenamide)	3	PA; SL (4 tablets per day.); SP
<b>CARIOSTATIC AGENTS - Vitamins and Fluoride</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	1	
CLINPRO 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	3	
DENTAGEL DENTAL GEL 1.1 % (sodium fluoride)	3	
<i>easygel dental gel 0.4 %</i>	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (sodium fluoride-vitamin d)	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (pediatric multivitamins-fl)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>fluoridex daily renewal mouth/throat concentrate 0.63 %</i>	1	
FLUORIDEX DENTAL PASTE 1.1 % ( <i>sodium fluoride</i> )	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % ( <i>sodium fluoride</i> )	3	
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % ( <i>sodium fluoride</i> )	3	
FLUORIMAX 5000 SENSITIVE DENTAL PASTE 1.1-5 % ( <i>sod fluoride-potassium nitrate</i> )	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % ( <i>sodium fluoride</i> )	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>multivitamin/fluoride tablet chewable 0.25 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 0.5 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 1 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG ( <i>pediatric multivitamins-fl</i> )	3	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>pediatric multivitamins-fl</i> )	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG ( <i>pediatric multivitamins-fl</i> )	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML ( <i>ped multivitamins-fl-iron</i> )	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG ( <i>ped multivitamins-fl-iron</i> )	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % ( <i>sodium fluoride</i> )	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % ( <i>sodium fluoride</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	3	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (sodium fluoride)	3	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML (pediatric multivitamins-fl)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (ped vit a-c-d-methylfolate-fl)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
VANISH DENTAL LIQUID EXTENDED RELEASE 5 % (sodium fluoride)	3	
vitamins acd-fluoride oral solution 0.25 mg/ml	1	
<b>COMPLEMENT INHIBITORS</b>		
BERINERT INTRAVENOUS KIT 500 UNIT (c1 esterase inhibitor (human))	3	PA; ST; SL (0.4 boxes per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML ( <i>pegcetacoplan</i> )	2	PA; SL (5.8 ml per day. 2,100 ml per 360 days.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT ( <i>c1 esterase inhibitor (human)</i> )	2	PA; SL (24 vials per month.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT ( <i>c1 esterase inhibitor (human)</i> )	2	PA; SL (16 vials per month.); SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT ( <i>c1 esterase inhibitor (recomb)</i> )	3	PA; SL (0.27 vials per day.); SP
TAVNEOS ORAL CAPSULE 10 MG ( <i>avacopan</i> )	3	PA; SL (6 capsules per day.); SP
<b>DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis</b>		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO- INJECTOR 162 MG/0.9ML ( <i>tocilizumab</i> )	3	PA; ST; SL (3.6 ml per 21 days.); SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML ( <i>tocilizumab</i> )	3	PA; ST; SL (4 syringes (36 mL) per month); SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO- INJECTOR 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML ( <i>adalimumab- atto</i> )	2	PA; SL (0.4 ml per day.); SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML ( <i>adalimumab- atto</i> )	3	PA; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML ( <i>adalimumab- atto</i> )	2	PA; SL (0.06 ml per day.); SP
AZASAN ORAL TABLET 100 MG, 75 MG ( <i>azathioprine</i> )	3	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG ( <i>sulfasalazine</i> )	3	
AZULFIDINE ORAL TABLET 500 MG ( <i>sulfasalazine</i> )	3	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG ( <i>abrocitinib</i> )	2	PA; SL (1 tablet per day.); SP; CM
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (6 mL per 365 days.); SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (1 kit per 21 days.); SP
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.072 mL per day.); SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.036 mL per day.); SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.072 mL per day.); SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.036 mL per day.); SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.0715 ml per day.); SP
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (0.08 syringe per day.); SP
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (0.08 syringe per day.); SP
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (6 auto-injector per 365 days.); SP
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (4 auto-injector per 365 days.); SP
DEPEN TITRATABS ORAL TABLET 250 MG ( <i>penicillamine</i> )	2	SP
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
HADLIMA PUSH TOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA PUSH TOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (6 pens (1 kit) per year.); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 kits per year); SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (3 syringes per year); SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML ( <i>sarilumab</i> )	3	PA; ST; SL (2.28 ml per month.); SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML ( <i>sarilumab</i> )	3	PA; ST; SL (2.28 mL per month); SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML ( <i>anakinra</i> )	3	PA; ST; SL (0.67 ml (1 syringe) per day.); SP
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
OLUMIANT ORAL TABLET 1 MG, 4 MG ( <i>baricitinib</i> )	2	PA; ST; SL (1 tablet per day.)
OLUMIANT ORAL TABLET 2 MG ( <i>baricitinib</i> )	2	PA; ST; SL (1 tablet per day.); SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML ( <i>abatacept</i> )	3	PA; ST; SL (4 auto-injectors per month.); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML ( <i>abatacept</i> )	3	PA; ST; SL (4 syringes per month); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML ( <i>abatacept</i> )	3	PA; SL (0.06 ml per day.); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML ( <i>abatacept</i> )	3	PA; SL (0.1 ml per day.); SP
OTEZLA ORAL TABLET 30 MG ( <i>apremilast</i> )	2	PA; SL (2 tablets per day.); SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG ( <i>apremilast</i> )	2	PA; SL (55 tablets (one starter pack) per year.); SP
<i>penicillamine oral tablet 250 mg</i>	1	SP
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (1 ml (4 auto-injectors) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML ( <i>methotrexate (anti-rheumatic)</i> )	2	SL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG ( <i>auranofin</i> )	3	SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG ( <i>upadacitinib</i> )	2	PA; SL (1 tablet per day.); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG ( <i>upadacitinib</i> )	2	PA; SL (84 tablets per 365 days.); SP
SANDIMMUNE ORAL SOLUTION 100 MG/ML ( <i>cyclosporine</i> )	3	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG ( <i>methotrexate sodium</i> )	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML ( <i>methotrexate</i> )	3	SL (4 ml per day); CM
XELJANZ ORAL SOLUTION 1 MG/ML ( <i>tofacitinib citrate</i> )	2	PA; SL (8 mL per day.); SP
XELJANZ ORAL TABLET 10 MG ( <i>tofacitinib citrate</i> )	2	PA; SL (2 tablets per day); SP
XELJANZ ORAL TABLET 5 MG ( <i>tofacitinib citrate</i> )	2	PA; SL (2 tablets per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG ( <i>tofacitinib citrate</i> )	2	PA; SL (1 tablet per day.); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG ( <i>tofacitinib citrate</i> )	2	PA; SL (1 tablet per day.)
<b>IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM</b>		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML ( <i>tocilizumab</i> )	3	PA; ST; SL (3.6 ml per 21 days.); SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML ( <i>tocilizumab</i> )	3	PA; ST; SL (4 syringes (36 mL) per month); SP
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML ( <i>interferon gamma-1b</i> )	2	PA; SL (8.5 mls per month.); SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; SL (0.03 ml per day.); SP
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML ( <i>interferon alfa-n3</i> )	2	
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.4 ml per day.); SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML ( <i>adalimumab-atto</i> )	3	PA; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML ( <i>adalimumab-atto</i> )	2	PA; SL (0.06 ml per day.); SP
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML ( <i>interferon beta-1a</i> )	2	PA; SL (4 pens (1 box) per month.); SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML ( <i>interferon beta-1a</i> )	2	PA; SL (4 syringes (1 box) per month.); SP
AZASAN ORAL TABLET 100 MG, 75 MG ( <i>azathioprine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG ( <i>sulfasalazine</i> )	3	
AZULFIDINE ORAL TABLET 500 MG ( <i>sulfasalazine</i> )	3	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG ( <i>monomethyl fumarate</i> )	2	PA; SL (4 capsules per day.); SP
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML ( <i>ropeginterferon alfa-2b-njft</i> )	3	PA; ST; SL (0.08 ml per day.)
BETASERON SUBCUTANEOUS KIT 0.3 MG ( <i>interferon beta-1b</i> )	2	PA; SL (15 vials per month)
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (6 mL per 365 days.); SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML ( <i>certolizumab pegol</i> )	2	PA; SL (1 kit per 21 days.); SP
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML ( <i>adalimumab-adbm</i> )	2	PA; SL (0.08 syringe per day.); SP
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1	PA; SL (56 capsules per year.)
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1	PA; SL (2 capsules per day.)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 &amp; 240 mg</i>	1	PA; SL (60 capsules (1 starter pack) per 365 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <i>etanercept</i> )	2	PA; SL (0.15 ml per day.); SP
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML ( <i>satralizumab-mwge</i> )	3	PA; SL (0.04 ml per day.); SP
<i>fingolimod hcl oral capsule 0.5 mg</i>	1	PA; SL (1 capsule per day)
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
GILENYA ORAL CAPSULE 0.25 MG ( <i>fingolimod hcl</i> )	3	PA; SL (1 capsule per day.)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	1	PA; SL (30 ml per month.)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	1	PA; SL (12 ml per 21 days.)
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	2	PA; SL (30 ml per month.)
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	2	PA; SL (12 ml per 21 days.)
HADLIMA PUSH TOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA PUSH TOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.03 ml per day.); SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	2	PA; SL (0.06 ml per day.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 pens per month.); SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (2 syringes per month.)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (6 pens (1 kit) per year.); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (2 kits per year); SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (3 syringes per year); SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	2	PA; SL (4 pens per 365 days.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	2	PA; SL (3 pens per year.); SP
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	1	
JOENJA ORAL TABLET 70 MG ( <i>leniolisib phosphate</i> )	2	PA; SL (2 tablets per day.); SP
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML ( <i>ofatumumab</i> )	2	PA; SL (0.02 ml per day.); SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML ( <i>anakinra</i> )	3	PA; ST; SL (0.67 ml (1 syringe) per day.); SP
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
<i>lenalidomide oral capsule 10 mg, 2.5 mg, 5 mg</i>	1	PA; SL (28 capsules per 21 days.); SP; CM
<i>lenalidomide oral capsule 15 mg, 20 mg, 25 mg</i>	1	PA; SL (21 capsules per 21 days.); SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG ( <i>cladribine</i> )	3	PA; ST; SL (40 tablets per 720 days.)
MAYZENT ORAL TABLET 0.25 MG ( <i>siponimod fumarate</i> )	3	PA; SL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG ( <i>siponimod fumarate</i> )	3	PA; SL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG ( <i>siponimod fumarate</i> )	3	PA; SL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG ( <i>siponimod fumarate</i> )	3	PA; SL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG ( <i>siponimod fumarate</i> )	3	PA; SL (7 tablets per 365 days.)
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML ( <i>abatacept</i> )	3	PA; ST; SL (4 auto-injectors per month.); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML ( <i>abatacept</i> )	3	PA; ST; SL (4 syringes per month); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML ( <i>abatacept</i> )	3	PA; SL (0.06 ml per day.); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML ( <i>abatacept</i> )	3	PA; SL (0.1 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
OTEZLA ORAL TABLET 30 MG ( <i>apremilast</i> )	2	PA; SL (2 tablets per day.); SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG ( <i>apremilast</i> )	2	PA; SL (55 tablets (one starter pack) per year.); SP
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML ( <i>peginterferon beta-1a</i> )	3	PA; SL (1 ml per month.)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML ( <i>peginterferon beta-1a</i> )	3	PA; SL (1 ml per year.); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML ( <i>peginterferon beta-1a</i> )	3	PA; SL (1 ml per year.); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML ( <i>peginterferon beta-1a</i> )	3	PA; SL (1 ml per month.); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML ( <i>peginterferon beta-1a</i> )	3	PA; SL (1 ml per month.); SP
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG ( <i>pomalidomide</i> )	3	PA; SP; CM
REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG ( <i>lenalidomide</i> )	2	PA; SL (28 capsules per 21 days.); SP; CM
REVLIMID ORAL CAPSULE 15 MG, 20 MG, 25 MG ( <i>lenalidomide</i> )	2	PA; SL (21 capsules per 21 days.); SP; CM
RIDAURA ORAL CAPSULE 3 MG ( <i>auranofin</i> )	3	SP
SANDIMMUNE ORAL SOLUTION 100 MG/ML ( <i>cyclosporine</i> )	3	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>golimumab</i> )	2	PA; SL (1 syringe per 21 days.); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML ( <i>golimumab</i> )	2	PA; SL (0.5 ml (1 syringe) per month); SP
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	1	PA; SL (1 tablet per day.)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG ( <i>thalidomide</i> )	2	PA; SP; CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG ( <i>methotrexate sodium</i> )	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML ( <i>methotrexate</i> )	3	SL (4 ml per day); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG ( <i>ozanimod hcl</i> )	3	PA; ST; SL (7 capsules per year.)
ZEPOSIA ORAL CAPSULE 0.92 MG ( <i>ozanimod hcl</i> )	3	PA; ST; SL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) ( <i>ozanimod hcl</i> )	3	PA; ST
<b>IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant</b>		
AZASAN ORAL TABLET 100 MG, 75 MG ( <i>azathioprine</i> )	3	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML ( <i>belimumab</i> )	2	PA; SL (4 ml per month.); SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML ( <i>belimumab</i> )	2	PA; SL (4 ml per month.); SP
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 50 MG	2	CM
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	1	
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	
<i>gengraf oral solution 100 mg/ml</i>	1	
HYFTOR EXTERNAL GEL 0.2 % ( <i>sirolimus</i> )	3	PA; SL (10 g per 23 days.)
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
LUPKYNIS ORAL CAPSULE 7.9 MG ( <i>voclosporin</i> )	3	PA; SL (6 capsules per day.); SP
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG ( <i>cladribine</i> )	3	PA; ST; SL (40 tablets per 720 days.)
<i>mercaptopurine oral tablet 50 mg</i>	1	CM
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	CM
<i>mycophenolate mofetil oral capsule 250 mg</i>	1	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	1	
<i>mycophenolic acid oral tablet delayed release 180 mg, 360 mg</i>	1	
NUJO EXTERNAL SOLUTION 0.1 %	3	
<i>pimecrolimus external cream 1 %</i>	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG ( <i>tacrolimus</i> )	3	
PROGRAF ORAL PACKET 0.2 MG, 1 MG ( <i>tacrolimus</i> )	3	
PURIXAN ORAL SUSPENSION 2000 MG/100ML ( <i>mercaptopurine</i> )	3	SP; CM
RAPAMUNE ORAL SOLUTION 1 MG/ML ( <i>sirolimus</i> )	3	
SANDIMMUNE ORAL SOLUTION 100 MG/ML ( <i>cyclosporine</i> )	3	
<i>sirolimus oral solution 1 mg/ml</i>	1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG ( <i>methotrexate sodium</i> )	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML ( <i>methotrexate</i> )	3	SL (4 ml per day); CM
<b>KALLIKREIN INHIBITORS</b>		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML ( <i>lanadelumab-flyo</i> )	2	PA; SL (0.075 ml per day.); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>lanadelumab-flyo</i> )	2	PA; SL (0.0375 ml per day.); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML ( <i>lanadelumab-flyo</i> )	2	PA; SL (0.075 ml per day.); SP
<b>KALLIKREIN-KININ SYSTEM INHIBITORS</b>		
BERINERT INTRAVENOUS KIT 500 UNIT ( <i>c1 esterase inhibitor (human)</i> )	3	PA; ST; SL (0.4 boxes per day.); SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML ( <i>pegcetacoplan</i> )	2	PA; SL (5.8 ml per day. 2,100 ml per 360 days.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT ( <i>c1 esterase inhibitor (human)</i> )	2	PA; SL (24 vials per month.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT ( <i>c1 esterase inhibitor (human)</i> )	2	PA; SL (16 vials per month.); SP
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; SL (0.6 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT ( <i>c1 esterase inhibitor (recomb)</i> )	3	PA; SL (0.27 vials per day.); SP
<i>sajazir subcutaneous solution prefilled syringe 30 mg/3ml</i>	1	PA; SL (0.6 ml per day.); SP
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML ( <i>lanadelumab-flyo</i> )	2	PA; SL (0.075 ml per day.); SP
TAVNEOS ORAL CAPSULE 10 MG ( <i>avacopan</i> )	3	PA; SL (6 capsules per day.); SP
<b>OTHER MISCELLANEOUS THERAPEUTIC AGENTS</b>		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG ( <i>rilonacept</i> )	2	PA; SP
<i>betaine oral powder</i>	1	SP
CARNITOR ORAL SOLUTION 1 GM/10ML ( <i>levocarnitine</i> )	3	
CARNITOR ORAL TABLET 330 MG ( <i>levocarnitine</i> )	3	
CARNITOR SF ORAL SOLUTION 1 GM/10ML ( <i>levocarnitine</i> )	3	
CERDELGA ORAL CAPSULE 84 MG ( <i>eliglustat tartrate</i> )	2	PA; SP
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG ( <i>prenat-fecb-fefum-fa-dha w/o a</i> )	3	
CYSTADANE ORAL POWDER ( <i>betaine</i> )	3	SP
CYSTAGON ORAL CAPSULE 150 MG, 50 MG ( <i>cysteamine bitartrate</i> )	2	SP
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	1	PA; SL (2 tablets per day)
DEMSEER ORAL CAPSULE 250 MG ( <i>metyrosine</i> )	3	
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % ( <i>prasterone (dhea)</i> )	3	
ELMIRON ORAL CAPSULE 100 MG ( <i>pentosan polysulfate sodium</i> )	3	ST
ENBRACE HR ORAL CAPSULE ( <i>prenat vit-fe gly cys-fa-omega</i> )	3	
ENDARI ORAL PACKET 5 GM ( <i>glutamine (sickle cell)</i> )	3	SL (6 packets per day)
EVOTAZ ORAL TABLET 300-150 MG ( <i>atazanavir-cobicistat</i> )	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML ( <i>risdiplam</i> )	2	PA; SL (6.7 ml per day, 1280 ml per 180 days.); SP
FILSPARI ORAL TABLET 200 MG, 400 MG ( <i>sparsentan</i> )	3	PA; SL (1 tablet per day.); SP
FIRDAPSE ORAL TABLET 10 MG ( <i>amifampridine phosphate</i> )	2	PA; SL (8 tablets per day.); SP
GALAFOLD ORAL CAPSULE 123 MG ( <i>migalastat hcl</i> )	3	PA; SL (14 capsules per 21 days.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ISTURISA ORAL TABLET 1 MG ( <i>osilodrostat phosphate</i> )	3	PA; SL (8 tablets per day.); SP
ISTURISA ORAL TABLET 5 MG ( <i>osilodrostat phosphate</i> )	3	PA; SL (2 tablets per day.); SP
JAVYGTOR ORAL PACKET 100 MG ( <i>sapropterin dihydrochloride</i> )	3	PA; SL (16 packets per day.); SP
JAVYGTOR ORAL PACKET 500 MG ( <i>sapropterin dihydrochloride</i> )	3	PA; SL (4 packets per day.); SP
JAVYGTOR ORAL TABLET 100 MG ( <i>sapropterin dihydrochloride</i> )	3	PA; SL (16 tablets per day.); SP
<i>levocarnitine oral solution 1 gm/10ml</i>	1	
<i>levocarnitine sf oral solution 1 gm/10ml</i>	1	
<i>me/naphos/mb/hyo1 oral tablet 81.6 mg</i>	1	
<i>metyrosine oral capsule 250 mg</i>	1	
<i>miglustat oral capsule 100 mg</i>	1	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG ( <i>prenat-fe-methylfol-dha w/o a</i> )	3	
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG ( <i>nitisinone</i> )	1	PA; SP
ORFADIN ORAL SUSPENSION 4 MG/ML ( <i>nitisinone</i> )	2	PA; SP
PREMESISRX ORAL TABLET 1 MG ( <i>prenatal ca-b6-b12-fa-ginger</i> )	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG ( <i>prenat-fecbn-feasp-meth-fa-dha</i> )	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PREZCOBIX ORAL TABLET 800-150 MG ( <i>darunavir-cobicistat</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PRIMACARE ORAL CAPSULE 30-1-470 MG ( <i>pren-fe-meth-fa-omeg w/o a</i> )	3	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG ( <i>cysteamine bitartrate</i> )	3	PA; ST; SP
PROCYSBI ORAL PACKET 300 MG, 75 MG ( <i>cysteamine bitartrate</i> )	3	SP
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG ( <i>belumosudil mesylate</i> )	3	PA; SL (1 tablet per day.); SP
<i>sapropterin dihydrochloride oral packet 100 mg</i>	1	PA; SL (16 packets per day.); SP
<i>sapropterin dihydrochloride oral packet 500 mg</i>	1	PA; SL (4 packets per day.); SP
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	1	PA; SL (16 tablets per day); SP
SKYCLARYS ORAL CAPSULE 50 MG ( <i>omaveloxolone</i> )	2	PA; SL (3 capsules per day.); SP
SODIUM SULFACETAMIDE-BAKUCHIOL EXTERNAL LIQUID 10 %	3	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG ( <i>palovarotene</i> )	3	PA; SL (1 capsule per day.); SP
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i>elviteg-cobic-emtricit-tenofdf</i> )	2	SL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	2	SL (1 tablet per day.)
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG ( <i>tiopronin</i> )	3	SP
THIOLA ORAL TABLET 100 MG ( <i>tiopronin</i> )	3	SP
<i>tiopronin oral tablet 100 mg</i>	1	SP
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TYBOST ORAL TABLET 150 MG ( <i>cobicistat</i> )	2	
URELLE ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sa</i> )	3	
<i>uretron d/s oral tablet 81.6 mg</i>	1	
URIMAR-T ORAL CAPSULE 120 MG ( <i>meth-hyo-m bl-na phos-ph sa</i> )	3	
<i>urin ds oral tablet 81.6 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
UROGESIC-BLUE ORAL TABLET 81.6 MG ( <i>methen-hyosc-meth blue-na phos</i> )	2	
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG ( <i>alpelisib</i> )	3	PA; SL (84 tablets per 72 days.); SP
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG ( <i>alpelisib</i> )	3	PA; SL (168 tablets per 72 days.); SP
VILEVEV MB ORAL TABLET 81 MG ( <i>meth-hyo-m bl-na phos-ph sal</i> )	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG ( <i>prenat-fe poly-methfol-fa-dha</i> )	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG ( <i>prenat-fefum-fered-fa-dha w/oa</i> )	3	
VOWST ORAL CAPSULE ( <i>fecal microb spores, live-brpk</i> )	3	PA; SL (12 capsules per 365 days.); SP
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG ( <i>vosoritide</i> )	3	PA; SL (1 vial per day.); SP
VYNDAMAX ORAL CAPSULE 61 MG ( <i>tafamidis</i> )	2	PA; SL (1 capsule per day.); SP
VYNDAQEL ORAL CAPSULE 20 MG ( <i>tafamidis meglumine (cardiac)</i> )	2	PA; SL (4 capsules per day.); SP
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
XURIDEN ORAL PACKET 2 GM ( <i>uridine triacetate</i> )	2	PA; SP
ZOKINVY ORAL CAPSULE 50 MG ( <i>lonafarnib</i> )	2	PA; SL (5 capsules per day.); SP
ZOKINVY ORAL CAPSULE 75 MG ( <i>lonafarnib</i> )	2	PA; SL (1 tablet per day.); SP
<b>PROTECTIVE AGENTS</b>		
MESNEX ORAL TABLET 400 MG ( <i>mesna</i> )	3	SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>NONHORMONAL CONTRACEPTIVES - Drugs for Women</b>		
<b>NONHORMONAL CONTRACEPTIVES - Drugs for Women</b>		
CAYA VAGINAL DIAPHRAGM ( <i>diaphragm arc-spring</i> )	3	H
CONDOMS	3	SL (1 box of 12 condoms per 30 days.); H
DUREX EXTRA SENSITIVE THIN DEVICE ( <i>condoms latex lubricated</i> )	3	SL (1 box of 12 condoms per 30 days.); H
ENCARE VAGINAL SUPPOSITORY 100 MG ( <i>nonoxynol-9</i> )	E	H
FC2 FEMALE CONDOM ( <i>condoms - female</i> )	E	H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM ( <i>cervical caps</i> )	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % ( <i>nonoxynol-9</i> )	E	H
PHEXXI VAGINAL GEL 1.8-1-0.4 % ( <i>lactic ac-citric ac-pot bitart</i> )	3	H
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % ( <i>nonoxynol-9</i> )	E	H
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % ( <i>nonoxynol-9</i> )	E	H
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	2	H
<b>OXYTOCICS - Drugs for Women</b>		
<b>OXYTOCICS - Drugs for Women</b>		
CERVIDIL VAGINAL INSERT 10 MG ( <i>dinoprostone</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>methergine oral tablet 0.2 mg</i>	1	SL (28 tablets per year.)
<i>methylergonovine maleate oral tablet 0.2 mg</i>	1	SL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG ( <i>mifepristone</i> )	3	SM
<i>mifepristone oral tablet 200 mg</i>	1	SM
PREPIDIL VAGINAL GEL 0.5 MG/3GM ( <i>dinoprostone</i> )	3	
<b>PHARMACEUTICAL AIDS</b>		
<b>PHARMACEUTICAL AIDS</b>		
KERAMATRIX REPLICINE 2CMX3CM EXTERNAL SHEET ( <i>wound dressings</i> )	3	
KERAMATRIX REPLICINE 5CMX5CM EXTERNAL SHEET ( <i>wound dressings</i> )	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL ( <i>transdermal base</i> )	3	
<b>RESPIRATORY TRACT AGENTS - Drugs for the Lungs</b>		
<b>ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD</b>		
ADRENALIN NASAL SOLUTION 0.1 % ( <i>epinephrine hcl (nasal)</i> )	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML ( <i>epinephrine</i> )	2	
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	1	
<b>ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD</b>		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT ( <i>ipratropium bromide hfa</i> )	2	SL (0.87 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <i>ipratropium-albuterol</i> )	2	SL (0.28 grams per day.)
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG ( <i>tiotropium bromide monohydrate</i> )	1	SL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT ( <i>tiotropium bromide monohydrate</i> )	2	SL (0.15 grams per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>ANTIFIBROTIC AGENTS - Drugs for the Lungs</b>		
OFEV ORAL CAPSULE 100 MG, 150 MG ( <i>nintedanib esylate</i> )	3	PA; SL (2 capsules per day.); SP
<i>pirfenidone oral capsule 267 mg</i>	1	PA; SL (9 capsules per day.); SP
<i>pirfenidone oral tablet 267 mg</i>	1	PA; SL (9 tablets per day.); SP
<i>pirfenidone oral tablet 534 mg</i>	1	PA; SL (3 tablets per day.)
<i>pirfenidone oral tablet 801 mg</i>	1	PA; SL (3 tablets per day.); SP
<b>ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation</b>		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>mepolizumab</i> )	3	PA; SL (0.04 mL per day.); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>mepolizumab</i> )	3	PA; SL (0.04 mL per day.); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>mepolizumab</i> )	3	PA; SL (0.015 ml per day.)
<b>ANTITUSSIVES - Drugs for Cough and Cold</b>		
<i>benzonatate oral capsule 100 mg, 150 mg, 200 mg</i>	1	
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML ( <i>pseudoeph-bromphen-dm</i> )	3	
<i>codeine sulfate oral tablet 30 mg, 60 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
<i>guaifenesin ac oral syrup 100-10 mg/5ml</i>	1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>hydrocod poli-chlorophe poli er oral suspension extended release 10-8 mg/5ml</i>	1	PA
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	1	PA
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	1	PA
<i>hydromet oral solution 5-1.5 mg/5ml</i>	1	PA
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	1	
<i>promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml</i>	1	PA
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1	
<i>pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG ( <i>chlorpheniramine-codeine</i> )	3	
<b>CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs</b>		
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (728 packets per 356 days.); SP
ORKAMBI ORAL PACKET 75-94 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (1456 tablets per 356 days.); SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG ( <i>tezacaftor-ivacaftor</i> )	2	PA; SL (728 tablets per 356 days.); SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG ( <i>tezacaftor-ivacaftor</i> )	2	PA; SL (728 tablets per 356 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (1092 tablets per 356 days.); SP
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (3 tablets per day. 1092 tablets per 364 days.); SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (2 packets per day. 728 packets per 356 days.); SP
<b>CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs</b>		
KALYDECO ORAL PACKET 13.4 MG ( <i>ivacaftor</i> )	2	PA; SL (2 packets per day. 728 packets per 356 days.)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG ( <i>ivacaftor</i> )	2	PA; SL (728 packets per 356 days.); SP
KALYDECO ORAL PACKET 5.8 MG ( <i>ivacaftor</i> )	2	PA; SL (2 packets per day and 728 packets per 365 days.)
KALYDECO ORAL TABLET 150 MG ( <i>ivacaftor</i> )	2	PA; SL (780 tablets per 356 days.); SP
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (728 packets per 356 days.); SP
ORKAMBI ORAL PACKET 75-94 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (2 packets per day and 56 packets per 21 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG ( <i>lumacaftor-ivacaftor</i> )	2	PA; SL (1456 tablets per 356 days.); SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG ( <i>tezacaftor-ivacaftor</i> )	2	PA; SL (728 tablets per 356 days.); SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG ( <i>tezacaftor-ivacaftor</i> )	2	PA; SL (728 tablets per 356 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (1092 tablets per 356 days.); SP
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (3 tablets per day. 1092 tablets per 364 days.); SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG ( <i>elexacaftor-tezacaftor-ivacaft</i> )	2	PA; SL (2 packets per day. 728 packets per 356 days.); SP
<b>ENDOTHELIN RECEPTOR ANTAGONISTS - Drugs for the Lungs</b>		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; SL (1 tablet per day.); SP
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; SL (2 tablets per day.); SP
FILSPARI ORAL TABLET 200 MG, 400 MG ( <i>sparsentan</i> )	3	PA; SL (1 tablet per day.); SP
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	2	PA; SL (1 tablet per day.); SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG ( <i>bosentan</i> )	2	PA; SL (2 tablets per day.); SP
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	2	PA; SL (4 tablets per day.); SP
<b>EXPECTORANTS - Drugs for the Lungs</b>		
<i>guaifenesin ac oral syrup 100-10 mg/5ml</i>	1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	1	
<i>iodine strong oral solution 5 %</i>	1	
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	1	
<i>potassium iodide oral solution 1 gm/ml</i>	1	
SSKI ORAL SOLUTION 1 GM/ML ( <i>potassium iodide (expectorant)</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy</b>		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML ( <i>diphenhydramine hcl</i> )	3	PA
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML ( <i>carbinoxamine maleate</i> )	3	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethegan rectal suppository 12.5 mg, 25 mg, 50 mg</i>	1	
<b>INTERLEUKIN ANTAGONISTS - Drugs for Inflammation</b>		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML ( <i>dupilumab</i> )	2	PA; SL (0.09 ml per day.); SP
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML ( <i>benralizumab</i> )	3	PA; SL (1 pen per 56 days.)
<b>LEUKOTRIENE MODIFIERS - Drugs for Inflammation</b>		
ACCOLATE ORAL TABLET 10 MG, 20 MG ( <i>zafirlukast</i> )	3	
<i>montelukast sodium oral packet 4 mg</i>	1	
<i>montelukast sodium oral tablet 10 mg</i>	1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	1	
SINGULAIR ORAL PACKET 4 MG ( <i>montelukast sodium</i> )	3	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	1	
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	1	ST
ZYFLO ORAL TABLET 600 MG ( <i>zileuton</i> )	3	ST
<b>MAST-CELL STABILIZERS - Drugs for Inflammation</b>		
ALOCRILOPHthalmic SOLUTION 2 % ( <i>nedocromil sodium</i> )	3	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>MUCOLYTIC AGENTS - Drugs for the Lungs</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % ( <i>sodium chloride</i> )	2	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 %, 6 % ( <i>sodium chloride</i> )	3	
PULMOSAL INHALATION NEBULIZATION SOLUTION 7 % ( <i>sodium chloride</i> )	2	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML ( <i>dornase alfa</i> )	2	PA; SL (5 ml per day.); SP
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %</i>	1	
<b>NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation</b>		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	
<i>mometasone furoate nasal suspension 50 mcg/act</i>	1	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT ( <i>beclomethasone diprop (nasal)</i> )	3	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT ( <i>beclomethasone diprop (nasal)</i> )	3	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT ( <i>olopatadine-mometasone</i> )	3	
<b>ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation</b>		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT ( <i>albuterol-budesonide</i> )	3	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT ( <i>fluticasone furoate</i> )	1	SL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>fluticasone furoate</i> )	1	SL (1 packet per day.)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1	SL (120 ml (2 boxes) per 30 days.)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1	SL (60 ml (1 box) per 30 days.)
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT	3	SL (1 inhaler per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3	SL (2 inhalers per month)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	1	SL (10.6 grams per month.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	1	SL (42.4 grams per month.)
<b>PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs</b>		
DALIRESP ORAL TABLET 250 MCG ( <i>roflumilast</i> )	3	PA; SL (31 tablets per year.)
DALIRESP ORAL TABLET 500 MCG ( <i>roflumilast</i> )	3	PA; SL (1 tablet per day)
<i>roflumilast oral tablet 250 mcg</i>	1	PA; SL (31 tablets per year.)
<i>roflumilast oral tablet 500 mcg</i>	1	PA; SL (1 tablet per day)
<b>PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs</b>		
<i>alyq oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; SL (186 ml per month.); SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	SL (6 tablets per month)
<i>sildenafil citrate oral tablet 20 mg</i>	1	SL (0.5 tablet per day.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	SL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML ( <i>tadalafil (pah)</i> )	3	PA; SL (10 ml per day.); SP
<b>PROSTACYCLIN &amp; PROSTACYCLIN DERIVATIVES - Drugs for the Lungs</b>		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (168 tablets per year.); SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (336 tablets per year.); SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (252 tablets per year.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG ( <i>treprostinil</i> )	2	PA; SL (112 cartridges per 23 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG ( <i>treprostinil</i> )	2	PA; SL (196 cartridges per 365 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG ( <i>treprostinil</i> )	2	PA; SL (252 cartridges per 365 days.); SP
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML ( <i>iloprost</i> )	2	PA; SP
<b>RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs</b>		
BRONCHITOL INHALATION CAPSULE 40 MG ( <i>mannitol (cystic fibrosis)</i> )	3	PA; ST; SL (20 capsules per day.); SP; CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG ( <i>mannitol (cystic fibrosis)</i> )	3	PA; ST; SL (20 capsules per day.); SP; CM
<i>pirfenidone oral capsule 267 mg</i>	1	PA; SL (9 capsules per day.); SP
<i>pirfenidone oral tablet 267 mg</i>	1	PA; SL (9 tablets per day.); SP
<i>pirfenidone oral tablet 534 mg</i>	1	PA; SL (3 tablets per day.)
<i>pirfenidone oral tablet 801 mg</i>	1	PA; SL (3 tablets per day.); SP
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML ( <i>tezepelumab-ekko</i> )	3	PA; SL (0.07 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>omalizumab</i> )	2	SL (0.08 ml per day.); SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML ( <i>omalizumab</i> )	2	SL (0.15 ml per day.); SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML ( <i>omalizumab</i> )	2	SL (0.04 ml per day.); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>omalizumab</i> )	2	PA; SL (0.08 ml per day.); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML ( <i>omalizumab</i> )	2	PA; SL (0.15 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML ( <i>omalizumab</i> )	2	PA; SL (0.04 ml per day.); SP
<b>SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy</b>		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	
<i>desloratadine oral tablet 5 mg</i>	1	
<i>desloratadine oral tablet dispersible 5 mg</i>	1	
<b>SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD</b>		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT ( <i>albuterol-budesonide</i> )	3	
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	1	
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1	
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	1	
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	1	SL (2 vials per day)
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	1	
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	
PERFORMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML ( <i>formoterol fumarate</i> )	3	SL (2 vials per day)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>salmeterol xinafoate</i> )	2	SL (2 blisters per day.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT ( <i>olodaterol hcl</i> )	2	SL (0.14 grams per day.)
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT ( <i>levalbuterol tartrate</i> )	3	
<b>VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG ( <i>riociguat</i> )	2	PA; SL (3 tablets per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>alyq oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	1	PA; SL (1 tablet per day.); SP
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	1	PA; SL (2 tablets per day.); SP
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	2	PA; SL (1 tablet per day.); SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (168 tablets per year.); SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (336 tablets per year.); SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (252 tablets per year.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day.); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG ( <i>treprostinil diolamine</i> )	3	PA; SL (6 tablets per day); SP
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; SL (186 ml per month.); SP
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	SL (6 tablets per month)
<i>sildenafil citrate oral tablet 20 mg</i>	1	SL (0.5 tablet per day.)
<i>tadalafil (pah) oral tablet 20 mg</i>	1	PA; SL (2 tablets per day); SP
TADLIQ ORAL SUSPENSION 20 MG/5ML ( <i>tadalafil (pah)</i> )	3	PA; SL (10 ml per day.); SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG ( <i>bosentan</i> )	2	PA; SL (2 tablets per day.); SP
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	2	PA; SL (4 tablets per day.); SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG ( <i>treprostinil</i> )	2	PA; SL (112 cartridges per 23 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG ( <i>treprostinil</i> )	2	PA; SL (196 cartridges per 365 days.); SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG ( <i>treprostinil</i> )	2	PA; SL (252 cartridges per 365 days.); SP
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	2	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG ( <i>selexipag</i> )	3	PA; SL (2 tablets per day.); SP
UPTRAVI TABLET 200 MCG ORAL ( <i>selexipag</i> )	3	PA; SL (140 tablets per 365 days.); SP
UPTRAVI TABLET 200 MCG ORAL ( <i>selexipag</i> )	3	PA; SL (2 tablets per day.); SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG ( <i>selexipag</i> )	3	PA; SL (200 tablets per year.); SP
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML ( <i>iloprost</i> )	2	PA; SP
<b>VASODILATING AGENTS, MISC - Drugs for the Lungs</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG ( <i>riociguat</i> )	2	PA; SL (3 tablets per day.); SP
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG ( <i>selexipag</i> )	3	PA; SL (2 tablets per day.); SP
UPTRAVI TABLET 200 MCG ORAL ( <i>selexipag</i> )	3	PA; SL (140 tablets per 365 days.); SP
UPTRAVI TABLET 200 MCG ORAL ( <i>selexipag</i> )	3	PA; SL (2 tablets per day.); SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG ( <i>selexipag</i> )	3	PA; SL (200 tablets per year.); SP
<b>XANTHINE DERIVATIVES - Drugs for Asthma/COPD</b>		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin</b>		
<b>ALLYLAMINES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin</b>		
<i>naftifine hcl external cream 1 %, 2 %</i>	1	
<i>naftifine hcl external gel 2 %</i>	1	
NAFTIN EXTERNAL GEL 1 %, 2 % ( <i>naftifine hcl</i> )	3	
<b>ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin</b>		
ACANYA EXTERNAL GEL 1.2-2.5 % ( <i>clindamycin phos-benzoyl perox</i> )	3	
ALTABAX EXTERNAL OINTMENT 1 % ( <i>retapamulin</i> )	3	
AMZEEQ EXTERNAL FOAM 4 % ( <i>minocycline hcl micronized</i> )	3	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
AVAR-E GREEN EXTERNAL CREAM 10-5 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
AVAR-E LS EXTERNAL CREAM 10-2 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
AVEIDA EXTERNAL GEL 1-1 %	3	
BENZAMYCIN EXTERNAL GEL 5-3 % ( <i>benzoyl peroxide-erythromycin</i> )	2	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	1	
<i>bp 10-1 external emulsion 10-1 %</i>	1	
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % ( <i>adapalene-benzoyl per-clindamy</i> )	3	
CLEOCIN VAGINAL CREAM 2 % ( <i>clindamycin phosphate</i> )	3	
CLEOCIN VAGINAL SUPPOSITORY 100 MG ( <i>clindamycin phosphate</i> )	2	
CLEOCIN-T EXTERNAL LOTION 1 % ( <i>clindamycin phosphate</i> )	3	
CLINDACIN ETZ EXTERNAL KIT 1 % ( <i>clindamycin phos &amp; cleanser</i> )	3	
<i>clindacin etz external swab 1 %</i>	1	
<i>clindacin external foam 1 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>clindacin-p external swab 1 %</i>	1	
CLINDAGEL EXTERNAL GEL 1 % ( <i>clindamycin phosphate</i> )	3	
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1	SL (1 bottle (45 grams) per month.)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %</i>	1	
<i>clindamycin phosphate external foam 1 %</i>	1	
<i>clindamycin phosphate external gel 1 %</i>	1	
<i>clindamycin phosphate external lotion 1 %</i>	1	
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>clindamycin phosphate vaginal cream 2 %</i>	1	
<i>clindamycin-tretinoin external gel 1.2-0.025 %</i>	1	
CLINDESSE VAGINAL CREAM 2 % ( <i>clindamycin phosphate (1 dose)</i> )	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % ( <i>clindamycin-tretinoin-cholesty</i> )	3	PA
<i>dapsone external gel 5 %, 7.5 %</i>	1	
DAZAVEIDAOXIA EXTERNAL GEL 0.25-1-1-4 %	3	
DEOXIATAR EXTERNAL SOLUTION 1-4-0.025 %	3	
DIASAXIATAR EXTERNAL GEL 8.5-2-0.025 %	3	
<i>ery external pad 2 %</i>	1	
ERYGEL EXTERNAL GEL 2 % ( <i>erythromycin</i> )	3	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
<i>gentamicin sulfate external cream 0.1 %</i>	1	
<i>gentamicin sulfate external ointment 0.1 %</i>	1	
IDARAN EXTERNAL OINTMENT 1-2 %	3	
KLARON EXTERNAL LOTION 10 % ( <i>sulfacetamide sodium (acne)</i> )	3	
METROCREAM EXTERNAL CREAM 0.75 % ( <i>metronidazole</i> )	3	
METROLOTION EXTERNAL LOTION 0.75 % ( <i>metronidazole</i> )	3	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %, 1 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>mupirocin calcium external cream 2 %</i>	1	
<i>mupirocin external ointment 2 %</i>	1	
NANRAN EXTERNAL OINTMENT 2-2 %	3	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % ( <i>neomycin-fluocinolone</i> )	3	
<i>neuac external gel 1.2-5 %</i>	1	SL (1 bottle (45 grams) per month.)
NUVESSA VAGINAL GEL 1.3 % ( <i>metronidazole</i> )	3	
ONEXTON EXTERNAL GEL 1.2-3.75 % ( <i>clindamycin phosphoyl perox</i> )	3	
OVACE PLUS EXTERNAL CREAM 10 % ( <i>sulfacetamide sodium</i> )	3	
OVACE PLUS EXTERNAL LOTION 9.8 % ( <i>sulfacetamide sodium</i> )	3	
OVACE PLUS EXTERNAL SHAMPOO 10 % ( <i>sulfacetamide sodium</i> )	3	
OVACE PLUS WASH EXTERNAL GEL 10 % ( <i>sulfacetamide sodium</i> )	3	
OVACE PLUS WASH EXTERNAL LIQUID 10 % ( <i>sulfacetamide sodium</i> )	3	
OVACE WASH EXTERNAL LIQUID 10 % ( <i>sulfacetamide sodium</i> )	3	
OXIAICE EXTERNAL LOTION 4-15 %	3	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
PLEXION EXTERNAL CREAM 9.8-4.8 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
PLEXION EXTERNAL LOTION 9.8-4.8 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
<i>sodium sulfacetamide external shampoo 10 %</i>	1	
<i>sodium sulfacetamide wash external liquid 10 %</i>	1	
SODIUM SULFACETAMIDE-BAKUCHIOL EXTERNAL LIQUID 10 %	3	
<i>sss 10-5 external cream 10-5 %</i>	1	
SSS 10-5 EXTERNAL FOAM 10-5 %	3	
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>sulfacetamide sodium (cleans) external gel 10 %</i>	1	
<i>sulfacetamide sodium external liquid 10 %</i>	1	
<i>sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external pad 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %</i>	1	
<i>sulfacetamide sod-sulfur wash external liquid 9-4 %</i>	1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
<i>sulfamez wash external emulsion 10-1 %</i>	1	
SUMAXIN CP EXTERNAL KIT 10-4 % ( <i>sulfacetamide-sulfur-cleanser</i> )	3	
SUMAXIN EXTERNAL PAD 10-4 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
VELTIN EXTERNAL GEL 1.2-0.025 % ( <i>clindamycin-tretinoin</i> )	3	
XACIATO VAGINAL GEL 2 % ( <i>clindamycin phosphate</i> )	2	
XEPI EXTERNAL CREAM 1 % ( <i>ozenoxacin</i> )	3	
ZILXI EXTERNAL FOAM 1.5 % ( <i>minocycline hcl micronized</i> )	3	PA; ST
<b>ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin</b>		
EXODERM EXTERNAL LOTION 25-1 % ( <i>sod thiosulfate-salicylic acid</i> )	3	
<b>ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin</b>		
EUCRISA EXTERNAL OINTMENT 2 % ( <i>crisaborole</i> )	3	ST
VTAMA EXTERNAL CREAM 1 % ( <i>tapinarof</i> )	3	PA
<b>ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin</b>		
7T LIDO EXTERNAL GEL 2 % ( <i>lidocaine hcl</i> )	3	
ANALPRAM HC EXTERNAL CREAM 2.5-1 % ( <i>hydrocortisone ace-pramoxine</i> )	3	
ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % ( <i>hydrocortisone ace-pramoxine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANALPRAM-HC EXTERNAL CREAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	3	
ANALPRAM-HC EXTERNAL LOTION 2.5-1 % ( <i>hydrocortisone ace-pramoxine</i> )	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylonol</i> )	3	
<i>doxepin hcl external cream 5 %</i>	1	PA
ENOVARX-LIDOCAINE HCL EXTERNAL CREAM 10 %, 5 %	3	PA
EPIFOAM EXTERNAL FOAM 1-1 % ( <i>pramoxine-hc</i> )	2	
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION ( <i>dph-lido-alhydr-mghydr-simeth</i> )	3	PA
<i>glydo external prefilled syringe 2 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % ( <i>ketoprofen-baclofen-gabap-lido</i> )	3	PA
<i>lidocaine external ointment 5 %</i>	1	SL (1.19 grams per day.)
<i>lidocaine external patch 5 %</i>	1	PA; SL (3 patches per day)
<i>lidocaine hcl external solution 4 %</i>	1	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	1	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	1	
LIDTOPIC MAX EXTERNAL CREAM 10 % ( <i>lidocaine hcl</i> )	3	PA
NANRAN EXTERNAL OINTMENT 2-2 %	3	
<i>phenazo oral tablet 200 mg</i>	1	
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	1	
PRAMOSONE EXTERNAL CREAM 1-1 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL CREAM 1-2.5 % ( <i>pramoxine-hc</i> )	3	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % ( <i>pramoxine-hc</i> )	3	
<i>premium lidocaine external ointment 5 %</i>	1	SL (1.19 grams per day.)
PROCORT EXTERNAL CREAM 1.85-1.15 % ( <i>hydrocortisone ace-pramoxine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	2	
PYRIDIUM ORAL TABLET 100 MG, 200 MG ( <i>phenazopyridine hcl</i> )	3	
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
<b>ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin</b>		
<i>acyclovir external cream 5 %</i>	1	
<i>acyclovir external ointment 5 %</i>	1	
DENAVIR EXTERNAL CREAM 1 % ( <i>penciclovir</i> )	3	
<i>penciclovir external cream 1 %</i>	1	
ZOVIRAX EXTERNAL CREAM 5 % ( <i>acyclovir</i> )	3	
<b>ASTRINGENTS - Drugs for the Skin</b>		
DRYSOL EXTERNAL SOLUTION 20 % ( <i>aluminum chloride</i> )	2	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % ( <i>miconazole-zinc oxide-petrolat</i> )	3	
<b>AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin</b>		
<i>clotrimazole mouth/throat troche 10 mg</i>	1	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	1	
<i>econazole nitrate external cream 1 %</i>	1	
ECOZA EXTERNAL FOAM 1 % ( <i>econazole nitrate</i> )	3	
EXELDERM EXTERNAL CREAM 1 % ( <i>sulconazole nitrate</i> )	3	
EXELDERM EXTERNAL SOLUTION 1 % ( <i>sulconazole nitrate</i> )	3	
GYNAZOLE-1 VAGINAL CREAM 2 % ( <i>butoconazole nitrate (1 dose)</i> )	3	
JUBLIA EXTERNAL SOLUTION 10 % ( <i>efinaconazole</i> )	3	SL (4 ml per month.)
<i>ketoconazole external cream 2 %</i>	1	
<i>ketoconazole external foam 2 %</i>	1	
<i>ketoconazole external shampoo 2 %</i>	1	
<i>ketodan external foam 2 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
LULICONAZOLE EXTERNAL CREAM 1 %	3	
LUZU EXTERNAL CREAM 1 % ( <i>luliconazole</i> )	3	
<i>miconazole 3 vaginal suppository 200 mg</i>	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3	
ORAVIG BUCCAL TABLET 50 MG ( <i>miconazole</i> )	3	
<i>oxiconazole nitrate external cream 1 %</i>	1	
OXISTAT EXTERNAL CREAM 1 % ( <i>oxiconazole nitrate</i> )	3	
OXISTAT EXTERNAL LOTION 1 % ( <i>oxiconazole nitrate</i> )	3	
PHEDRAX EXTERNAL SHAMPOO 2-2 %	3	
PHEOXIA EXTERNAL CREAM 2-4 %	3	
PODIATROLE EXTERNAL THERAPY PACK 2 & 20 % ( <i>ketoconazole-urea</i> )	3	
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	1	
<i>terconazole vaginal suppository 80 mg</i>	1	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % ( <i>miconazole-zinc oxide-petrolat</i> )	3	
XOLEGEL COREPAK EXTERNAL KIT 2 & 1 % ( <i>ketoconazole-hydrocortisone</i> )	3	
XOLEGEL DUO/HEAD & SHOULDERS EXTERNAL KIT 2 & 1 % ( <i>ketoconazole &amp; pyrithione zinc</i> )	3	
XOLEGEL DUO/XOLEX EXTERNAL KIT 2 & 1 % ( <i>ketoconazole &amp; pyrithione zinc</i> )	3	
<b>BASIC LOTIONS AND LINIMENTS - Drugs for the Skin</b>		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % ( <i>salicylic acid-lactic acid</i> )	2	
<i>methyl salicylate external liquid</i>	1	
PRONAL EXTERNAL GEL 40-10 % ( <i>urea-lactic acid</i> )	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % ( <i>salicylic acid-urea in lactac</i> )	3	
<i>turpentine external spirit</i>	1	
VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % ( <i>benzoyl peroxide-hyaluronate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>BASIC POWDERS AND DEMULCENTS - Drugs for the Skin</b>		
<i>benzoin compound external tincture</i>	1	
<i>benzoin external tincture</i>	1	
<b>CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin</b>		
ALTRENO EXTERNAL LOTION 0.05 % ( <i>tretinoin</i> )	3	PA
<i>clindamycin-tretinoin external gel 1.2-0.025 %</i>	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % ( <i>clindamycin-tretinoin-cholesty</i> )	3	PA
DEOXIATAR EXTERNAL SOLUTION 1-4-0.025 %	3	
DIASAXIATAR EXTERNAL GEL 8.5-2-0.025 %	3	
KATARAXAP EXTERNAL EMULSION 4-0.025-0.025 %	3	
KEVARAXAP EXTERNAL EMULSION 6-0.05-0.025 %	3	
KEVARTIA EXTERNAL EMULSION 6-0.05 %	3	
KOTARAXAP EXTERNAL EMULSION 5-0.025-0.025 %	3	
KUTAR EXTERNAL EMULSION 8-0.025 %	3	
KUTARVIA EXTERNAL EMULSION 8-0.025 %	3	
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % ( <i>tretinoin microsphere</i> )	3	PA
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	1	
<i>tretinoin external gel 0.01 %</i>	1	
<i>tretinoin external gel 0.05 %</i>	1	PA
<i>tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %</i>	1	PA
<i>tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %</i>	1	PA
TWYNEO EXTERNAL CREAM 0.1-3 % ( <i>tretinoin-benzoyl peroxide</i> )	3	
VELTIN EXTERNAL GEL 1.2-0.025 % ( <i>clindamycin-tretinoin</i> )	3	
<b>CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin</b>		
ALA SCALP EXTERNAL LOTION 2 % ( <i>hydrocortisone</i> )	3	
<i>alclometasone dipropionate external cream 0.05 %</i>	1	
<i>alclometasone dipropionate external ointment 0.05 %</i>	1	
<i>amcinonide external ointment 0.1 %</i>	1	
ANALPRAM HC EXTERNAL CREAM 2.5-1 % ( <i>hydrocortisone ace-pramoxine</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	3	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (hydrocortisone ace-pramoxine)	3	
ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
anucort-hc rectal suppository 25 mg	1	
ANUSOL-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	3	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	3	
APEXICON E EXTERNAL CREAM 0.05 % (diflorasone diacet emoll base)	2	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BRYHALI EXTERNAL LOTION 0.01 % (halobetasol propionate)	3	ST
budesonide rectal foam 2 mg	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
CAPEX EXTERNAL SHAMPOO 0.01 % (fluocinolone acetonide)	2	
clobetasol prop emollient base external cream 0.05 %	1	
clobetasol propionate e external cream 0.05 %	1	
clobetasol propionate emulsion external foam 0.05 %	1	
clobetasol propionate external cream 0.05 %	1	
clobetasol propionate external foam 0.05 %	1	
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external liquid 0.05 %	1	
clobetasol propionate external lotion 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>clobetasol propionate external ointment 0.05 %</i>	1	
<i>clobetasol propionate external shampoo 0.05 %</i>	1	
<i>clobetasol propionate external solution 0.05 %</i>	1	
LOBETAVIX EXTERNAL KIT 0.05 %	3	
<i>clocortolone pivalate external cream 0.1 %</i>	1	
<i>clodan external shampoo 0.05 %</i>	1	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	1	
CORDRAN EXTERNAL CREAM 0.05 % ( <i>flurandrenolide</i> )	3	
CORDRAN EXTERNAL LOTION 0.05 % ( <i>flurandrenolide</i> )	3	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM ( <i>flurandrenolide</i> )	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylenol</i> )	3	
CORTENEMA RECTAL ENEMA 100 MG/60ML ( <i>hydrocortisone</i> )	3	
CORTIFOAM EXTERNAL FOAM 10 % ( <i>hydrocortisone acetate</i> )	2	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % ( <i>fluocinolone acetonide</i> )	3	
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % ( <i>fluocinolone acetonide</i> )	3	
<i>desonide external cream 0.05 %</i>	1	
<i>desonide external gel 0.05 %</i>	1	
<i>desonide external lotion 0.05 %</i>	1	
<i>desonide external ointment 0.05 %</i>	1	
DESOWEN EXTERNAL CREAM 0.05 % ( <i>desonide</i> )	3	
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	1	
<i>desoximetasone external gel 0.05 %</i>	1	
<i>desoximetasone external liquid 0.25 %</i>	1	
<i>desoximetasone external ointment 0.05 %, 0.25 %</i>	1	
<i>diflorasone diacetate external cream 0.05 %</i>	1	
<i>diflorasone diacetate external ointment 0.05 %</i>	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % ( <i>betamethasone dipropionate aug</i> )	3	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % ( <i>calcipotriene-betameth diprop</i> )	3	
EPIFOAM EXTERNAL FOAM 1-1 % ( <i>pramoxine-hc</i> )	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>fluocinolone acetonide body external oil 0.01 %</i>	1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	1	
<i>fluocinolone acetonide external solution 0.01 %</i>	1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	1	
<i>fluocinonide emulsified base external cream 0.05 %</i>	1	
<i>fluocinonide external cream 0.05 %, 0.1 %</i>	1	
<i>fluocinonide external gel 0.05 %</i>	1	
<i>fluocinonide external ointment 0.05 %</i>	1	
<i>fluocinonide external solution 0.05 %</i>	1	
FLUOXIA EXTERNAL CREAM 0.05-4 %	3	
<i>flurandrenolide external cream 0.05 %</i>	1	
<i>flurandrenolide external lotion 0.05 %</i>	1	
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external lotion 0.05 %</i>	1	
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>halcinonide external cream 0.1 %</i>	1	
<i>halobetasol propionate external cream 0.05 %</i>	1	
<i>halobetasol propionate external ointment 0.05 %</i>	1	
HALOG EXTERNAL OINTMENT 0.1 % ( <i>halcinonide</i> )	3	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG, 30 MG ( <i>hydrocortisone acetate</i> )	3	
HYDROCORT LOTION COMPLETE KIT EXTERNAL KIT 2 %	3	
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	1	
<i>hydrocortisone butyrate external ointment 0.1 %</i>	1	
<i>hydrocortisone butyrate external solution 0.1 %</i>	1	
<i>hydrocortisone external cream 2.5 %</i>	1	
<i>hydrocortisone external lotion 2.5 %</i>	1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	1	
<i>hydrocortisone valerate external cream 0.2 %</i>	1	
<i>hydrocortisone valerate external ointment 0.2 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	1	
KATARAXAP EXTERNAL EMULSION 4-0.025-0.025 %	3	
KEVARAXAP EXTERNAL EMULSION 6-0.05-0.025 %	3	
KOTARAXAP EXTERNAL EMULSION 5-0.025-0.025 %	3	
<i>kourzeq mouth/throat paste 0.1 %</i>	1	
<i>mometasone furoate external cream 0.1 %</i>	1	
<i>mometasone furoate external ointment 0.1 %</i>	1	
<i>mometasone furoate external solution 0.1 %</i>	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % ( <i>neomycin-fluocinolone</i> )	3	
NUCORT EXTERNAL LOTION 2 % ( <i>hydrocortisone acetate</i> )	3	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	1	
<i>oralone mouth/throat paste 0.1 %</i>	1	
PANDEL EXTERNAL CREAM 0.1 % ( <i>hydrocortisone probutate</i> )	3	
PRAMOSONE EXTERNAL CREAM 1-1 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL CREAM 1-2.5 % ( <i>pramoxine-hc</i> )	3	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % ( <i>pramoxine-hc</i> )	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % ( <i>pramoxine-hc</i> )	3	
PROCORT EXTERNAL CREAM 1.85-1.15 % ( <i>hydrocortisone ace-pramoxine</i> )	3	
PROCTOCORT RECTAL SUPPOSITORY 30 MG ( <i>hydrocortisone acetate</i> )	3	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	2	
<i>procto-med hc external cream 2.5 %</i>	1	
<i>proctosol hc external cream 2.5 %</i>	1	
<i>proctozone-hc external cream 2.5 %</i>	1	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % ( <i>hc &amp; sal acid-sulfur &amp; shampoo</i> )	3	
SERNIVO EXTERNAL EMULSION 0.05 % ( <i>betamethasone dipropionate</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
SYNALAR EXTERNAL CREAM 0.025 % ( <i>fluocinolone acetonide</i> )	3	
SYNALAR EXTERNAL OINTMENT 0.025 % ( <i>fluocinolone acetonide</i> )	3	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % ( <i>calcipotriene-betameth diprop</i> )	1	
TEXACORT EXTERNAL SOLUTION 2.5 % ( <i>hydrocortisone</i> )	2	
TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % ( <i>desoximetasone</i> )	3	
TOPICORT EXTERNAL GEL 0.05 % ( <i>desoximetasone</i> )	3	
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % ( <i>desoximetasone</i> )	3	
<i>tovet external foam 0.05 %</i>	1	
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	1	
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	1	
<i>triderm external cream 0.5 %</i>	1	
VERDESO EXTERNAL FOAM 0.05 % ( <i>desonide</i> )	3	
XOLEGEL COREPAK EXTERNAL KIT 2 & 1 % ( <i>ketconazole-hydrocortisone</i> )	3	
<b>DEPIGMENTING AGENTS - Drugs for the Skin</b>		
KATARAXAP EXTERNAL EMULSION 4-0.025-0.025 %	3	
KEVARAXAP EXTERNAL EMULSION 6-0.05-0.025 %	3	
KEVARTIA EXTERNAL EMULSION 6-0.05 %	3	
KOTARAXAP EXTERNAL EMULSION 5-0.025-0.025 %	3	
KUTAR EXTERNAL EMULSION 8-0.025 %	3	
KUTARVIA EXTERNAL EMULSION 8-0.025 %	3	
<b>EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin</b>		
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % ( <i>benzoyl perox-salicyl ac-vit e</i> )	3	
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % ( <i>benzoyl perox-salicyl ac-vit e</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % ( <i>benzoyl peroxide-vitamin e</i> )	3	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % ( <i>miconazole-zinc oxide-petrolat</i> )	3	
<b>HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin</b>		
<i>ciclodan external solution 8 %</i>	1	
<i>ciclopirox external gel 0.77 %</i>	1	
<i>ciclopirox external shampoo 1 %</i>	1	
<i>ciclopirox external solution 8 %</i>	1	
<i>ciclopirox olamine external cream 0.77 %</i>	1	
<i>ciclopirox olamine external suspension 0.77 %</i>	1	
<i>ciclopirox treatment external kit 8 %</i>	1	
HEXIOUNYL EXTERNAL LOTION 3-5-20 %	3	
<b>IMMUNOMODULATORY AGENT(S) - Drugs for the Skin</b>		
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>tralokinumab-ldrm</i> )	2	PA; SL (0.15 ml per day.); SP
HYFTOR EXTERNAL GEL 0.2 % ( <i>sirolimus</i> )	3	PA; SL (10 g per 23 days.)
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>tildrakizumab-asmn</i> )	3	PA; ST; SL (1 ml per 63 days.); SP
NUJO EXTERNAL SOLUTION 0.1 %	3	
<i>pimecrolimus external cream 1 %</i>	1	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (1 ml per 63 days.); SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (1 ml per 63 days.); SP
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML ( <i>guselkumab</i> )	2	PA; SL (1 ml per 42 days.); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>guselkumab</i> )	2	PA; SL (2 ml per 2 months); SP
<b>KERATOLYTIC AGENTS - Drugs for the Skin</b>		
AVAR CLEANSER EXTERNAL LIQUID 10-5 % ( <i>sulfacetamide sodium-sulfur</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (sulfacetamide sodium-sulfur)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (sulfacetamide sodium-sulfur)	3	
AVAR-E GREEN EXTERNAL CREAM 10-5 % (sulfacetamide sodium-sulfur)	3	
AVAR-E LS EXTERNAL CREAM 10-2 % (sulfacetamide sodium-sulfur)	3	
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline-sunscreen-sal acid)	3	
bp 10-1 external emulsion 10-1 %	1	
cerovel external lotion 40 %	1	
DERMACINRX UREA EXTERNAL CREAM 41 % (urea)	3	
EXODERM EXTERNAL LOTION 25-1 % (sod thiosulfate-salicylic acid)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (salicylic acid-lactic acid)	2	
HEXIOUNYL EXTERNAL LOTION 3-5-20 %	3	
HYDRO 40 EXTERNAL FOAM 40 % (urea)	3	
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % (benzoyl perox-salicyl ac-vit e)	3	
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % (benzoyl perox-salicyl ac-vit e)	3	
KERALYT SCALP EXTERNAL KIT 6 % (salicylic acid)	3	
NUTRASEB EXTERNAL CREAM (antiseborrheic products, misc.)	3	
PHEDRAX EXTERNAL SHAMPOO 2-2 %	3	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (sulfacetamide sodium-sulfur)	3	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (sulfacetamide sodium-sulfur)	3	
PLEXION EXTERNAL CREAM 9.8-4.8 % (sulfacetamide sodium-sulfur)	3	
PLEXION EXTERNAL LOTION 9.8-4.8 % (sulfacetamide sodium-sulfur)	3	
PODIATROLE EXTERNAL THERAPY PACK 2 & 20 % (ketoconazole-urea)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PROMISEB EXTERNAL CREAM ( <i>antiseborrheic products, misc.</i> )	3	
PRONAL EXTERNAL GEL 40-10 % ( <i>urea-lactic acid</i> )	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RAYASAL EXTERNAL CREAM 5.9 %	3	
SALICATE EXTERNAL LIQUID 10 % ( <i>salicylic acid</i> )	3	
<i>salicylic acid external solution 26 %</i>	1	
SALIMEZ EXTERNAL CREAM 6 %	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % ( <i>salicylic acid-urea in lactac</i> )	3	
SALYCIM EXTERNAL CREAM 6 % ( <i>salicylic acid</i> )	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % ( <i>hc &amp; sal acid-sulfur &amp; shampoo</i> )	3	
<i>sss 10-5 external cream 10-5 %</i>	1	
SSS 10-5 EXTERNAL FOAM 10-5 %	3	
<i>sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external pad 9.8-4.8 %</i>	1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %</i>	1	
<i>sulfacetamide sod-sulfur wash external liquid 9-4 %</i>	1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
<i>sulfamez wash external emulsion 10-1 %</i>	1	
SUMAXIN CP EXTERNAL KIT 10-4 % ( <i>sulfacetamide-sulfur-cleanser</i> )	3	
SUMAXIN EXTERNAL PAD 10-4 % ( <i>sulfacetamide sodium-sulfur</i> )	3	
UMECTA MOUSSE EXTERNAL FOAM 40 % ( <i>urea</i> )	3	
URAMAXIN EXTERNAL GEL 45 % ( <i>urea</i> )	3	
<i>urea cream 20 % external (rx)</i>	1	
<i>urea external cream 40 %, 41 %, 45 %</i>	1	
<i>urea external lotion 40 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>urea nail external gel 45 %</i>	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
<b>KERATOPLASTIC AGENTS - Drugs for the Skin</b>		
<i>coal tar external solution 20 %</i>	1	
<b>LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin</b>		
ACANYA EXTERNAL GEL 1.2-2.5 % ( <i>clindamycin phos-benzoyl perox</i> )	3	
<i>benzalkonium chloride external solution</i>	2	
<i>benzalkonium chloride external solution 50 %</i>	1	
BENZAMYCIN EXTERNAL GEL 5-3 % ( <i>benzoyl peroxide-erythromycin</i> )	2	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	1	
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % ( <i>adapalene-benzoyl per-clindamy</i> )	3	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1	SL (1 bottle (45 grams) per month.)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %</i>	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylenol</i> )	3	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % ( <i>sulfuric acid-sulf phenolics</i> )	2	
FEM PH VAGINAL GEL 0.9-0.025 % ( <i>acetic acid-oxyquinoline</i> )	3	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	1	
INOVA 4/1 ACNE CONTROL THERAPY EXTERNAL KIT 4 & 1 & 5 % ( <i>benzoyl perox-salicyl ac-vit e</i> )	3	
INOVA 8/2 ACNE CONTROL THERAPY EXTERNAL KIT 8 & 2 & 5 % ( <i>benzoyl perox-salicyl ac-vit e</i> )	3	
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % ( <i>benzoyl peroxide-vitamin e</i> )	3	
<i>iodine tincture external tincture 2 %</i>	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
<i>mafenide acetate external packet 5 %</i>	1	
<i>neuac external gel 1.2-5 %</i>	1	SL (1 bottle (45 grams) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ONEXTON EXTERNAL GEL 1.2-3.75 % ( <i>clindamycin phosphoyl perox</i> )	3	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % ( <i>chlorhexidine gluconate</i> )	3	
<i>perio gard mouth/throat solution 0.12 %</i>	1	
<i>selenium sulfide external lotion 2.5 %</i>	1	
SILVADENE EXTERNAL CREAM 1 % ( <i>silver sulfadiazine</i> )	3	
<i>silver sulfadiazine external cream 1 %</i>	1	
<i>ssd external cream 1 %</i>	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM ( <i>mafenide acetate</i> )	3	
SULFAMYLON EXTERNAL PACKET 5 % ( <i>mafenide acetate</i> )	3	
TWYNEO EXTERNAL CREAM 0.1-3 % ( <i>tretinoin-benzoyl peroxide</i> )	3	
XOLEGEL DUO/HEAD & SHOULDERS EXTERNAL KIT 2 & 1 % ( <i>ketoconazole &amp; pyrithione zinc</i> )	3	
XOLEGEL DUO/XOLEX EXTERNAL KIT 2 & 1 % ( <i>ketoconazole &amp; pyrithione zinc</i> )	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % ( <i>benzoyl peroxide-hyaluronate</i> )	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
<b>NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin</b>		
<i>diclofenac sodium external gel 3 %</i>	1	PA
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
ENOVARX-IBUPROFEN EXTERNAL CREAM 10 %	3	PA
ENOVARX-NAPROXEN EXTERNAL CREAM 10 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FROTEK EXTERNAL CREAM 10 % ( <i>ketoprofen</i> )	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % ( <i>ketoprofen-baclofen-gabap-lido</i> )	3	PA
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
<b>OXABOROLES - Drugs for the Skin</b>		
<i>tavaborole external solution 5 %</i>	1	SL (4 ml per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<b>PIGMENTING AGENTS - Drugs for the Skin</b>		
<i>methoxsalen rapid oral capsule 10 mg</i>	1	
<b>POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin</b>		
<i>klayesta external powder 100000 unit/gm</i>	1	
<i>nyamyc external powder 100000 unit/gm</i>	1	
<i>nystatin external cream 100000 unit/gm</i>	1	
<i>nystatin external ointment 100000 unit/gm</i>	1	
<i>nystatin external powder 100000 unit/gm</i>	1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	1	
<i>nystop external powder 100000 unit/gm</i>	1	
<b>SCABICIDES AND PEDICULICIDES - Drugs for the Skin</b>		
AVEIDA EXTERNAL GEL 1-1 %	3	
CROTAN EXTERNAL LOTION 10 % ( <i>crotamiton</i> )	3	
DAZAVEIDAOXIA EXTERNAL GEL 0.25-1-1-4 %	3	
<i>malathion external lotion 0.5 %</i>	1	
OVIDE EXTERNAL LOTION 0.5 % ( <i>malathion</i> )	3	
<i>permethrin external cream 5 %</i>	1	
SOOLANTRA EXTERNAL CREAM 1 % ( <i>ivermectin</i> )	1	
<i>spinosad external suspension 0.9 %</i>	1	
<i>sulfurated lime external solution</i>	1	
<b>SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin</b>		
A.A.G.C. KIT IN TERODERM EXTERNAL CREAM 8-4-10-4 % ( <i>amantad-amitrip-gabap-cycloben</i> )	3	PA
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	1	
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>tralokinumab-ldrm</i> )	2	PA; SL (0.15 ml per day.); SP
AKLIEF EXTERNAL CREAM 0.005 % ( <i>trifarotene</i> )	3	PA
ALEVAMAX EXTERNAL CREAM	3	
AMELUZ EXTERNAL GEL 10 % ( <i>aminolevulinic acid hcl</i> )	3	
<i>amnesteam oral capsule 10 mg, 20 mg, 40 mg</i>	1	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML ( <i>fibrin sealant component</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
ARTISS EXTERNAL SOLUTION ( <i>fibrin sealant component</i> )	3	
<i>azelaic acid external gel 15 %</i>	1	
AZELEX EXTERNAL CREAM 20 % ( <i>azelaic acid</i> )	3	
B & C EXTERNAL OINTMENT	3	
<i>balsam peru-castor oil external ointment</i>	1	
<i>bexarotene external gel 1 %</i>	1	SP
<i>brimonidine tartrate external gel 0.33 %</i>	1	PA
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % ( <i>adapalene-benzoyl per-clindamy</i> )	3	
<i>calcipotriene external cream 0.005 %</i>	1	
<i>calcipotriene external ointment 0.005 %</i>	1	
<i>calcipotriene external solution 0.005 %</i>	1	
<i>calcipotriene-betameth diprop external ointment 0.005-0.064 %</i>	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % ( <i>calcipotriene</i> )	3	
<i>calcitriol external ointment 3 mcg/gm</i>	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG ( <i>abrocitinib</i> )	2	PA; SL (1 tablet per day.); SP; CM
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
<i>clindamycin-tretinoin external gel 1.2-0.025 %</i>	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % ( <i>clindamycin-tretinoin-cholesty</i> )	3	PA
COLLANEX EXTERNAL POWDER ( <i>wound dressings</i> )	3	
CONDYLOX EXTERNAL GEL 0.5 % ( <i>podofilox</i> )	3	
COPASIL EXTERNAL GEL ( <i>scar treatment products</i> )	3	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.072 mL per day.); SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.036 mL per day.); SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.072 mL per day.); SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.036 mL per day.); SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML ( <i>secukinumab</i> )	3	PA; ST; SL (0.0715 ml per day.); SP
<i>dapsone external gel 5 %, 7.5 %</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DAZAVEIDAOXIA EXTERNAL GEL 0.25-1-1-4 %	3	
DEOXIATAR EXTERNAL SOLUTION 1-4-0.025 %	3	
DERMASO PLUS EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
DEXERYL EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
DIASAXIATAR EXTERNAL GEL 8.5-2-0.025 %	3	
DIOOXIA EXTERNAL CREAM 0.005-4 %	3	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML ( <i>dupilumab</i> )	2	PA; SL (0.09 ml per day.); SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML ( <i>dupilumab</i> )	2	PA; SL (0.15 ml per day.); SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML ( <i>dupilumab</i> )	2	PA; SL (0.15 ml per day.); SP
EFUDEX EXTERNAL CREAM 5 % ( <i>fluorouracil</i> )	3	
ENOVARX-TRAMADOL EXTERNAL CREAM 5 %	3	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % ( <i>calcipotriene-betameth diprop</i> )	3	
FABIOR EXTERNAL FOAM 0.1 % ( <i>tazarotene</i> )	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FEM PH VAGINAL GEL 0.9-0.025 % ( <i>acetic acid-oxyquinoline</i> )	3	
FINACEA EXTERNAL FOAM 15 % ( <i>azelaic acid</i> )	2	
<i>fluorouracil external cream 5 %</i>	1	
<i>fluorouracil external solution 2 %, 5 %</i>	1	
FLUOXIA EXTERNAL CREAM 0.05-4 %	3	
HALUCORT EXTERNAL GEL ( <i>dermatological products, misc.</i> )	3	
HPR PLUS EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
HYDROCORT LOTION COMPLETE KIT EXTERNAL KIT 2 %	3	
HYFTOR EXTERNAL GEL 0.2 % ( <i>sirolimus</i> )	3	PA; SL (10 g per 23 days.)
HYLATOPIC PLUS EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>tildrakizumab-asmn</i> )	3	PA; ST; SL (1 ml per 63 days.); SP
<i>imiquimod external cream 5 %</i>	1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % ( <i>ketoprofen-baclofen-gabap-lido</i> )	3	PA
KLISYRI EXTERNAL OINTMENT 1 % ( <i>tirbanibulin</i> )	3	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % ( <i>aminolevulinic acid hcl</i> )	3	
LITFULO ORAL CAPSULE 50 MG ( <i>ritlecitinib tosylate</i> )	3	PA; SL (1 capsule per day.); SP
LUXAMEND EXTERNAL CREAM ( <i>wound dressings</i> )	3	
MEDERMA SPF 30 EXTERNAL CREAM ( <i>scar treatment products</i> )	3	PA
<i>minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	1	
MIRVASO EXTERNAL GEL 0.33 % ( <i>brimonidine tartrate</i> )	3	PA
NEOSALUS EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
<i>nitroglycerin rectal ointment 0.4 %</i>	1	SL (30 grams per month.)
NUJO EXTERNAL SOLUTION 0.1 %	3	
OPZELURA EXTERNAL CREAM 1.5 % ( <i>ruxolitinib phosphate</i> )	3	PA; SL (540 grams per 365 days.); SP
OTEZLA ORAL TABLET 30 MG ( <i>apremilast</i> )	2	PA; SL (2 tablets per day.); SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG ( <i>apremilast</i> )	2	PA; SL (55 tablets (one starter pack) per year.); SP
OXIAICE EXTERNAL LOTION 4-15 %	3	
PANRETIN EXTERNAL GEL 0.1 % ( <i>alitretinoin</i> )	3	
PHEOXIA EXTERNAL CREAM 2-4 %	3	
<i>pimecrolimus external cream 1 %</i>	1	
PODOCON-25 EXTERNAL SOLUTION 25 % ( <i>podophyllum resin</i> )	3	
<i>podofilox external gel 0.5 %</i>	1	
<i>podofilox external solution 0.5 %</i>	1	
PRUCLAIR EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
PRUMYX EXTERNAL CREAM ( <i>dermatological products, misc.</i> )	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % ( <i>nitroglycerin</i> )	3	SL (30 grams per month.)
REGANEX EXTERNAL GEL 0.01 % ( <i>becaplermin</i> )	2	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
REMIGEN EXTERNAL CREAM	3	
RHOFADE EXTERNAL CREAM 1 % ( <i>oxymetazoline hcl</i> )	3	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM ( <i>collagenase</i> )	3	
SCARCIN EXTERNAL CREAM	3	PA
SILATRIX MOUTH/THROAT GEL 10 %	3	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (1 ml per 63 days.); SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>risankizumab-rzaa</i> )	2	PA; SL (1 ml per 63 days.); SP
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG ( <i>minocycline hcl</i> )	3	
SOTYKTU ORAL TABLET 6 MG ( <i>deucravacitinib</i> )	3	PA; ST; SL (1 tablet per day.); SP
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML ( <i>ustekinumab</i> )	2	PA; SL (0.006 ml per day.); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML ( <i>ustekinumab</i> )	2	PA; SL (0.006 ml per day.); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML ( <i>ustekinumab</i> )	2	PA; SL (0.012 ml per day.); SP
STRATA CTX EXTERNAL GEL ( <i>dermatological products, misc.</i> )	3	
STRATA XRT EXTERNAL GEL ( <i>dermatological products, misc.</i> )	3	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % ( <i>calcipotriene-betameth diprop</i> )	1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	1	
<i>tazarotene external cream 0.1 %</i>	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	3	PA
<i>tazarotene external gel 0.05 %, 0.1 %</i>	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % ( <i>tazarotene</i> )	3	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % ( <i>tazarotene</i> )	3	PA
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML ( <i>fibrin sealant component</i> )	3	
TOLAK EXTERNAL CREAM 4 % ( <i>fluorouracil</i> )	3	
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML ( <i>guselkumab</i> )	2	PA; SL (1 ml per 42 days.); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>guselkumab</i> )	2	PA; SL (2 ml per 2 months); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VALCHLOR EXTERNAL GEL 0.016 % ( <i>mechlorethamine hcl (topical)</i> )	2	PA; SP
VELTIN EXTERNAL GEL 1.2-0.025 % ( <i>clindamycin-tretinoin</i> )	3	
VEVELEX EXTERNAL OINTMENT ( <i>balsam peru-castor oil</i> )	3	
VEREGEN EXTERNAL OINTMENT 15 % ( <i>sinecatechins</i> )	3	ST
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
VTAMA EXTERNAL CREAM 1 % ( <i>tapinarof</i> )	3	PA
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
ZENPHOR WOUND PAD EXTERNAL PAD	3	
ZORYVE EXTERNAL CREAM 0.3 % ( <i>roflumilast</i> )	3	PA; SL (60 grams per 30 days.)
<b>SUNSCREEN AGENTS - Drugs for the Skin</b>		
AVIDOXY DK COMBINATION KIT 100 MG ( <i>doxycycline-sunscreen-sal acid</i> )	3	
<b>THIOCARBAMATES(SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin</b>		
MYCOZYL AL EXTERNAL SOLUTION 1 % ( <i>tolnaftate</i> )	3	
<b>SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles</b>		
<b>ANTIMUSCARINICS - Drugs for the Urinary System</b>		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	1	
<i>flavoxate hcl oral tablet 100 mg</i>	1	
GELNIQUE TRANSDERMAL GEL 10 % ( <i>oxybutynin chloride</i> )	3	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	1	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride oral tablet 2.5 mg, 5 mg</i>	1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	1	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	1	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	1	
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	1	
<i>tropium chloride oral tablet 20 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VESICARE LS ORAL SUSPENSION 5 MG/5ML ( <i>solifenacin succinate</i> )	3	
VESICARE ORAL TABLET 10 MG, 5 MG ( <i>solifenacin succinate</i> )	3	
<b>RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs</b>		
<i>elixophyllin oral elixir 80 mg/15ml</i>	3	
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	1	PA; SL (186 ml per month.); SP
<i>sildenafil citrate oral tablet 20 mg</i>	1	SL (0.5 tablet per day.)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	3	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
<i>theophylline oral elixir 80 mg/15ml</i>	1	
<i>theophylline oral solution 80 mg/15ml</i>	1	
<b>SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System</b>		
GEMTESA ORAL TABLET 75 MG ( <i>vibegron</i> )	3	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG ( <i>mirabegron</i> )	3	
<b>VITAMINS</b>		
<b>MULTIVITAMIN PREPARATIONS</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	1	
ATABEX OB ORAL TABLET 29-1 MG ( <i>prenatal vit w/ fe bisg-fa</i> )	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG ( <i>prenat-fecb-fefum-fa-dha w/o a</i> )	3	
ELITE-OB ORAL TABLET 50-1.25 MG ( <i>prenatal vit-iron carbonyl-fa</i> )	3	
ENBRACE HR ORAL CAPSULE ( <i>prenat vit-fe gly cys-fa-omega</i> )	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML ( <i>pediatric multivitamins-fl</i> )	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>multivitamin/fluoride tablet chewable 0.25 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 0.5 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 1 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG ( <i>pediatric multivitamins-fl</i> )	3	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
NEONATAL 19 ORAL TABLET 1 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG, 29-1 MG	3	
NEONATAL FE ORAL TABLET 90-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG ( <i>prenat-fe-methylfol-dha w/o a</i> )	3	
NESTABS ORAL TABLET 32-1 MG ( <i>prenat-fe bisgly-fa-w/o vit a</i> )	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>pediatric multivitamins-fl</i> )	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG ( <i>pediatric multivitamins-fl</i> )	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML ( <i>ped multivitamins-fl-iron</i> )	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG ( <i>ped multivitamins-fl-iron</i> )	3	
PREMESISRX ORAL TABLET 1 MG ( <i>prenatal ca-b6-b12-fa-ginger</i> )	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
<i>prenatal oral tablet 27-1 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG ( <i>prenatal-feaspgly-methylfol-fa</i> )	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG ( <i>prenat-fecbn-feasp-meth-fa-dha</i> )	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG ( <i>prenat mv-min-methylfolate-fa</i> )	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATVITE COMPLETE ORAL TABLET 1 MG	3	
PRENATVITE PLUS ORAL TABLET 1 MG	3	
PRENATVITE RX ORAL TABLET 0.8 MG	3	
PRIMACARE ORAL CAPSULE 30-1-470 MG ( <i>pren-fe-meth-fa-omeg w/o a</i> )	3	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML, 0.5 MG/ML ( <i>pediatric multivitamins-fl</i> )	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG ( <i>pediatric multivitamins-fl</i> )	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG ( <i>prenatal vit-fe psac cmplx-fa</i> )	3	
TRINATE ORAL TABLET ( <i>prenatal vit-fe fumarate-fa</i> )	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>ped vit a-c-d-methylfolate-fl</i> )	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
VINATE ONE ORAL TABLET 60-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG ( <i>prenat-fe poly-methfol-fa-dha</i> )	3	
VITAFOL STRIPS ORAL FILM 1 MG ( <i>prenatal-b6-b12-d3-folic acid</i> )	3	
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG ( <i>prenatal-fe fum-methf-fa w/o a</i> )	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	1	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG ( <i>prenat-fefum-fered-fa-dha w/oa</i> )	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<b>VITAMIN A</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	1	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>ped vit a-c-d-methylfolate-fl</i> )	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	1	
<b>VITAMIN B COMPLEX</b>		
ATABEX OB ORAL TABLET 29-1 MG ( <i>prenatal vit w/ fe bisg-fa</i> )	3	
CALCIFOL ORAL WAFER 1342-1.6 MG ( <i>ca carb-fa-d-b6-b12-boron-mg</i> )	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG ( <i>prenat-fecb-fefum-fa-dha w/o a</i> )	3	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
<i>cyanocobalamin nasal solution 500 mcg/0.1ml</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.



Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DODEX INJECTION SOLUTION 1000 MCG/ML (cyanocobalamin)	3	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	1	H
ELITE-OB ORAL TABLET 50-1.25 MG ( <i>prenatal vit-iron carbonyl-fa</i> )	3	
ENBRACE HR ORAL CAPSULE ( <i>prenat vit-fe gly cys-fa-omega</i> )	3	
<i>folic acid oral tablet 1 mg</i>	1	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	E	H
<i>hematinic/folic acid oral tablet 324-1 mg</i>	1	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>multivitamin/fluoride tablet chewable 0.25 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 0.5 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
<i>multivitamin/fluoride tablet chewable 1 mg oral (rx)</i>	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (cyanocobalamin)	3	
NATAL PNV ORAL TABLET 6-0.5 MG	3	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
NEONATAL COMPLETE ORAL TABLET 27-1 MG, 29-1 MG	3	
NEONATAL FE ORAL TABLET 90-1 MG	3	
NEONATAL PLUS ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG ( <i>prenat-fe-methylfol-dha w/o a</i> )	3	
NESTABS ORAL TABLET 32-1 MG ( <i>prenat-fe bisgly-fa-w/o vit a</i> )	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
PREMESISRX ORAL TABLET 1 MG ( <i>prenatal ca-b6-b12-fa-ginger</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
<i>prenatal oral tablet 27-1 mg</i>	1	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG ( <i>prenatal-feaspgly-methylfol-fa</i> )	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG ( <i>prenat-fecbn-feasp-meth-fa-dha</i> )	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG ( <i>prenat mv-min-methylfolate-fa</i> )	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
PRENATVITE COMPLETE ORAL TABLET 1 MG	3	
PRENATVITE PLUS ORAL TABLET 1 MG	3	
PRENATVITE RX ORAL TABLET 0.8 MG	3	
PRIMACARE ORAL CAPSULE 30-1-470 MG ( <i>pren-fe-meth-fa-omeg w/o a</i> )	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG ( <i>prenatal vit-fe psac cmplx-fa</i> )	3	
TRINATE ORAL TABLET ( <i>prenatal vit-fe fumarate-fa</i> )	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>ped vit a-c-d-methylfolate-fl</i> )	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
<i>tydemy oral tablet 3-0.03-0.451 mg</i>	1	H
VINATE ONE ORAL TABLET 60-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG ( <i>prenat-fe poly-methfol-fa-dha</i> )	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG ( <i>prenatal-fe fum-methf-fa w/o a</i> )	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG ( <i>prenat-fefum-fered-fa-dha w/oa</i> )	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG ( <i>prenatal vit-fe fumarate-fa</i> )	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
<b>VITAMIN C</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	1	
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM ( <i>peg-kcl-nacl-nasulf-na asc-c</i> )	2	
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	1	
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	1	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM ( <i>peg-kcl-nacl-nasulf-na asc-c</i> )	2	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>ped vit a-c-d-methylfolate-fl</i> )	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	1	
<b>VITAMIN D</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	1	
CALCIFOL ORAL WAFER 1342-1.6 MG ( <i>ca carb-fa-d-b6-b12-boron-mg</i> )	3	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	1	
<i>calcitriol oral solution 1 mcg/ml</i>	1	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

Prescription Drug Name	Drug Tier	Coverage Requirements & Limits
DRISDOL ORAL CAPSULE 1.25 MG (50000 UT) ( <i>ergocalciferol</i> )	3	
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML ( <i>sodium fluoride-vitamin d</i> )	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT ( <i>alendronate-cholecalciferol</i> )	3	
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	1	
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG ( <i>calcitriol</i> )	3	
ROCALTROL ORAL SOLUTION 1 MCG/ML ( <i>calcitriol</i> )	3	
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML ( <i>ped vit a-c-d-methylfolate-fl</i> )	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	1	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG ( <i>paricalcitol</i> )	3	
<b>VITAMIN E</b>		
<i>wheat germ oil oral oil</i>	1	
<b>VITAMIN K ACTIVITY</b>		
<i>phytonadione oral tablet 5 mg</i>	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your highest cost medications; PA: Prior authorization required; SL: Supply Limit; ST: Step Therapy; H: Part of health care reform preventive when age and/or condition appropriate; SP: Specialty medication; CM: Orally administered anticancer medication; E: Excluded from coverage unless covered as part of health care reform preventive; SM: \$0 cost-share by state mandate when condition appropriate.

## Index of Drugs

7T LIDO.....	239	ADEMPAS.....	233, 235	ALORA.....	177, 203
A.A.G.C. KIT IN TERODERM.	254	ADIPEX-P.....	90	<i>alose tron hcl</i> .....	155
<i>abacavir sulfate</i> .....	25	ADLARITY.....	54	ALPHAGAN P.....	145
<i>abacavir sulfate-lamivudine</i> .....	25	ADRENALIN.....	48, 154, 225	ALPHANATE.....	61
<i>abiraterone acetate</i> .....	33	ADVAIR HFA.....	55, 164	ALPHANINE SD.....	62
ABRYSVO.....	44	ADVATE.....	61	<i>alprazolam</i> .....	107
<i>acamprosate calcium</i> .....	109	ADYNOVATE.....	61	<i>alprazolam er</i> .....	107
ACANYA.....	236, 252	ADZENYS XR-ODT.....	91	<i>alprazolam intensol</i> .....	107
<i>acarbose</i> .....	166	AEMCOLO.....	31	<i>alprazolam xr</i> .....	107
ACCOLATE.....	229	AEROCHAMBER HOLDING		ALPROLIX.....	62
ACCU-CHEK AVIVA.....	129	CHAMBER.....	129	ALREX.....	149
ACCU-CHEK FASTCLIX		AEROCHAMBER PLS FLOVU		ALTABAX.....	236
LANCET KIT.....	129	MTHPIECE.....	129	ALTACAINE.....	153
ACCU-CHEK GUIDE.....	129, 135	AEROCHAMBER PLUS FLO-		<i>altafrin</i> .....	153, 154
ACCU-CHEK GUIDE		VU INTERM.....	129	<i>altavera</i> .....	170, 177, 188
CONTROL.....	129	AEROCHAMBER PLUS FLO-		ALTOPREV.....	84
ACCU-CHEK GUIDE ME.....	129	VU LARGE.....	129	ALTRENO.....	243
ACCU-CHEK SMARTVIEW		AEROCHAMBER PLUS FLO-		ALTUVIIIO.....	62
CONTROL.....	129	VU MEDIUM.....	129	ALUNBRIG.....	33
ACCU-CHEK SOFTCLIX		AEROCHAMBER PLUS FLO-		<i>alvimopan</i> .....	159
LANCET DEVICE KIT.....	129	VU SMALL.....	129	<i>alyacen 1/35</i> .....	170, 177, 189
ACCURETIC.....	71, 142	<i>afirmelle</i> .....	170, 177, 188	<i>alyacen 7/7/7</i> .....	170, 177, 189
<i>accutane</i> .....	254	AFLURIA QUADRIVALENT.....	44	<i>alyq</i> .....	86, 231, 234
ACD-A NOCLOT-50.....	58	AFREZZA.....	196	<i>amabelz</i> .....	177, 189
<i>acebutolol hcl</i> .....	57, 73, 74, 79	AFSTYLA.....	61	<i>amantadine hcl</i> .....	14, 15, 90
<i>acetaminophen-codeine</i> .....	92, 114	<i>aftera</i> .....	170, 188	<i>ambrisentan</i> .....	88, 228, 234
<i>acetazolamide</i> .....	77, 94, 138, 148	AIMOVIG.....	108, 109	<i>amcinonide</i> .....	243
<i>acetazolamide er</i> .....	77, 94, 138, 148	AIRSUPRA55, 149, 164, 230, 233		AMELUZ.....	254
<i>acetic acid</i> .....	151	AKLIEF.....	254	<i>amethia</i> .....	170, 177, 189
<i>acetylcysteine</i> .....	201, 230	AKTEN.....	153	<i>amethyst</i> .....	170, 177, 189
<i>acitretin</i> .....	254	AKYNZEO.....	154, 162	<i>amiloride hcl</i> .....	87, 140
ACTEMRA.....	208, 213	ALA SCALP.....	243	<i>amiloride-hydrochlorothiazide</i>	140, 142
ACTEMRA ACTPEN.....	208, 213	<i>albendazole</i> .....	16	<i>aminoamrms</i> .....	138
ACTHAR.....	135, 188	<i>albuterol sulfate</i> .....	55, 233	<i>aminocaproic acid</i> .....	62
ACTHIB.....	44	ALBUTEROL SULFATE ...	55, 233	<i>aminoreliefrms</i> .....	138
ACTIMMUNE.....	213	<i>albuterol sulfate hfa</i> .....	55, 233	<i>amiodarone hcl</i> .....	80
ACTIVELLA.....	177, 188	ALCAINE.....	153	<i>amitriptyline hcl</i> .....	127
ACTOPLUS MET.....	169, 199	<i>alclometasone dipropionate</i> .....	243	AMJEVITA.....	159, 208, 213
ACULAR.....	152	ALCOHOL PREP PADS.....	129	AMJEVITA-PED.10K159,208,213	
ACULAR LS.....	152	ALECENSA.....	33	AMJEVITA-PED.15K159,208,213	
ACUVAIL.....	152	<i>alendronate sodium</i> .....	203	AMLODIPINE	
<i>acyclovir</i> .....	28, 29, 241	ALEVAMAX.....	254	BES+SYRSPEND SF ...	81, 82, 88
ADACEL.....	43, 44	ALFERON N.....	28, 33, 213	<i>amlodipine besylate</i> .....	81, 82, 88
ADALIMUMAB-ADAZ		<i>alfuzosin hcl er</i> .....	55	<i>amlodipine besylate-benazepril</i>	
.....	159, 208, 213	ALINIA.....	18	<i>hcl</i> .....	71, 81
ADASUVE.....	103	<i>aliskiren fumarate</i> .....	87	<i>amlodipine besylate-valsartan</i>	
ADBRY.....	249, 254	<i>allopurinol</i> .....	202	.....	70, 81
<i>adc/f (0.5mg/ml)</i>		ALLOPURINOL.....	202	<i>amlodipine-atorvastatin</i> .....	82, 84
.....	205, 260, 263, 266	ALLZITAL.....	92, 106	<i>amlodipine-olmesartan</i> .....	70, 82
ADDERALL XR.....	91	<i>almotriptan malate</i> .....	125		
ADDYI.....	109	ALOCRIIL.....	145, 229		
<i>adefovir dipivoxil</i> .....	29	ALOMIDE.....	13, 146		



<i>amlodipine-valsartan-hctz</i>	ARAKODA.....	16	AUGMENTIN.....	16
..... 70, 82, 142	<i>aranelle</i> .....	170, 177, 189	AUM INSULIN SAFETY PEN	
<i>amnesteam</i> .....	ARANESP (ALBUMIN FREE)		NEEDLE .....	129
..... 254	.....	57, 58, 60	AUM MINI INSULIN PEN	
<i>amoxapine</i> .....	ARCALYST.....	220	NEEDLE .....	130
<i>amoxicill-clarithro-lansopraz</i>	AREXVY.....	44	AUM PEN NEEDLE .....	130
..... 15, 29, 162	<i>arformoterol tartrate</i> .....	55	AUM READYGARD DUO PEN	
<i>amoxicillin</i> .....	ARIKAYCE.....	15	NEEDLE .....	130
<i>amoxicillin-potassium</i>	<i>aripiprazole</i> .....	99, 104	AUM SAFETY PEN NEEDLE .	130
<i>clavulanate</i> .....	<i>armodafinil</i> .....	128	<i>aurovela 1.5/30</i> .....	170, 177, 189
<i>amoxicillin-potassium</i>	ARMOUR THYROID.....	199	<i>aurovela 1/20</i> .....	170, 177, 189
<i>clavulanate er</i> .....	ARNUITY ELLIPTA .....	164, 230	<i>aurovela 24 fe</i> .....	170, 178, 189
..... 15, 156	ARTISS.....	254, 255	<i>aurovela fe 1.5/30</i> ...	170, 178, 189
<i>amoxicillin-potassium</i>	ARZOL SILVER NIT		<i>aurovela fe 1/20</i> .....	170, 178, 189
<i>clavulanate</i> .....	APPLICATORS .....	151	AUSTEDO.....	128
<i>amoxicillin-potassium</i>	<i>ascomp-codeine</i>		AUSTEDO XR.....	128
<i>clavulanate er</i> .....	.....	106, 114, 121, 123	AUSTEDO XR PATIENT	
..... 15	<i>asenapine maleate</i> .....	99, 104	TITRATION.....	128
<i>amphetamine sulfate</i> .....	<i>ashlyna</i> .....	170, 177, 189	AUTOLET LANCING DEVICE	130
..... 91	<i>aspirin</i> .....	68, 101, 124	AUVELITY .....	98
<i>amphetamine-</i>	<i>aspirin 81</i> .....	67, 68, 101, 123	AUVI-Q.....	48, 225
<i>dextroamphetamine</i> .....	<i>aspirin adult low dose</i>		AVAR CLEANSER.....	236, 249
..... 91	.....	67, 68, 101, 123	AVAR LS CLEANSER ....	236, 250
<i>amphetamine-</i>	<i>aspirin adult low strength</i>		AVAR-E EMOLLIENT ....	236, 250
<i>dextroamphetamine er</i> .....	.....	67, 68, 101, 123	AVAR-E GREEN.....	236, 250
..... 91	<i>aspirin childrens</i> ..	67, 68, 101, 123	AVAR-E LS.....	236, 250
<i>amphet-dextroamphet 3-bead</i>	<i>aspirin ec low dose</i>		AVEIDA.....	236, 254
<i>er</i> .....	.....	67, 68, 101, 123	<i>aviane</i> .....	170, 178, 189
..... 91	<i>aspirin ec low strength</i>		<i>avidoxy</i> .....	17, 31
<i>ampicillin</i> .....	.....	67, 68, 101, 124	AVIDOXY DK.....	31, 250, 259
..... 16	<i>aspirin low dose</i> ..	67, 68, 101, 124	AVONEX PEN.....	213
AMZEEQ.....	<i>aspirin regimen</i> .....	68, 101, 124	AVONEX PREFILLED .....	213
..... 236	<i>aspirin-dipyridamole er</i> .....	68, 124	<i>ayuna</i> .....	170, 178, 189
<i>anagrelide hcl</i> .....	ASPRUZYO SPRINKLE.....	77	AYVAKIT.....	33
..... 68	ASSURE ID DUO PRO PEN		AZASAN.....	208, 213, 218
ANALPRAM HC .....	NEEDLES .....	129	AZASITE.....	146
..... 239, 243	ASSURE ID PRO PEN		<i>azathioprine</i> .....	208, 214, 218
ANALPRAM HC SINGLES	NEEDLES.....	129	<i>azelaic acid</i> .....	255
.....	ASTRINGYN.....	62	<i>azelastine hcl</i> .....	146, 233
..... 239, 244	ATABEX OB.....	65, 260, 263	AZELEX.....	255
ANALPRAM-HC .....	<i>atazanavir sulfate</i> .....	27	AZILECT.....	113
..... 240, 244	<i>atenolol</i> .....	57, 73, 74, 79	<i>azithromycin</i> .....	29
ANASPAZ.....	.....	57, 73, 74, 79	AZSTARYS.....	121
..... 49	ATENOLOL+SYRSPEND SF		AZULFIDINE ....	31, 156, 209, 214
<i>anastrozole</i> .....	.....	57, 73, 74, 79	AZULFIDINE EN-TABS	
..... 33, 168	<i>atenolol-chlorthalidone</i> .....	73, 143	.....	31, 156, 209, 214
ANCOBON.....	<i>atomoxetine hcl</i> .....	110	<i>azurette</i> .....	170, 178, 189
..... 30	ATORVALIQ.....	84	B & C.....	255
ANDRODERM.....	<i>atorvastatin calcium</i> .....	84	<i>bac</i> .....	92, 106, 121
..... 167	<i>atovaquone</i> .....	18	<i>bacitracin</i> .....	146
ANGELIQ.....	<i>atovaquone-proguanil hcl</i> .....	17	<i>bacitracin-polymyxin b</i> .....	146
..... 177, 189	<i>atropine sulfate</i> .....	153		
ANNOVERA.....	ATROVENT HFA.....	49, 225		
..... 170, 177, 189	<i>aubra eq</i> .....	170, 177, 189		
ANORO ELLIPTA .....				
..... 49, 55				
ANTICOAGULANT SODIUM				
CITRATE .....				
..... 58				
<i>anucort-hc</i> .....				
..... 244				
ANUSOL-HC.....				
..... 244				
ANZEMET.....				
..... 154				
APADAZ.....				
..... 92, 114				
<i>apap-caff-dihydrocodeine</i>				
.....				
..... 92, 114, 121				
APEXICON E.....				
..... 244				
APOKYN.....				
..... 113				
<i>apomorphine hcl</i> .....				
..... 113				
<i>apraclonidine hcl</i> .....				
..... 151				
<i>aprepitant</i> .....				
..... 162				
<i>apri</i> .....				
..... 170, 177, 189				
APRISO.....				
..... 156				
APTENSIO XR.....				
..... 121				
APTIOM.....				
..... 94				
APTIVUS.....				
..... 27				
AQ INSULIN SYRINGE.....				
..... 129				
AQINJECT PEN NEEDLE .....				
..... 129				
AQUORAL.....				
..... 151				

<i>bacitra-neomycin-polymyxin-hc</i> ..... 146, 149	BETADINE OPHTHALMIC PREP ..... 151	<i>brinzolamide</i> .....149
BACLOFEN .....52	<i>betaine</i> ..... 220	BRIVIACT ..... 94
<i>baclofen</i> ..... 52	<i>betamethasone dipropionate</i> .. 244	BROMFED DM ..... 13, 48, 226
BACTRIM..... 18, 31, 32	<i>betamethasone dipropionate</i> <i>aug</i> .....244	<i>bromfenac sodium</i> ..... 152
BACTRIM DS ..... 18, 31, 32	<i>betamethasone valerate</i> ..... 244	<i>bromfenac sodium (once-daily)</i> ..... 152
BAFIERTAM ..... 214	BETAPACE AF . 53, 73, 74, 79, 80	<i>bromocriptine mesylate</i> ..... 112
BALCOLTRA ..... 170, 178, 189	BETASERON.....214	BROMSITE ..... 152
<i>balsalazide disodium</i> .....156	<i>betaxolol hcl</i> .... 57, 73, 74, 79, 148	BRONCHITOL..... 232
<i>balsam peru-castor oil</i> .....255	<i>bethanechol chloride</i> ..... 54	BRONCHITOL TOLERANCE TEST .....232
BALVERSA ..... 33, 34	BETIMOL ..... 148	BROVANA ..... 56
<i>balziva</i> ..... 170, 178, 189	BETOPTIC-S ..... 148	BRUKINSA .....34
BANZEL .....94	BEVESPI AEROSPHERE..49, 56	BRYHALI .....244
BAQSIMI ONE PACK..... 185, 201	<i>bexarotene</i> ..... 34, 255	<i>budesonide</i> ..... 164, 230, 244
BAQSIMI TWO PACK..... 185, 201	BEXSERO .....44	<i>bumetanide</i> ..... 85, 138
BARACLUDE ..... 29	BEYFORTUS ..... 28	BUMEX ..... 85, 138
BAXDELA ..... 30	<i>bicalutamide</i> ..... 34	<i>buprenorphine</i> ..... 118, 119
BD AUTOSHIELD DUO PEN NEEDLES ..... 130	BIJUVA..... 178, 189	<i>buprenorphine hcl</i> ..... 118
BD ECLIPSE LUER-LOK NEEDLE .....130	BIKTARVY ..... 24, 25	<i>buprenorphine hcl-naloxone</i> <i>hcl</i> ..... 117, 118
BD ECLIPSE NEEDLE ..... 130	BILTRICIDE ..... 16	<i>bupropion hcl</i> ..... 98
BD SHARPS COLLECTOR .... 130	<i>bimatoprost</i> ..... 153	<i>bupropion hcl er (smoking det)</i> . 98
BD ULTRA-FINE INSULIN SYRINGES..... 130	BINAXNOW COVID-19 AG HOME TEST ..... 136	<i>bupropion hcl er (sr)</i> ..... 98
BD ULTRA-FINE PEN NEEDLES ..... 130	BINOSTO .....203	<i>bupropion hcl er (xl)</i> ..... 98
BELBUCA ..... 118	<i>bis subcit-metronid-tetracyc</i> ..... 16, 18, 31, 154, 156	BUPROPION HCL ER (XL) ..... 98
<i>belladonna alkaloids-opium</i> ..... 49, 114	<i>bisacodyl</i> ..... 157	<i>buspirone hcl</i> .....103
BELSOMRA ..... 103, 119	<i>bisacodyl ec</i> ..... 157	<i>butalbital-acetaminophen</i> ..92, 106
<i>benazepril hcl</i> .....71	<i>bismuth/metronidaz/tetracyclin</i> ..... 16, 18, 31, 155, 156	<i>butalbital-apap-caff-cod</i> ..... 92, 106, 114, 121
<i>benazepril-hydrochlorothiazide</i> ..... 71, 142	<i>bisoprolol fumarate</i> . 57, 73, 74, 79	<i>butalbital-apap-caffeine</i> ..... 92, 106, 121, 122
BENEFIX .....62	<i>bisoprolol-hydrochlorothiazide</i> ..... 73, 142	<i>butalbital-asa-caff-codeine</i> ..... 106, 114, 122, 124
BENLYSTA ..... 218	<i>blisovi 24 fe</i> ..... 170, 178, 189	<i>butalbital-aspirin-caffeine</i> ..... 106, 122, 124
<i>benzalkonium chloride</i> ..... 252	<i>blisovi fe 1.5/30</i> ..... 170, 178, 189	<i>butorphanol tartrate</i> .....101, 119
BENZAMYCIN ..... 236, 252	<i>blisovi fe 1/20</i> ..... 170, 178, 189	BYDUREON BCISE AUTOINJECTOR ..... 186
BENZHYDROCODONE- ACETAMINOPHEN .....92, 114	BOOSTRIX..... 43, 44, 45	BYETTA 10 MCG PEN ..... 186
BENZNIDAZOLE ..... 18	<i>bosentan</i> ..... 88, 228, 234	BYETTA 5 MCG PEN ..... 186
<i>benzoin</i> ..... 243	BOSULIF .....34	BYLVAY ..... 159
<i>benzoin compound</i> .....243	<i>bp 10-1</i> .....236, 250	BYLVAY (PELLETS) ..... 159
<i>benzonatate</i> ..... 226	BRAFTOVI ..... 34	<i>cabergoline</i> ..... 112
<i>benzoyl peroxide-erythromycin</i> ..... 236, 252	BREATHE COMFORT CHAMBER/ADULT ..... 130	CABLIVI ..... 58
<i>benzphetamine hcl</i> .....91	BREATHE COMFORT CHAMBER/CHILD ..... 130	CABOMETRYX ..... 34
<i>benztropine mesylate</i> ..... 51, 94	BREO ELLIPTA ..... 56, 164	CABTREO .....236, 252, 255
<i>bepotastine besilate</i> ..... 146	BREXAFEMME ..... 16	<i>caffeine citrate</i> ..... 101, 122
BERINERT .....207, 219	BREZTRI AEROSPHERE ..... 49, 56, 164	CALCIFOL..... 140, 263, 266
BESIVANCE ..... 146	<i>briellyn</i> .....170, 178, 189	<i>calcipotriene</i> .....255
BESREMI ..... 28, 34, 214	BRILINTA .....68	<i>calcipotriene-betameth diprop</i> ..... 244, 255
	<i>brimonidine tartrate</i> ..... 145, 255	<i>calcitonin (salmon)</i> ..... 168, 203

CALCITRENE .....	255	<i>carvedilol</i> .....	53, 55, 69, 73, 74, 79	CIMZIA.....	159, 209, 214
<i>calcitriol</i> .....	255, 266	<i>carvedilol phosphate er</i>	.....	CIMZIA STARTER KIT	.....
<i>calcium acetate</i> .....	139, 140	.....	53, 55, 69, 73, 74, 79	.....	159, 209, 214
<i>calcium acetate (phos binder)</i>	.....	CASODEX.....	34	<i>cinacalcet hcl</i> .....	168
.....	139, 140	CAVERJECT.....	88	CIPRO.....	19, 30
CALQUENCE .....	34	CAVERJECT IMPULSE .....	88	CIPRO HC.....	146, 149
CAMBIA.....	102, 119	CAYA.....	224	<i>ciprofloxacin hcl</i> .....	19, 30, 146
<i>camila</i> .....	170, 189	CAYSTON.....	28	<i>ciprofloxacin-dexamethasone</i>	.....
<i>camrese</i> .....	170, 178, 189	<i>cefaclor</i> .....	14	.....	146, 149
<i>camrese lo</i> .....	170, 178, 189	<i>cefaclor er</i> .....	14	CITALOPRAM	
CAMZYOS .....	77	<i>cefadroxil</i> .....	14	HYDROBROMIDE .....	126
<i>candesartan cilexetil</i> .....	69, 70	<i>cefdirinir</i> .....	14	<i>citalopram hydrobromide</i> .....	126
<i>candesartan cilexetil-hctz</i> ..	70, 143	<i>cefixime</i> .....	14	CITRANATAL MEDLEY	
<i>capecitabine</i> .....	34	<i>cefepodoxime proxetil</i> .....	14	.....	65, 220, 260, 263
CAPEX.....	244	<i>cefprozil</i> .....	14	<i>citroma</i> .....	157
CAPLYTA.....	104	<i>cefuroxime axetil</i> .....	14	<i>claravis</i> .....	255
CAPRELSA.....	34	<i>celecoxib</i> .....	111	CLARINEX-D 12 HOUR.....	14, 48
<i>captopril</i> .....	71	CELONTIN .....	127	<i>clarithromycin</i> .....	19, 29, 156
<i>captopril-hydrochlorothiazide</i>	.....	<i>cephalexin</i> .....	14	<i>clarithromycin er</i> .....	19, 29, 156
.....	71, 143	CEQUR SIMPLICITY 2U.....	131	CLEARDETECT COVID-19	
<i>carbamazepine</i> .....	95, 99	CERDELGA.....	220	AG HOME.....	136
<i>carbamazepine er</i> .....	94, 95, 99	<i>cerovel</i> .....	250	<i>clearlax</i> .....	157
CARBATROL.....	95, 99	CERVIDIL.....	224	<i>clemastine fumarate</i> .....	12, 229
<i>carbidopa</i> .....	111	CETRAXAL.....	146	CLENPIQ.....	157
<i>carbidopa-levodopa</i> .....	111	<i>cevimeline hcl</i> .....	54	CLEOCIN.....	28, 236
<i>carbidopa-levodopa er</i> .....	111	<i>charlotte 24 fe</i> .....	170, 178, 189	CLEOCIN-T.....	236
<i>carbidopa-levodopa-</i>		<i>chateal eq</i> .....	170, 178, 189	CLEVER CHOICE COMFORT	
<i>entacapone</i> .....	109, 111	CHEMET .....	163, 201	EZ.....	131
<i>carbinoxamine maleate</i> .....	12, 229	CHEMSTRIP BG LOG BOOK.....	131	CLIMARA PRO.....	178, 190
CARDURA.....	53, 69	CHEMSTRIP K.....	136	<i>clindacin</i> .....	236
CARDURA XL.....	53, 69	CHEMSTRIP UGK.....	137	CLINDACIN ETZ.....	236
CAREPOINT POLY HUB		CHENODAL.....	158	<i>clindacin etz</i> .....	236
NEEDLE.....	130	<i>chlordiazepoxide hcl</i> .....	107	<i>clindacin-p</i> .....	237
CAREPOINT SAFETY 1ST		<i>chlordiazepoxide-amitriptyline</i>	.....	CLINDAGEL.....	237
NEEDLE.....	130	.....	107, 127	<i>clindamycin hcl</i> .....	28
CARESENS CONTROL		<i>chlordiazepoxide-clidinium</i>	49, 107	<i>clindamycin palmitate hcl</i> .....	28
SOLUTION A/B.....	130	<i>chlorhexidine gluconate</i> ..	151, 252	<i>clindamycin phos-benzoyl</i>	
CARESENS LANCETS 30G...	130	<i>chloroquine phosphate</i> .....	17	<i>perox</i> .....	237, 252
CARESTART COVID-19		<i>chlorpromazine hcl</i> .....	121	<i>clindamycin phosphate</i> .....	237
HOME TEST.....	136	<i>chlorthalidone</i> .....	87, 144	<i>clindamycin-tretinoin</i>	237, 243, 255
CARETOUCH CONTROL SOL		<i>chlorzoxazone</i> .....	52	CLINDESSE .....	237
LEVEL 2.....	130	CHOLBAM .....	159	CLINITEST RAPID COVID-19	
CARETOUCH HYPODERMIC		<i>cholestyramine</i> .....	75	TEST.....	136
NEEDLE.....	131	<i>cholestyramine light</i> .....	75	CLINOIN.....	75, 237, 243, 255
CARETOUCH		CIBINQO.....	209, 255	CLINPRO 5000.....	205
LANCING/EJECTOR.....	131	<i>ciclodan</i> .....	249	<i>clobazam</i> .....	106, 107, 108
<i>carglumic acid</i> .....	137	<i>ciclopirox</i> .....	249	<i>clobetasol prop emollient base</i>	244
<i>carisoprodol</i> .....	52	<i>ciclopirox olamine</i> .....	249	<i>clobetasol propionate</i> .....	244, 245
CARNITOR.....	220	<i>ciclopirox treatment</i> .....	249	<i>clobetasol propionate e</i> .....	244
CARNITOR SF.....	220	<i>cilostazol</i> .....	68, 86	<i>clobetasol propionate emulsion</i>	.....
CAROSPIR.....	85, 87, 140	CILOXAN.....	146	.....	244
<i>carteolol hcl</i> .....	148	CIMDUO.....	25	CLOBETAVIX.....	245
<i>cartia xt</i> .....	75, 76, 80, 88	<i>cimetidine</i> .....	13, 162	<i>clocortolone pivalate</i> .....	245



<i>clodan</i> .....	245	CORTANE-B.....	240, 245, 252	CYLTEZO-PSORIASIS/UV	
<i>clomipramine hcl</i> .....	127	CORTEF.....	164	STARTER.....	209
<i>clonazepam</i> .....	107, 108	CORTENEMA.....	245	<i>cyproheptadine hcl</i> .....	12, 229
<i>clonidine</i> .....	48, 78	CORTIFOAM.....	245	<i>cyred eq</i> .....	171, 178, 190
<i>clonidine hcl</i> .....	48, 78	CORTISONE ACETATE.....	164	CYSTADANE.....	220
<i>clonidine hcl er</i> .....	48, 78	CORTISPORIN-TC.....	146, 149	CYSTADROPS.....	152
<i>clopidogrel bisulfate</i> .....	68	CORTROPHIN.....	135, 188	CYSTAGON.....	220
<i>clorazepate dipotassium</i> .....	107, 108	CORTROSYN.....	135	CYSTARAN.....	152
<i>clotrimazole</i> .....	241	COSENTYX (300 MG DOSE)		CYTOTEC.....	162
<i>clotrimazole-betamethasone</i>		.....	209, 255	<i>cytra k crystals</i> .....	137
.....	241, 245	COSENTYX 150 MG/ML	209, 255	<i>dabigatran etexilate mesylate</i> ...	60
<i>clozapine</i> .....	104	COSENTYX SENSOREADY		<i>dalfampridine er</i> .....	220
CLOZARIL.....	104	(300 MG).....	209, 255	DALIRESP.....	231
COAGADEX.....	62	COSENTYX SENSOREADY		<i>danazol</i> .....	167
<i>coal tar</i> .....	252	PEN.....	209, 255	DANTRIUM.....	52
COARTEM.....	17	COSENTYX UNOREADY		<i>dantrolene sodium</i> .....	52
<i>codeine sulfate</i> .....	114, 226	.....	209, 255	<i>dapsone</i> .....	18, 237, 255
<i>colchicine</i> .....	202	COSOPT.....	148, 149	DAPTACEL.....	44, 45
<i>colchicine-probenecid</i> .....	144, 202	<i>cosyntropin</i> .....	135	DARAPRIM.....	17
<i>colesevelam hcl</i> .....	75, 168	COTELLIC.....	34	<i>darifenacin hydrobromide er</i> ...	259
COLESTID.....	75	COTEMPLA XR-ODT.....	122	<i>darunavir</i> .....	27
COLESTID FLAVORED.....	75	COVARYX.....	167, 178	<i>dasetta 1/35</i> .....	171, 178, 190
<i>colestipol hcl</i> .....	75	COVARYX HS.....	167, 178	<i>dasetta 7/7/7</i> .....	171, 178, 190
<i>colistimethate sodium (cba)</i> .....	30	COVID-19 AT HOME		DAURISMO.....	35
COLLANEX.....	255	ANTIGEN TEST.....	136	DAYBUE.....	110
COLY-MYCIN M.....	30	COVID-19 AT-HOME TEST...	136	DAYPRO.....	119
COMBIGAN.....	145, 148	CREON.....	144, 158	<i>daysee</i> .....	171, 178, 190
COMBIPATCH.....	178, 190	CRESEMBA.....	20	DAYVIGO.....	103, 119
COMBIVENT RESPIMAT		CRINONE.....	190	DAZAVEIDAOXIA...	237, 254, 256
.....	49, 56, 225	<i>cromolyn sodium</i> .....	146, 152, 229	DEBACTEROL.....	152, 252
COMETRIQ.....	34	CROTAN.....	254	<i>deblitane</i> .....	171, 190
COMFORT EZ PRO PEN		<i>cryselle-28</i> .....	170, 178, 190	<i>deferasirox</i> .....	163
NEEDLES.....	131	<i>curae</i> .....	171, 190	<i>deferasirox granules</i> .....	163
COMIRNATY.....	45	CUVPOSA.....	49	<i>deferiprone</i> .....	163
COMPLERA.....	25	CVS KETONE CARE.....	137	DELESTROGEN.....	178, 203
<i>compro</i> .....	121, 155	<i>cyanocobalamin</i> .....	67, 263	DELSTRIGO.....	25
COMTAN.....	109	CYANOCOBALAMIN.....	67, 263	<i>delyla</i> .....	171, 178, 190
CONDOMS.....	224	<i>cyclobenzaprine hcl</i> .....	52	<i>demeclocycline hcl</i> .....	31
CONDYLOX.....	255	CYCLOGYL.....	153	DEMSEK.....	137, 220
<i>constulose</i> .....	137	CYCLOMYDRIL.....	153, 154	DENAVIR.....	241
CONTOUR CONTROL.....	131	<i>cyclopentolate hcl</i> .....	153	DENG VAXIA.....	45
CONTOUR NEXT CONTROL .	131	<i>cyclophosphamide</i> .....	34, 218	DENTA 5000 PLUS.....	205
CONTOUR NEXT MONITOR .	131	CYCLOPHOSPHAMIDE...	35, 218	DENTAGEL.....	205
CONTOUR NEXT ONE.....	131	<i>cycloserine</i> .....	19	DEOXIATAR.....	237, 243, 256
CONTOUR NEXT TEST.....	135	CYCLOSET.....	168	DEPAKOTE.....	95, 99, 102
CONTRACE.....	94	<i>cyclosporine</i> .....	209, 214, 218	DEPAKOTE ER.....	95, 99, 102
CONZIP.....	114	<i>cyclosporine modified</i>		DEPAKOTE SPRINKLES	
COPASIL.....	255	.....	209, 214, 218	.....	95, 99, 102
COPIKTRA.....	34	CYLTEZO (2 PEN).....	209	DEPEN TITRATABS.....	163, 209
CORDRAN.....	245	CYLTEZO (2 SYRINGE)		DEPO-ESTRADIOL.....	179, 203
CORGARD.....	53, 73, 74	.....	160, 209, 214	DEPO-PROVERA.....	171, 190
CORIFACT.....	62	CYLTEZO-CD/UC/HS			
CORLANOR.....	77, 78, 88	STARTER.....	209		

DEPO-SUBQ PROVERA 104	<i>diclofenac potassium(migraine)</i>	<i>dorzolamide hcl-timolol mal</i>
..... 171, 190	..... 102, 119	..... 148, 149
DEPO-TESTOSTERONE ..... 167	<i>diclofenac sodium</i>	<i>dorzolamide hcl-timolol mal pf</i>
DERMACINRX UREA.....250	..... 119, 128, 152, 253	..... 148, 149
DERMA-SMOOTH/FS BODY	<i>diclofenac sodium er</i> ..... 119	<i>dotti</i> ..... 179, 203
..... 245	<i>diclofenac-misoprostol</i> .... 120, 162	DOUBLE PM..... 146, 149
DERMA-SMOOTH/FS	<i>dicloxacillin sodium</i> ..... 30	DOVATO .....24, 26
SCALP ..... 245	DICOPANOL FUSEPAQ	<i>doxazosin mesylate</i> ..... 53, 69
DERMASO PLUS..... 256	..... 12, 51, 94, 103, 226, 229	<i>doxepin hcl</i> ..... 127, 240
DERMOTIC ..... 149	<i>dicyclomine hcl</i> .....49	<i>doxercalciferol</i> .....266
DESCOVY ..... 26	<i>diethylpropion hcl</i> ..... 90	<i>doxycycline hyclate</i> ..... 17, 32
<i>desipramine hcl</i> ..... 127	<i>diethylpropion hcl er</i> .....90	DOXYCYCLINE HYCLATE .17, 32
<i>desloratadine</i> ..... 14, 233	DIFICID.....29	<i>doxycycline monohydrate</i> ... 17, 32
<i>desmopressin ace spray refrig</i>	<i>diflorasone diacetate</i> .....245	DRISDOL.....267
..... 62, 188	<i>diflunisal</i> ..... 120	<i>dronabinol</i> ..... 155
<i>desmopressin acetate</i> .....62, 188	<i>difluprednate</i> ..... 149	DROPSAFE SAFETY
DESMOPRESSIN ACETATE	<i>digoxin</i> .....72, 78	SYRINGE/NEEDLE ..... 131
..... 62, 188	<i>dihydroergotamine mesylate</i>	<i>drospiren-eth estrad-levomefol</i>
<i>desmopressin acetate pf</i> ...62, 188	..... 54, 102	..... 171, 179, 190, 264
<i>desmopressin acetate spray</i>	DILANTIN .....79, 112	<i>drospirenone-ethinyl estradiol</i>
..... 62, 188	DILANTIN INFATABS ..... 79, 112	..... 171, 179, 190
<i>desogestrel-ethinyl estradiol</i>	<i>diltiazem hcl</i> ..... 76, 77, 81, 88	DROXIA..... 35
..... 171, 179, 190	<i>diltiazem hcl er</i> ..... 76, 77, 81, 88	<i>droxidopa</i> ..... 48
<i>desonide</i> ..... 245	<i>diltiazem hcl er beads</i>	DRYSOL..... 241
DESOWEN..... 245	..... 75, 76, 80, 88	DUAL COMPLEX FORMULA 1
<i>desoximetasone</i> .....245	<i>diltiazem hcl er coated beads</i>	KIT..... 52, 253, 256
DESVENLAFAXINE ER ..... 124	..... 76, 81, 88	DUAVEE..... 177, 179
<i>desvenlafaxine succinate er</i> ... 124	<i>dilt-xr</i> ..... 76, 77, 81, 88	DUETACT ..... 199
<i>dexamethasone</i> ..... 164, 165	<i>dimethyl fumarate</i> ..... 214	DULERA..... 56, 165
<i>dexamethasone intensol</i> ..... 164	<i>dimethyl fumarate starter pack</i> 214	<i>duloxetine hcl</i> ..... 112, 124
<i>dexamethasone sodium</i>	DIOOXIA.....256	DUOPA..... 111
<i>phosphate</i> ..... 149	DIPENTUM..... 156	DUPIXENT.....229, 256
DEXCOM G6 RECEIVER..... 131	<i>diphenhydramine hcl</i>	DUREX EXTRA SENSITIVE
DEXCOM G6 SENSOR ..... 131	..... 12, 51, 94, 103, 226, 229	THIN.....224
DEXCOM G6 TRANSMITTER 131	<i>diphenoxylate-atropine</i> .....49, 155	DUREZOL..... 149
DEXCOM G7 RECEIVER..... 131	DIPROLENE ..... 245	<i>dutasteride</i> ..... 200
DEXCOM G7 SENSOR..... 131	<i>dipyridamole</i> .....68, 88, 135	<i>dutasteride-tamsulosin hcl</i> 55, 201
DEXERYL..... 256	<i>disopyramide phosphate</i> ..... 78	DYANAVEL XR .....91
<i>dexmethylphenidate hcl</i> ..... 122	<i>disulfiram</i> .....201	E.E.S. GRANULES .....21
<i>dexmethylphenidate hcl er</i> ..... 122	DIURIL..... 87, 143	EASIVENT ..... 131
<i>dextroamphetamine sulfate</i> .....91	<i>divalproex sodium</i> ..... 95, 99, 102	EASY COMFORT SHARPS
<i>dextroamphetamine sulfate er</i> .. 91	<i>divalproex sodium er</i> ...95, 99, 102	CONTAINER ..... 131
DIACOMIT ..... 95	DIVIGEL..... 179, 203	<i>easygel</i> .....205
DIASAXIATAR..... 237, 243, 256	DODDEX..... 67, 264	EASYMAX 15 LEVEL 2-3
DIATRUST COVID-19 HOME	<i>dofetilide</i> .....80	CONTROL ..... 131
TEST ..... 136	DOJOLVI..... 138	EASYMAX CONTROL ..... 131
<i>diazepam</i> ..... 107, 108	<i>dolishale</i> ..... 171, 179, 190	EASYMAX CONTROL
<i>diazepam intensol</i> ..... 107, 108	<i>donepezil hcl</i> ..... 54	NORMAL/HIGH ..... 132
<i>diazoxide</i> ..... 168	DOPTLET ..... 60	EC-NAPROSYN..... 102, 120, 202
<i>dichlorphenamide</i> .....205	DORYX MPC ..... 17, 31	<i>ec-naproxen</i> ..... 102, 120, 202
<i>diclofenac potassium</i> ..... 119	DORZOLAMIDE HCL..... 149	<i>econazole nitrate</i> .....241
	<i>dorzolamide hcl</i> ..... 149	<i>econtra one-step</i> ..... 171, 190
		ECOZA.....241



EC-RX DHEA.....	220	ENDARI.....	220	<i>erythromycin base</i> .....	21
EC-RX ESTRADIOL.....	179, 203	<i>endocet</i> .....	93, 114	<i>erythromycin ethylsuccinate</i> .....	21
EC-RX PROGESTERONE.....	190	ENDOMETRIN.....	190	<i>escitalopram oxalate</i> .....	126
EC-RX TESTOSTERONE.....	167	ENGERIX-B.....	45	ESGIC.....	93, 106, 122
EDARBI.....	69, 70	<i>enilloring</i> .....	171, 179, 190	<i>esomeprazole magnesium</i> .....	162
EDARBYCLOR.....	70, 143	ENLITE GLUCOSE SENSOR.....	132	<i>est estrogens-methyltest</i> .....	167, 179
EDEX.....	88	ENOVARX-AMITRIPTYLINE..	127	<i>est estrogens-methyltest ds</i>	..... 167, 179
EDLUAR.....	103	ENOVARX-BACLOFEN.....	52	<i>est estrogens-methyltest hs</i>	..... 167, 179
EDURANT.....	25	ENOVARX-		<i>estarylla</i> .....	171, 179, 191
EEMT.....	167, 179	CYCLOBENZAPRINE HCL.....	52	<i>estazolam</i> .....	108
EEMT HS.....	167, 179	ENOVARX-IBUPROFEN.....	253	<i>estradiol</i> .....	179, 180, 203, 204
<i>efavirenz</i> .....	25	ENOVARX-LIDOCAINE HCL..	240	<i>estradiol valerate</i> .....	180, 204
<i>efavirenz-emtricitab-tenofo df</i>	..... 25, 26	ENOVARX-NAPROXEN.....	253	<i>estradiol-norethindrone acet</i>	..... 180, 191
<i>efavirenz-lamivudine-tenofovir</i>	..... 25, 26	ENOVARX-TRAMADOL.....	256	ESTRING.....	180, 204
EFFER-K.....	140	<i>enoxaparin sodium</i> .....	65	ESTROGEL.....	180, 204
<i>effer-k</i> .....	140	<i>enpresse-28</i> .....	171, 179, 190	<i>eszopiclone</i> .....	103
EFUDEX.....	256	<i>enskyce</i> .....	171, 179, 190	<i>ethacrynic acid</i> .....	85, 138
EGATEN.....	16	ENSPRYNG.....	214	<i>ethambutol hcl</i> .....	19
EGRIFTA SV.....	198	ENSTILAR.....	245, 256	<i>ethosuximide</i> .....	127
ELESTRIN.....	179, 203	<i>entacapone</i> .....	109	<i>ethynodiol diac-eth estradiol</i>	..... 171, 180, 191
<i>eletriptan hydrobromide</i> .....	125	ENTADFI.....	86, 201	<i>etodolac</i> .....	120
<i>elinest</i> .....	171, 179, 190	<i>entecavir</i> .....	29	<i>etodolac er</i> .....	120
ELIQUIS.....	59	ENTEREG.....	160	<i>etonogestrel-ethinyl estradiol</i>	..... 171, 180, 191
ELIQUIS DVT/PE STARTER		ENTRESTO.....	70, 87	<i>etoposide</i> .....	35
PACK.....	59	<i>enulose</i> .....	138	<i>etravirine</i> .....	25
ELITE-OB.....	65, 260, 264	EPANED.....	71	EUCRISA.....	239
<i>elixophyllin</i> .....	83, 122, 138, 235, 260	EPCLUSA.....	22, 23	<i>euthyrox</i> .....	199
ELLA.....	171, 190	EPIDIOLEX.....	95	EVAMIST.....	180, 204
ELLUME COVID-19 HOME		EPIFOAM.....	240, 245	EVEKEO.....	91
TEST.....	136	<i>epinastine hcl</i> .....	146	EVEKEO ODT.....	91
ELMIRON.....	220	<i>epinephrine</i> .....	48, 225	<i>everolimus</i> .....	35, 218
ELOCTATE.....	62	<i>epinephrine hcl (nasal)</i>	..... 48, 154, 225	EVOTAZ.....	27, 220
<i>eluryng</i> .....	171, 179, 190	<i>epitol</i> .....	95, 99	EVRYSDI.....	220
EMBRACE PEN NEEDLES ...	132	EPIVIR.....	26	EXELDERM.....	241
EMCYT.....	35	<i>eplerenone</i> .....	85, 87, 140	<i>exemestane</i> .....	35, 168
EMEND.....	162	EQUETRO.....	95, 99	EXKIVITY.....	35
EMGALITY.....	109	<i>ergocalciferol</i> .....	267	EXODERM.....	239, 250
EMPAVELI.....	208, 219	<i>ergoloid mesylates</i> .....	54	EYSUVIS.....	149
EMSAM.....	113	ERGOMAR.....	54, 102	EZALLOR SPRINKLE.....	84
<i>emtricitabine</i> .....	26	<i>ergotamine-caffeine</i> ..	54, 102, 122	<i>ezetimibe</i> .....	78
<i>emtricitabine-tenofovir df</i> .....	26	ERIVEDGE.....	35	EZETIMIBE-ROSUVASTATIN	..... 78, 84
EMTRIVA.....	26	ERLEADA.....	35	<i>ezetimibe-simvastatin</i> .....	78, 84
EMVERM.....	16	<i>erlotinib hcl</i> .....	35	FABIOR.....	256
<i>enalapril maleate</i> .....	71	ERMEZA.....	199	<i>falmina</i> .....	171, 180, 191
<i>enalapril-hydrochlorothiazide</i>	..... 71, 143	<i>errin</i> .....	171, 191	<i>famciclovir</i> .....	29
ENBRACE HR ..	65, 220, 260, 264	<i>ery</i> .....	237	<i>famotidine</i> .....	13, 162
ENBREL.....	209, 210, 214	ERYGEL.....	237	FANAPT.....	104, 105
ENBREL MINI.....	209, 214	ERYPED 200.....	21		
ENBREL SURECLICK....	210, 214	ERYPED 400.....	21		
ENCARE.....	224	ERY-TAB.....	21		
		ERYTHROCIN STEARATE.....	21		
		<i>erythromycin</i> .....	21, 146, 237		

FANAPT TITRATION PACK ...	105	FLEQSUVY .....	52	FLUTICASONE PROPIONATE	
FANATREX FUSEPAQ .....	93, 95	FLEXICHAMBER .....	132	HFA .....	165, 230, 231
FASENRA PEN .....	229	FLEXICHAMBER ADULT		FLUTICASONE-	
FASTEP COVID-19 ANTIGEN		MASK/SMALL .....	132	SALMETEROL .....	56, 165
TEST .....	136	FLEXICHAMBER CHILD		<i>fluticasone-salmeterol</i> .....	56, 165
FBL KIT .....	52, 240, 253, 256	MASK/LARGE .....	132	<i>fluvastatin sodium</i> .....	84
FC2 FEMALE CONDOM .....	224	FLEXICHAMBER CHILD		<i>fluvastatin sodium er</i> .....	84
<i>febuxostat</i> .....	202	MASK/SMALL .....	132	<i>fluvoxamine maleate</i> .....	126
FEIBA .....	62	FLOLIPID .....	84	<i>fluvoxamine maleate er</i> .....	126
<i>felbamate</i> .....	95	FLORIVA .....	205, 267	FLUZONE HIGH-DOSE	
FELBATOL .....	95	FLORIVA PLUS .....	205, 260	QUADRIVALENT .....	45
FELDENE .....	120	FLOWFLEX COVID-19 AG		FLUZONE QUADRIVALENT	
<i>felodipine er</i> .....	82	HOME TEST .....	136	.....	45, 46
FEM PH .....	252, 256	FLUAD QUADRIVALENT .....	45	FML FORTE .....	150
FEMCAP .....	224	FLUARIX QUADRIVALENT .....	45	FML LIQUIFILM .....	150
FEMRING .....	180, 204	FLUBLOK QUADRIVALENT .....	45	FOCALIN .....	122
<i>fenofibrate</i> .....	83	FLUCELVAX		<i>folic acid</i> .....	264
<i>fenofibrate micronized</i> .....	83	QUADRIVALENT .....	45	<i>fondaparinux sodium</i> .....	58
<i>fenofibric acid</i> .....	84	<i>fluconazole</i> .....	20	FORA TEST N'GO ADV-	
<i>fentanyl</i> .....	114	<i>flucytosine</i> .....	30	VOICE-6 CON .....	135
<i>fentanyl citrate</i> .....	114	<i>fludrocortisone acetate</i> .....	165	FORANE .....	112
FENTANYL CITRATE .....	114	FLULAVAL QUADRIVALENT .....	45	FORFIVO XL .....	98
FENTORA .....	114	FLUMIST QUADRIVALENT .....	45	<i>formaldehyde</i> .....	137
FERRIPROX .....	163	<i>flunisolide</i> .....	149, 165, 230	<i>formoterol fumarate</i> .....	56, 233
FETZIMA .....	124	<i>fluocinolone acetonide</i> .....	149, 246	FORTISCARE CONTROL .....	132
FETZIMA TITRATION .....	124	<i>fluocinolone acetonide body</i> .....	246	FOSAMAX .....	204
FIBRICOR .....	84	<i>fluocinolone acetonide scalp</i> .....	246	FOSAMAX PLUS D .....	204, 267
FILSPARI .....	220, 228	<i>fluocinonide</i> .....	246	<i>fosamprenavir calcium</i> .....	27
FINACEA .....	256	<i>fluocinonide emulsified base</i> .....	246	<i>fosfomycin tromethamine</i> .....	32
<i>finasteride</i> .....	201	FLUORIDEX .....	206	<i>fosinopril sodium</i> .....	71, 72
<i>ingolimod hcl</i> .....	214	<i>fluoridex daily renewal</i> .....	206	<i>fosinopril sodium-hctz</i> .....	72, 143
FINTEPLA .....	95	FLUORIDEX ENHANCED		FOSRENOL .....	139, 201
<i>finzala</i> .....	171, 180, 191	WHITENING .....	206	FOTIVDA .....	35
FIORICET .....	93, 106, 122	FLUORIDEX SENSITIVITY		FRAGMIN .....	65
FIRDAPSE .....	54, 220	RELIEF .....	128, 206	FREESTYLE LIBRE 14 DAY	
FIRMAGON .....	35, 168	FLUORIMAX 5000 .....	206	READER .....	132
FIRMAGON (240 MG DOSE)		FLUORIMAX 5000 SENSITIVE		FREESTYLE LIBRE 14 DAY	
.....	35, 168	.....	128, 206	SENSOR .....	132
FIRST PANTOPRAZOLE .....	162	<i>fluorometholone</i> .....	149	FREESTYLE LIBRE 2	
FIRST-LANSOPRAZOLE .....	162	<i>fluorouracil</i> .....	256	READER .....	132
FIRST-METRONIDAZOLE		<i>fluoxetine hcl</i> .....	126	FREESTYLE LIBRE 2	
.....	15, 18, 156	<i>fluoxetine hcl (pmd)</i> .....	126	SENSOR .....	132
FIRST-MOUTHWASH BLM		FLUOXIA .....	246, 256	FREESTYLE LIBRE 3	
.....	12, 153, 154, 155, 157, 240	<i>fluphenazine hcl</i> .....	121	READER .....	132
FIRST-OMEPRAZOLE .....	162	<i>flurandrenolide</i> .....	246	FREESTYLE LIBRE 3	
FIRST-PROGESTERONE		<i>flurazepam hcl</i> .....	108	SENSOR .....	132
VGS .....	191	<i>flurbiprofen</i> .....	120	FREESTYLE LIBRE READER	132
FIRVANQ .....	21	<i>flurbiprofen sodium</i> .....	152	FROTEK .....	253
<i>flac</i> .....	149	FLUTICASONE FUROATE-		<i>frovatriptan succinate</i> .....	125
FLAGYL .....	15, 18, 157	VILANTEROL .....	56, 165	FRUZAQLA .....	35
FLAREX .....	149	<i>fluticasone propionate</i>		<i>ft aspirin low dose</i> .....	68, 102, 124
<i>flavoxate hcl</i> .....	259	.....	149, 165, 230, 246	<i>ft clearlax</i> .....	157
<i>flecainide acetate</i> .....	79			<i>ft laxative</i> .....	157

<i>ft magnesium citrate</i> .....	157	<i>glyburide micronized</i> .....	199	HAVRIX.....	46
<i>ft nicotine</i> .....	51	<i>glyburide-metformin</i> .....	169, 199	<i>heather</i> .....	172, 191
<i>ft nicotine mini</i> .....	51	<i>glycolax</i> .....	157	HEMANGEOL. 53, 73, 74, 79, 102	
FUROSCIX.....	85, 139	<i>glycopyrrolate</i> .....	49	<i>hematinic/folic acid</i> .....	65, 264
<i>furosemide</i> .....	85, 139	<i>glydo</i> .....	240	HEMLIBRA.....	63
FUZEON.....	24	GLYXAMBI.....	176, 197	HEMMOREX-HC.....	246
<i>fyavolv</i> .....	180, 191	GOLYTELY.....	157	HEMOFIL M.....	63
FYCOMPA.....	95	<i>goodsense aspirin low dose</i>		<i>heparin na (pork) lock flsh pf</i> .....	65
<i>gabapentin</i> .....	93, 95	.....	68, 102, 124	<i>heparin sod (pork) lock flush</i> .....	65
GALAFOLD.....	220	<i>goodsense nicotine</i> .....	51	<i>heparin sodium (porcine)</i> .....	65
<i>galantamine hydrobromide</i> .....	54	GORDOFILM.....	242, 250	<i>heparin sodium (porcine) pf</i> .....	65
<i>galantamine hydrobromide er</i> ...	54	<i>granisetron hcl</i> .....	154	HEPLISAV-B.....	46
GALZIN.....	140	GRASTEK.....	43	<i>her style</i> .....	172, 191
GARDASIL 9.....	46	<i>griseofulvin microsize</i> .....	16	HETLIOZ.....	104
<i>gatifloxacin</i> .....	146	<i>griseofulvin ultramicrosize</i> .....	16	HETLIOZ LQ.....	103
GATTEX.....	160	<i>guaifenesin ac</i> .....	226, 228	HEXIOUNYL.....	20, 249, 250
<i>gavilax</i> .....	157	<i>guaifenesin-codeine</i> .....	226, 228	HIBERIX.....	46
<i>gavilyte-c</i> .....	157	<i>guanfacine hcl</i> .....	78, 110	HIPREX.....	32
<i>gavilyte-g</i> .....	157	<i>guanfacine hcl er</i> .....	110	HPR PLUS.....	256
GAVRETO.....	35	GUARDIAN 4 GLUCOSE		HUMALOG.....	196, 197
<i>gefitinib</i> .....	35	SENSOR.....	132	HUMALOG KWIKPEN.....	196
GELFILM.....	62	GUARDIAN 4 TRANSMITTER	132	HUMALOG MIX 50/50	
GEL-FLOW.....	62	GUARDIAN CONNECT		KWIKPEN.....	196
GELFOAM-JMI POWDER.....	62	TRANSMITTER.....	132	HUMALOG MIX 50/50 VIAL...	196
GELFOAM-JMI SPONGE.....	62	GUARDIAN LINK 3		HUMALOG MIX 75/25	
GELNIQUE.....	259	TRANSMITTER.....	132	KWIKPEN.....	196
<i>gemfibrozil</i> .....	84	GUARDIAN SENSOR (3).....	132	HUMALOG MIX 75/25 VIAL...	196
<i>gemmily</i> .....	171, 180, 191	GUARDIAN SENSOR 3.....	132	HUMALOG U-100 JUNIOR	
GEMTESA.....	260	GVOKE HYPOPEN 1-PACK		KWIKPEN.....	197
<i>generlac</i> .....	138	.....	185, 201	HUMATE-P.....	63
<i>gengraf</i> .....	210, 214, 218	GVOKE HYPOPEN 2-PACK		HUMIRA (2 PEN)....	160, 210, 215
<i>gentamicin sulfate</i> .....	146, 237	.....	185, 201	HUMIRA (2 SYRINGE)	
<i>gentle laxative</i> .....	157	GVOKE KIT.....	186, 201	.....	160, 210, 215
<i>gentlelax</i> .....	157	GVOKE PFS.....	186, 201	HUMIRA-CD/UC/HS	
GENVOYA.....	24, 26	GYNAZOLE-1.....	241	STARTER.....	160, 210, 215
GILENYA.....	215	<i>habitrol</i> .....	51	HUMIRA-PED	
GILOTRIF.....	35	HADLIMA.....	160, 210, 215	.....	160, 210, 215
<i>glatiramer acetate</i> .....	215	HADLIMA PUSH TOUCH		HUMIRA-PED>=40KG	
<i>glatopa</i> .....	215	.....	160, 210, 215	CROHNS START ...	160, 210, 215
GLEOSTINE.....	36	HAEGARDA.....	208, 219	HUMIRA-PED>=40KG UC	
<i>glimepiride</i> .....	199	<i>hailey 1.5/30</i> .....	171, 181, 191	STARTER.....	160, 210, 215
<i>glipizide</i> .....	199	<i>hailey 24 fe</i> .....	172, 181, 191	HUMIRA-PSORIASIS/UEVIT	
<i>glipizide er</i> .....	199	<i>hailey fe 1.5/30</i> .....	172, 181, 191	STARTER.....	160, 211, 216
<i>glipizide xl</i> .....	199	<i>hailey fe 1/20</i> .....	172, 181, 191	HUMULIN 70/30 KWIKPEN	
<i>glipizide-metformin hcl</i> ....	169, 199	<i>halcinonide</i> .....	246	.....	187, 197
GLOPERBA.....	202	HALCION.....	108	HUMULIN 70/30 VIAL....	187, 197
GLUCAGEN HYPOKIT...	185, 201	<i>halobetasol propionate</i> .....	246	HUMULIN N KWIKPEN.....	187
<i>glucagon emergency kit</i> ..	185, 201	<i>haloette</i> .....	172, 181, 191	HUMULIN N VIAL.....	187
GLUCAGON EMERGENCY		HALOG.....	246	HUMULIN R U-500 KWIKPEN	197
KIT.....	185, 201	<i>haloperidol</i> .....	108	HUMULIN R U-500 VIAL.....	197
GLUCOTROL XL.....	199	<i>haloperidol lactate</i> .....	108	HUMULIN R VIAL.....	197
<i>glutaraldehyde</i> .....	137	HALUCORT.....	256	HYCANTIN.....	36
<i>glyburide</i> .....	199	HARVONI.....	22, 23	<i>hydralazine hcl</i> .....	83

HYDREA.....	36	ILUMYA.....	249, 256	INTELENCE.....	25
HYDRO 40.....	250	<i>imatinib mesylate</i> .....	36	INTELISWAB COVID-19	
<i>hydrochlorothiazide</i> .....	87, 143	IMBRUVICA.....	36	RAPID TEST.....	136
<i>hydrocod poli-chlorphe poli er</i>		IMCIVREE.....	94, 164	INTRAROSA.....	165
.....	13, 226	<i>imipramine hcl</i> .....	127	<i>introvale</i> .....	172, 181, 191
<i>hydrocodone bitartrate er</i>	114, 115	<i>imipramine pamoate</i> .....	127	INVELTYS.....	150
<i>hydrocodone bit-homatrop mbr</i>		<i>imiquimod</i> .....	256	<i>iodine strong</i> .....	228
.....	49, 226	IMPAVIDO.....	18	<i>iodine tincture</i> .....	252
<i>hydrocodone-acetaminophen</i>		IMVEXXY MAINTENANCE		IOPIDINE.....	152
.....	93, 115	PACK.....	181	IPOL.....	46
<i>hydrocodone-ibuprofen</i> ...	115, 120	IMVEXXY STARTER PACK...	181	<i>ipratropium bromide</i> .....	50, 225
HYDROCORT LOTION		INBRIJA.....	111	<i>ipratropium-albuterol</i> ...	50, 56, 225
COMPLETE KIT.....	246, 256	<i>incassia</i> .....	172, 191	<i>irbesartan</i> .....	70
<i>hydrocortisone</i> .....	165, 246	INCRELEX.....	198	<i>irbesartan-hydrochlorothiazide</i>	
<i>hydrocortisone (perianal)</i> .....	246	<i>indapamide</i> .....	87, 144	.....	70, 143
<i>hydrocortisone ace-pramoxine</i>		INDERAL LA... 53, 73, 74, 79, 102		IRESSA.....	37
.....	240, 246	INDICAID COVID-19 RAPID		ISENTRESS.....	24
<i>hydrocortisone acetate</i> .....	246	TEST.....	136	ISENTRESS HD.....	24
<i>hydrocortisone butyrate</i> .....	246	INDOCIN.....	120, 202	<i>isibloom</i> .....	172, 181, 191
<i>hydrocortisone valerate</i> .....	246	<i>indomethacin</i> .....	120, 202	<i>isoflurane</i> .....	112
<i>hydrocortisone-acetic acid</i>		<i>indomethacin er</i> .....	120, 202	<i>isoniazid</i> .....	19
.....	150, 152	INFANRIX.....	44, 46	<i>isosorb dinitrate-hydralazine</i>	
<i>hydrocortisone-iodoquinol</i>		INLYTA.....	36	.....	83, 86
.....	247, 252	INOVA.....	249, 252	<i>isosorbide dinitrate</i> .....	86
<i>hydrocort-pramoxine (perianal)</i>		INOVA 4/1 ACNE CONTROL		<i>isosorbide mononitrate</i> .....	86
.....	240, 247	THERAPY.....	248, 250, 252	<i>isosorbide mononitrate er</i> .....	86
<i>hydromet</i> .....	49, 226	INOVA 8/2 ACNE CONTROL		<i>isotretinoin</i> .....	256
<i>hydromorphone hcl</i> .....	115	THERAPY.....	248, 250, 252	<i>isradipine</i> .....	82
<i>hydromorphone hcl er</i> .....	115	INPEN 100-BLUE-LILLY-		ISTALOL.....	148
<i>hydroxychloroquine sulfate</i>		HUMALOG.....	133	ISTURISA.....	221
.....	17, 211, 216	INPEN 100-BLUE-NOVOLOG-		<i>itraconazole</i> .....	20
<i>hydroxyurea</i> .....	36	FIASP.....	133	<i>ivermectin</i> .....	16
<i>hydroxyzine hcl</i> .....	12, 13, 104	INPEN 100-GREY-LILLY-		IWILFIN.....	37
<i>hydroxyzine pamoate</i> ..	12, 13, 104	HUMALOG.....	133	<i>jaimiess</i> .....	172, 181, 191
HYFTOR.....	218, 249, 256	INPEN 100-GREY-		JAKAFI.....	37
HYLATOPIC PLUS.....	256	NOVOLOG-FIASP.....	133	<i>jantoven</i> .....	59
<i>hyoscyamine sulfate</i> .....	49	INPEN 100-PINK-LILLY-		JARDIANCE.....	197
<i>hyoscyamine sulfate er</i> .....	49	HUMALOG.....	133	<i>jasmiel</i> .....	172, 181, 191
<i>hyoscyamine sulfate sl</i> .....	49	INPEN 100-PINK-NOVOLOG-		JAVYGTOR.....	221
<i>hyosyne</i> .....	49, 50	FIASP.....	133	JAYPIRCA.....	37
HYPERSAL.....	230	INQOVI.....	36	<i>jencycla</i> .....	172, 191
<i>ibandronate sodium</i> .....	204	INREBIC.....	36	JENTADUETO.....	169, 176
IBRANCE.....	36	INSPIREASE RESERVOIR		JENTADUETO XR.....	169, 176
<i>ibuprofen</i> .....	102, 120	BAGS.....	133	<i>jinteli</i> .....	181, 191
<i>icatibant acetate</i> .....	205, 219	INSULIN LISPRO.....	197	JIVI.....	63
<i>iclevia</i> .....	172, 181, 191	INSULIN LISPRO (1 UNIT		JOENJA.....	216
ICLUSIG.....	36	DIAL).....	197	<i>jolessa</i> .....	172, 181, 191
IDARAN.....	237	INSULIN LISPRO JUNIOR		JORNAY PM.....	122
IDELVION.....	63	KWIKPEN.....	197	<i>joyeaux</i> .....	172, 181, 191
IDHIFA.....	36	INSULIN LISPRO PROT &		JUBLIA.....	241
IHEALTH COVID-19 RAPID		LISPRO.....	197	<i>juleber</i> .....	172, 181, 191
TEST.....	136	INSULIN PEN NEEDLES.....	133	JULUCA.....	24, 25
ILEVRO.....	152	INSULIN SYRINGES.....	133	<i>junel 1.5/30</i> .....	172, 181, 191



<i>junel 1/20</i> .....	172, 181, 191	KOATE.....	63	LATANOPROST.....	153
<i>junel fe 1.5/30</i> .....	172, 181, 191	KOATE-DVI.....	63	<i>latanoprost</i> .....	153
<i>junel fe 1/20</i> .....	172, 181, 191	KOGENATE FS.....	63	<i>layolis fe</i> .....	172, 181, 192
<i>junel fe 24</i> .....	172, 181, 191	KORLYM.....	168	L-CYSTINE.....	138
JUST RIGHT 5000.....	206	KOSELUGO.....	37	LEDIPASVIR-SOFOSBUVIR	
JUXTAPID.....	72	KOTARAXAP.....	243, 247, 248	.....	22, 23
JYNARQUE.....	144	<i>kourzeq</i> .....	247	<i>leena</i> .....	172, 182, 192
K.B.G.L IN TERODERM		KOVALTRY.....	63	<i>leflunomide</i> .....	211, 216, 218
.....	53, 120, 240, 253, 257	K-PHOS.....	140	<i>lenalidomide</i> .....	37, 216
<i>kaitlib fe</i> .....	172, 181, 192	K-PHOS NO 2.....	137	LENVIMA.....	37
KALETRA.....	27	K-PHOS-NEUTRAL.....	140	<i>lessina</i> .....	173, 182, 192
<i>kalliga</i> .....	172, 181, 192	<i>k-prime</i> .....	141	<i>letrozole</i> .....	37, 168
KALYDECO.....	227	KRAZATI.....	37	LETS.....	48, 200
KAPSPARGO SPRINKLE		KRINTAFEL.....	17	<i>leucovorin calcium</i> .....	201, 264
.....	57, 73, 74, 80	KRISTALOSE.....	138	LEUKERAN.....	37
KARBINAL ER.....	12, 229	K-TAB.....	141	LEUKINE.....	60
<i>kariva</i> .....	172, 181, 192	<i>kurvelo</i> .....	172, 181, 192	<i>leuprolide acetate</i> .....	37, 186
KATARAXAP.....	243, 247, 248	KUTAR.....	243, 248	<i>levabuterol hcl</i> .....	56, 233
KATERZIA.....	82, 83, 88	KUTARVIA.....	243, 248	LEVALBUTEROL HFA.....	56, 233
<i>kelnor 1/35</i> .....	172, 181, 192	KYZATREX.....	167	LEVBID.....	50
<i>kelnor 1/50</i> .....	172, 181, 192	<i>labetalol hcl</i> .....	53, 55, 69, 73, 74, 80	<i>levetiracetam</i> .....	96
KEPPRA.....	95, 96	<i>lacosamide</i> .....	96	<i>levetiracetam er</i> .....	96
KEPPRA XR.....	96	LACRISERT.....	152	<i>levobunolol hcl</i> .....	148
KERALYT SCALP.....	250	<i>lactulose</i> .....	138	<i>levocarnitine</i> .....	221
KERAMATRIX REPLICINE		<i>lactulose encephalopathy</i> .....	138	<i>levocarnitine sf</i> .....	221
2CMX3CM.....	225	LAGEVRIO.....	29	<i>levocetirizine dihydrochloride</i> .....	14
KERAMATRIX REPLICINE		LAMICTAL.....	96, 100	<i>levofloxacin</i> .....	19, 30, 146
5CMX5CM.....	225	LAMICTAL ODT.....	96, 100	<i>levonest</i> .....	173, 182, 192
KERENDIA.....	85	LAMICTAL STARTER.....	96, 100	<i>levonorgest-eth est &amp; eth est</i>	
KESIMPTA.....	216	LAMICTAL XR.....	96, 100	.....	173, 182, 192
<i>ketoconazole</i> .....	20, 241	<i>lamivudine</i> .....	26	<i>levonorgest-eth estrad 91-day</i>	
<i>ketodan</i> .....	241	<i>lamivudine-zidovudine</i> .....	26	.....	173, 182, 192
KETO-DIASTIX.....	137	<i>lamotrigine</i> .....	96, 100	<i>levonorgest-eth estradiol-iron</i>	
KETONE TEST.....	136	<i>lamotrigine er</i> .....	96, 100	.....	173, 182, 192
<i>ketorolac tromethamine</i> ..	120, 152	<i>lamotrigine starter kit-blue</i> .....	96, 100	<i>levonorgestrel</i> .....	173, 192
KETOSTIX.....	136	<i>lamotrigine starter kit-green</i>		<i>levonorgestrel-ethinyl estrad</i>	
KEVARAXAP.....	243, 247, 248	.....	96, 100	.....	173, 182, 192
KEVARTIA.....	243, 248	<i>lamotrigine starter kit-orange</i>		<i>levonorg-eth estrad triphasic</i>	
KEVEYIS.....	205	.....	96, 100	.....	173, 182, 192
KEVZARA.....	211	LAMPIT.....	18	<i>levora 0.15/30 (28)</i> ..	173, 182, 192
KINERET.....	211, 216	LANCETS.....	133	<i>levorphanol tartrate</i> .....	115
KISQALI.....	37	LANOXIN.....	72, 78	<i>levo-t</i> .....	200
KISQALI FEMARA.....	37, 168	<i>lansoprazole</i> .....	163	LEVOTHYROXINE SODIUM..	200
KLARON.....	237	<i>lanthanum carbonate</i> .....	139, 201	<i>levothyroxine sodium</i> .....	200
<i>klayesta</i> .....	254	LANTUS SOLOSTAR.....	187	<i>levoxyl</i> .....	200
KLISYRI.....	257	LANTUS U-100 VIAL.....	187	LEVSIN.....	50
<i>klor-con</i> .....	140	<i>lapatinib ditosylate</i> .....	37	LEVSIN/SL.....	50
<i>klor-con 10</i> .....	140	<i>larin 1.5/30</i> .....	172, 181, 192	LEVULAN KERASTICK.....	257
<i>klor-con m10</i> .....	140	<i>larin 1/20</i> .....	172, 181, 192	<i>lidocaine</i> .....	240
<i>klor-con m15</i> .....	140	<i>larin 24 fe</i> .....	172, 181, 192	<i>lidocaine hcl</i> .....	153, 240
<i>klor-con m20</i> .....	140	<i>larin fe 1.5/30</i> .....	172, 181, 192	<i>lidocaine hcl urethral/mucosal</i> .....	240
<i>klor-con/ef</i> .....	140	<i>larin fe 1/20</i> .....	172, 181, 192	<i>lidocaine viscous hcl</i> .....	153
KLOXXADO.....	117	LASIX.....	85, 139	<i>lidocaine-prilocaine</i> .....	240



LIDTOPIC MAX.....	240	LUPKYNIS.....	218	<i>melphalan</i> .....	38
<i>linezolid</i> .....	30	<i>lurasidone hcl</i> .....	105	<i>memantine hcl</i> .....	110
LINZESS.....	161	<i>lutea</i> .....	173, 182, 192	<i>memantine hcl er</i> .....	110
<i>liothyronine sodium</i> .....	200	LUXAMEND.....	257	MENEST.....	182, 205
LIPOFEN.....	84	LUZU.....	242	MENOSTAR.....	182, 205
<i>lisdexamfetamine dimesylate</i>		<i>lyleq</i> .....	173, 192	MENQUADFI.....	46
.....	91, 92	<i>lyllana</i> .....	182, 205	MENVEO.....	46
<i>lisinopril</i> .....	71, 72	LYNPARZA.....	38	<i>meperidine hcl</i> .....	115
<i>lisinopril-hydrochlorothiazide</i>		LYRICA.....	96, 97, 112	<i>meprobamate</i> .....	104
.....	72, 143	LYSODREN.....	38	<i>mercaptopurine</i> .....	38, 218
L-ISOLEUCINE.....	138	LYTGOBI (12 MG DAILY		<i>merzee</i> .....	173, 182, 193
LITFULO.....	257	DOSE).....	38	<i>mesalamine</i> .....	156
<i>lithium</i> .....	100	LYTGOBI (16 MG DAILY		<i>mesalamine-cleanser</i> .....	156
<i>lithium carbonate</i> .....	100	DOSE).....	38	MESNEX.....	223
<i>lithium carbonate er</i> .....	100	LYTGOBI (20 MG DAILY		MESTINON.....	54
LITHOBID.....	100	DOSE).....	38	<i>metaxalone</i> .....	52
LITHOSTAT.....	138	LYUMJEV KWIKPEN.....	197	<i>metformin hcl</i> .....	169
LIVALO.....	84	LYUMJEV VIAL.....	197	<i>metformin hcl er</i> .....	169
LIVMARLI.....	161	<i>lyza</i> .....	173, 192	<i>methadone hcl</i> .....	115
LIVTENCITY.....	20	MACROBID.....	32	<i>methadone hcl intensol</i> .....	115
LO LOESTRIN FE ...	173, 182, 192	MACRODANTIN.....	32	METHADOSE.....	115
<i>lojaimiess</i> .....	173, 182, 192	<i>mafenide acetate</i> .....	252	<i>methadose</i> .....	115
LOKELMA.....	139	<i>magnesium citrate</i> .....	157	METHADOSE SUGAR-FREE.....	115
LOMAIRA.....	90	MALARONE.....	17	<i>methamphetamine hcl</i> .....	92
LOMOTIL.....	50, 155	<i>malathion</i> .....	254	<i>methazolamide</i> .....	77, 149
LONSURF.....	37, 38	<i>maraviroc</i> .....	24	<i>methenamine hippurate</i> .....	32
LOPID.....	84	MARINOL.....	155	<i>methenamine mandelate</i> .....	33
<i>lopinavir-ritonavir</i> .....	27	<i>marlissa</i> .....	173, 182, 192	<i>methergine</i> .....	225
LOPRESSOR.....	57, 73, 74, 80	MARPLAN.....	113	<i>methimazole</i> .....	169
<i>lorazepam</i> .....	107, 108	MATULANE.....	38	METHITEST.....	167
<i>lorazepam intensol</i> .....	107, 108	<i>matzim la</i> .....	76, 77, 81, 89	<i>methocarbamol</i> .....	25, 52
LORBRENA.....	38	MAVENCLAD.....	216, 218	<i>methotrexate sodium</i>	
LOREEV XR.....	107, 108	MAVYRET.....	22, 23	.....	38, 211, 216, 218
<i>loryna</i> .....	173, 182, 192	MAXIDEX.....	150	<i>methotrexate sodium (pf)</i>	
LORZONE.....	52	MAXITROL.....	146, 147, 150	.....	38, 211, 216, 218
<i>losartan potassium</i> .....	70	<i>maxi-tuss ac</i> .....	226, 228	<i>methoxsalen rapid</i> .....	254
<i>losartan potassium-hctz</i> ....	70, 143	MAXZIDE.....	140, 143	<i>methscopolamine bromide</i> .....	50
LOTEMAX.....	150	MAXZIDE-25.....	140, 143	<i>methsuximide</i> .....	127
LOTEMAX SM.....	150	MAYZENT.....	216	<i>methyl salicylate</i> .....	242
LOTENSIN.....	71, 72	MAYZENT STARTER PACK ..	216	METHYLDOPA.....	48, 78
LOTENSIN HCT.....	72, 143	<i>me/naphos/mb/hyo1</i> ... 32, 50, 221		<i>methylergonovine maleate</i> .....	225
<i>loteprednol etabonate</i> .....	150	<i>meclofenamate sodium</i> .....	120	METHYLIN.....	122
<i>lovastatin</i> .....	84	MEDERMA SPF 30.....	257	<i>methylphenidate</i> .....	123
<i>low-ogestrel</i> .....	173, 182, 192	MEDROL.....	165	<i>methylphenidate hcl</i> .....	123
<i>loxapine succinate</i> .....	103	<i>medroxyprogesterone acetate</i>		<i>methylphenidate hcl er</i> .....	123
<i>lo-zumandimine</i> .....	173, 182, 192	.....	173, 193	<i>methylphenidate hcl er (cd)</i> ....	122
<i>lubiprostone</i> .....	161	<i>mefenamic acid</i> .....	120	<i>methylphenidate hcl er (la)</i>	
LUCEMYRA.....	48	<i>mefloquine hcl</i> .....	17	.....	122, 123
LUGOLS STRONG IODINE ....	252	<i>megestrol acetate</i> .....	38, 193	<i>methylphenidate hcl er (osm)</i> ..	123
LULICONAZOLE.....	242	MEKINIST.....	38	<i>methylphenidate hcl er (xr)</i> ....	123
LUMAKRAS.....	38	MEKTOVI.....	38	<i>methylprednisolone</i> .....	165
LUMIGAN.....	153	MELOXICAM.....	120	<i>methyltestosterone</i> .....	167
LUMRYZ.....	110	<i>meloxicam</i> .....	120	<i>metoclopramide hcl</i> .....	162

<i>metolazone</i> .....	88, 144	MODERNA COVID-19 VAC	<i>na sulfate-k sulfate-mg sulf</i> .....	157
<i>metoprolol succinate er</i>		6M-11Y .....	<i>nabumetone</i> .....	120
.....	57, 73, 74, 80	<i>moexipril hcl</i> .....	<i>nadolol</i> .....	53, 73, 74
<i>metoprolol tartrate</i> ...	57, 73, 74, 80	<i>molindone hcl</i> .....	<i>naftifine hcl</i> .....	236
<i>metoprolol-hydrochlorothiazide</i>		<i>mometasone furoate</i>	NAFTIN .....	236
.....	73, 143	.....	<i>naloxone hcl</i> .....	117, 201
METROCREAM .....	237	<i>mondoxyne nl</i> .....	<i>naltrexone hcl</i> .....	117, 201
METROLOTION .....	237	<i>mono-linyah</i> .....	NAMZARIC .....	54, 110
<i>metronidazole</i> .....	15, 18, 157, 237	MONSELS FERRIC	NANRAN .....	238, 240
METRONIDAZOLE		SUBSULFATE .....	NAPROSYN.....	102, 120, 202
BENZO+SYRSPEND ..	15, 18, 157	<i>montelukast sodium</i> .....	<i>naproxen</i> .....	102, 120, 202, 203
<i>metirosine</i> .....	137, 221	<i>morphine sulfate</i> .....	<i>naproxen dr</i> .....	102, 120, 202
<i>mexiletine hcl</i> .....	79	<i>morphine sulfate (concentrate)</i>	<i>naproxen sodium</i> ....	103, 120, 203
MIACALCIN.....	169, 205	<i>morphine sulfate er</i> .....	<i>naproxen sodium er</i>	102, 120, 203
<i>mibelas 24 fe</i> .....	173, 182, 193	<i>morphine sulfate er beads</i>	<i>naratriptan hcl</i> .....	125
<i>miconazole 3</i> .....	242	.....	NARCAN.....	117
MICONAZOLE-ZINC OXIDE-		MOTTEGRITY .....	NARDIL.....	113
PETROLAT .....	241, 242, 249	MOTOFEN .....	NASCOBAL.....	67, 264
<i>microgestin 1.5/30</i> ...	173, 182, 193	MOUNJARO .....	NATACYN .....	148
<i>microgestin 1/20</i> .....	173, 182, 193	MOVIPREP .....	NATAL PNV .....	65, 261, 264
<i>microgestin 24 fe</i> .....	173, 182, 193	<i>moxifloxacin hcl</i> .....	NATAZIA.....	174, 183, 193
<i>microgestin fe 1.5/30</i>		<i>moxifloxacin hcl (2x day)</i> .....	<i>nateglinide</i> .....	187
.....	173, 182, 193	MOZOBIL.....	NAYZILAM.....	107
<i>microgestin fe 1/20</i> ..	173, 182, 193	MUCOSITISRX.....	<i>nebivolol hcl</i> .....	53, 73
MICROLET NEXT LANCING		MULPLETA .....	NEBUPENT .....	18
DEVICE .....	133	MULTAQ .....	NEBUSAL.....	230
<i>midazolam hcl</i> .....	108	<i>multivitamin w/fluoride</i> ....	<i>necon 0.5/35 (28)</i> ....	174, 183, 193
MIDAZOLAM+SYRSPEND SF		<i>multivitamin/fluoride</i>	<i>nefazodone hcl</i> .....	126
.....	108	206, 261, 264	<i>neomycin sulfate</i> .....	15
<i>midodrine hcl</i> .....	48	MULTIVITAMIN/FLUORIDE	<i>neomycin-bacitracin zn-</i>	
MIFEPREX.....	225	.....	<i>polymyx</i> .....	147
<i>mifepristone</i> .....	168, 225	206, 261, 264	<i>neomycin-polymyxin-dexameth</i>	
MIGERGOT.....	54, 102, 123	<i>multi-vitamin/fluoride/iron</i>	.....	147, 150
<i>miglitol</i> .....	166	.....	<i>neomycin-polymyxin-</i>	
<i>miglustat</i> .....	221	MULTI-VIT-FLOR .....	<i>gramicidin</i> .....	147
<i>mili</i> .....	173, 182, 193	206, 261	<i>neomycin-polymyxin-hc</i> ..	147, 150
<i>mimvey</i> .....	182, 193	<i>mupirocin</i> .....	NEONATAL + DHA	
<i>mineral oil heavy</i> .....	157	<i>mupirocin calcium</i> .....	.....	65, 141, 221, 261, 264
MINIPRESS .....	54, 69	MUSE .....	NEONATAL 19 .....	261
<i>minocycline hcl</i> .....	17, 32	<i>my choice</i> .....	NEONATAL COMPLETE	
<i>minocycline hcl er</i> .....	32, 257	<i>my way</i> .....	.....	65, 261, 264
<i>minoxidil</i> .....	83	MYALEPT .....	NEONATAL FE .....	65, 261, 264
<i>mirtazapine</i> .....	98	MYAMBUTOL .....	NEONATAL PLUS ....	66, 261, 264
MIRVASO.....	257	MYCOBUTIN .....	<i>neo-polycin</i> .....	147
<i>misoprostol</i> .....	162	<i>mycophenolate mofetil</i> .....	<i>neo-polycin hc</i> .....	147, 150
MITIGARE.....	202	<i>mycophenolate sodium</i> .....	NEOSALUS.....	257
MITOSOL.....	147	<i>mycophenolic acid</i> .....	NEO-SYNALAR.....	238, 247
<i>mm aspirin</i> .....	68, 102, 124	MYCOZYL AL.....	NERLYNX .....	38
<i>mm clearlax</i> .....	157	MYDAYIS.....	NESTABS .....	66, 261, 264
M-M-R II.....	46	MYFEMBREE .....	NESTABS ONE	66, 221, 261, 264
M-NATAL PLUS .....	65, 260, 264	MYLERAN .....	<i>neuac</i> .....	238, 252
<i>modafinil</i> .....	128	MYRBETRIQ .....	NEULASTA .....	61
		MYSOLINE .....	NEUPRO.....	113
		MYTESI.....		
		MYXREDLIN.....		
		141, 197		

NEURAPTINE .....	93	<i>norethin ace-eth estrad-fe</i>	174, 183, 193	NUTROPIN AQ NUSPIN 10	188, 198
NEURONTIN .....	93, 97	<i>norethindrone</i> .....	174, 194	NUTROPIN AQ NUSPIN 20	188, 198
NEVANAC .....	152	<i>norethindrone acetate</i> .....	194	NUTROPIN AQ NUSPIN 5	188, 198
<i>nevirapine</i> .....	25	<i>norethindrone acet-ethinyl est</i>	174, 183, 194	NUVESSA.....	15, 238
<i>nevirapine er</i> .....	25	<i>norethindrone-eth estradiol</i>	183, 194	NUWIQ.....	63, 64
<i>new day</i> .....	174, 193	<i>norethindron-ethinyl estrad-fe</i>	174, 183, 194	NUZYRA.....	15
NEXIUM.....	163	<i>norethin-eth estradiol-fe</i>	174, 183, 194	<i>nyamyc</i> .....	254
NEXLETOL .....	72	<i>norgestimate-eth estradiol</i>	174, 183, 194	<i>nylia 1/35</i> .....	174, 183, 194
NEXLIZET .....	72, 78	<i>norgestimate-ethinyl estradiol</i>	174, 183, 194	<i>nylia 7/7/7</i> .....	174, 183, 194
NEXTSTELLIS .....	174, 183, 193	<i>norgestimate-ethinyl estradiol</i>	174, 183, 194	NYMALIZE .....	82, 83, 89
NGENLA .....	188	<i>nortrel 0.5/35 (28)</i> ...	174, 183, 194	<i>nymyo</i> .....	174, 183, 194
<i>niacin er (antihyperlipidemic)</i> ....	72	<i>nortrel 1/35 (21)</i> .....	174, 183, 194	<i>nystatin</i> .....	30, 254
<i>nicardipine hcl</i> .....	82, 83, 89	<i>nortrel 1/35 (28)</i> .....	174, 183, 194	<i>nystatin-triamcinolone</i> ....	247, 254
NICORETTE .....	51	<i>nortrel 7/7/7</i> .....	174, 183, 194	<i>nystop</i> .....	254
NICORETTE MINI .....	51	<i>nortriptyline hcl</i> .....	127	OCALIVA.....	161
<i>nicotine</i> .....	51	NORLYROC.....	174, 194	<i>ocella</i> .....	174, 183, 194
<i>nicotine mini</i> .....	51	NORPACE .....	79	<i>octreotide acetate</i> .....	161, 198
<i>nicotine polacrilex</i> .....	51	NORPACE CR .....	78	OCUFLOX .....	147
<i>nicotine polacrilex mini</i> .....	51	NORPRAMIN.....	127	ODACTRA .....	43
<i>nicotine step 1</i> .....	51	<i>nortrel 0.5/35 (28)</i> ...	174, 183, 194	ODEFSEY .....	25, 26
<i>nicotine step 2</i> .....	51	<i>nortrel 1/35 (21)</i> .....	174, 183, 194	ODOMZO .....	39
<i>nicotine step 3</i> .....	51	<i>nortrel 1/35 (28)</i> .....	174, 183, 194	OFEV .....	226
NICOTROL .....	51	<i>nortrel 7/7/7</i> .....	174, 183, 194	<i>ofloxacin</i> .....	30, 147
NICOTROL NS .....	51	NORVIR.....	27	OGSIVEO.....	39
<i>nifedipine</i> .....	82, 83, 89	NOURIANZ.....	110	<i>olanzapine</i> .....	100, 105
<i>nifedipine er</i> .....	82, 83, 89	NOVAVAX COVID-19		<i>olanzapine-fluoxetine hcl</i>	105, 126
<i>nifedipine er osmotic release</i>	82, 83, 89	VACCINE .....	46	<i>olmesartan medoxomil</i> .....	70
<i>nikki</i> .....	174, 183, 193	NOVOEIGHT .....	63	<i>olmesartan medoxomil-hctz</i>	70, 143
<i>nimodipine</i> .....	82, 83, 89	NOVOFINE AUTOCOVER		<i>olmesartan-amlodipine-hctz</i>	70, 82, 143
NINLARO .....	39	PEN NEEDLE .....	133	<i>olopatadine hcl</i> .....	13, 146
<i>nisoldipine er</i> .....	82, 83	NOVOFINE PEN NEEDLE .....	133	OLUMIANT .....	211
<i>nitazoxanide</i> .....	18	NOVOFINE PLUS PEN		OMECLAMOX-PAK....	16, 29, 163
NITRO-BID .....	86	NEEDLE .....	133	<i>omega-3-acid ethyl esters</i> .....	72
NITRO-DUR.....	86	NOVOPEN ECHO .....	133	<i>omeprazole</i> .....	163
<i>nitrofurantoin</i> .....	33	NOVOSEVEN RT .....	63	OMEPRAZOLE+SYRSPEND	
<i>nitrofurantoin macrocrystal</i> .....	33	NOXAFIL.....	20	SF ALKA .....	163
<i>nitrofurantoin monohydrate</i>		<i>np thyroid</i> .....	200	OMNARIS .....	150
<i>macrocrystals</i> .....	33	NUBEQA.....	39	OMNIPOD 5 G6 INTRO (GEN	
<i>nitroglycerin</i> .....	86, 257	NUCALA .....	226	5).....	133
NITROSTAT .....	86	NUCORT .....	247	OMNIPOD 5 G6 PODS (GEN	
NITRO-TIME .....	86	NUCYNTA .....	116	5).....	134
NIVA THYROID .....	200	NUCYNTA ER .....	116	ON/GO COVID-19 ANTIGEN	
NOCDURNA.....	63, 188	NUEDEXTA .....	110	TEST .....	136
<i>nora-be</i> .....	174, 193	NUJO.....	219, 249, 257	ON/GO ONE COVID-19	
NORDIPEN 5 INJECTION		NULEV .....	50	HOME TEST .....	136
DEVICE.....	133	NUPLAZID.....	105	<i>ondansetron hcl</i> .....	154
NORDITROPIN FLEXPRO		NURTEC .....	109	<i>ondansetron odt</i> .....	154
.....	188, 198	NUTRASEB .....	250		
<i>norelgestromin-eth estradiol</i>					
.....	174, 183, 193				

ONE VITE WOMENS PLUS ..... 66, 261, 264	<i>oseltamivir phosphate</i> ..... 28	<i>peg-kcl-nacl-nasulf-na asc-c</i> ..... 158, 266
ONETOUCH DELICA PLUS LANCING ..... 134	OSPHENA..... 177	PEG-PREP..... 158
ONETOUCH DELICA SAFETY LANCING ..... 134	OTEZLA ..... 211, 217, 257	PEMAZYRE ..... 39
ONETOUCH ULTRA ..... 134, 135	OVACE PLUS..... 238	PENBRAYA..... 46
ONETOUCH ULTRA 2 ..... 134	OVACE PLUS WASH..... 238	<i> penciclovir</i> ..... 241
ONETOUCH VERIO..... 134, 135	OVACE WASH..... 238	<i> penicillamine</i> ..... 163, 211
ONETOUCH VERIO FLEX SYSTEM..... 134	OVIDE..... 254	<i> penicillin v potassium</i> ..... 28
ONETOUCH VERIO REFLECT..... 134	<i> oxaprozín</i> ..... 121	PENTACEL ..... 44, 46
ONEXTON ..... 238, 253	<i> oxazepam</i> ..... 108	<i> pentamidine isethionate</i> ..... 18
ONFI ..... 107, 108	OXBRYTA..... 59	<i> pentazocine-naloxone hcl</i> 117, 119
ONGENTYS ..... 109	<i> oxcarbazepine</i> ..... 97	<i> pentoxifylline er</i> ..... 61
ONUREG ..... 39	OXERVATE ..... 152	PERFOROMIST ..... 56, 233
ONZETRA XSAIL..... 125	OXIAICE..... 238, 257	PERIDEX..... 151, 253
<i> opcicon one-step</i> ..... 174, 194	<i> oxiconazole nitrate</i> ..... 242	<i> perindopril erbumine</i> ..... 71, 72
<i> opium</i> ..... 155	OXISTAT ..... 242	<i> periogard</i> ..... 151, 253
OPSUMIT..... 89, 228, 234	<i> oxybutynin chloride</i> ..... 259	<i> permethrin</i> ..... 254
<i> option 2</i> ..... 174, 194	<i> oxybutynin chloride er</i> ..... 259	<i> perphenazine</i> ..... 121
OPTIONS GYNOL II CONTRACEPTIVE ..... 224	<i> oxycodone hcl</i> ..... 116	<i> perphenazine-amitriptyline</i> ..... 121, 127
OPVEE..... 117	..... 93, 116	PERTZYE ..... 145, 158
OPZELURA..... 257	OXYCODONE- ACETAMINOPHEN ..... 93, 116	PFIZER COVID-19 VAC-TRIS 5-11Y..... 46
ORACIT..... 137	<i> oxymorphone hcl</i> ..... 116	PFIZER COVID-19 VAC-TRIS 6M-4Y ..... 47
ORALAIR..... 43	<i> oxymorphone hcl er</i> ..... 116	PHEDRAX..... 242, 250
ORALAIR ADULT STARTER PACK..... 43	OZEMPIC..... 186	<i> phenazo</i> ..... 240
ORALAIR CHILDRENS STARTER PACK ..... 43	OZOBAX DS ..... 53	<i> phenazopyridine hcl</i> ..... 240
<i> oralone</i> ..... 247	PACERONE ..... 80	<i> phendimetrazine tartrate</i> ..... 90
ORAPRED ODT..... 165	PALFORZIA..... 43	<i> phendimetrazine tartrate er</i> ..... 90
ORAVIG..... 242	<i> paliperidone er</i> ..... 105	<i> phenelzine sulfate</i> ..... 113
ORENCIA..... 211, 216	PALYNZIQ ..... 144	<i> phenobarbital</i> ..... 106
ORENCIA CLICKJECT... 211, 216	PANCREAZE ..... 145, 158	<i> phenoxybenzamine hcl</i> ..... 54, 85
ORENITRAM ..... 89, 231, 234	PANDEL..... 247	<i> phentermine hcl</i> ..... 91
ORENITRAM MONTH 1 ..... 89, 231, 234	PANRETIN..... 257	<i> phenylephrine hcl</i> ..... 153, 154
ORENITRAM MONTH 2 ..... 89, 231, 234	<i> pantoprazole sodium</i> ..... 163	<i> phenytek</i> ..... 79, 112
ORENITRAM MONTH 3 ..... 89, 231, 234	PARI VORTEX ADULT MASK 134	<i> phenytoin</i> ..... 79, 112
ORFADIN..... 221	<i> paricalcitol</i> ..... 267	<i> phenytoin infatabs</i> ..... 79, 112
ORGOVYX..... 39, 168	PARNATE ..... 113	<i> phenytoin sodium extended</i> ..... 79, 112
ORIAHNN ..... 168, 183, 194	<i> paroxetine hcl</i> ..... 126	PHEOXIA..... 242, 257
ORILISSA..... 168	<i> paroxetine hcl er</i> ..... 126	PHEXXI..... 224
ORKAMBI..... 227, 228	<i> paroxetine mesylate</i> ..... 126	<i> philith</i> ..... 175, 183, 194
ORLISTAT ..... 161	PAXIL..... 126	PHOSPHA 250 NEUTRAL..... 141
<i> orphenadrine citrate er</i> .. 53, 57, 94	PAXLOVID (150/100)..... 20	PHOSPHOLINE IODIDE..... 153
ORSERDU..... 39	PAXLOVID (300/100)..... 20	<i> phosphorous</i> ..... 141
OSCIMIN..... 50	<i> pazopanib hcl</i> ..... 39	<i> phospho-trin 250 neutral</i> ..... 141
	PEDIAPRED..... 165	PHOXILLUM B22K4/0 ..... 141
	PEDIARIX..... 44, 46	PHOXILLUM BK4/2.5 ..... 141
	PEDVAX HIB ..... 46	<i> phytonadione</i> ..... 201, 267
	<i> peg 3350-kcl-na bicarb-nacl</i> ... 157	PIFELTRO ..... 25
	<i> peg-3350/electrolytes</i> ..... 157	<i> pilocarpine hcl</i> ..... 54, 153
	<i> peg-3350/electrolytes/ascorbat</i> ..... 158, 266	
	PEGASYS..... 28	



PILOT COVID-19 AT-HOME TEST.....	136	<i>prednisolone</i> .....	165, 166	PREVIDENT 5000 SENSITIVE.....	128, 207
<i>pimecrolimus</i> .....	219, 249, 257	<i>prednisolone acetate</i> .....	150	PREVNAR 20.....	47
<i>pimozide</i> .....	103	<i>prednisolone sodium phosphate</i> .....	150, 166	PREVYMIS.....	20
<i>pimtrex</i> .....	175, 184, 194	<i>prednisone</i> .....	166	PREZCOBIX.....	27, 221
<i>pindolol</i> .....	53, 73, 74, 80	<i>prednisone intensol</i> .....	166	PREZISTA.....	27
<i>pioglitazone hcl</i> .....	199	<i>pregabalin</i> .....	97, 112	PRIFTIN.....	19, 31
<i>pioglitazone hcl-glimepiride</i> .....	199	<i>pregabalin er</i> .....	93	PRILOSEC.....	163
<i>pioglitazone hcl-metformin hcl</i> .....	169, 199	PREHEVBRIO.....	47	PRIMACARE.....	66, 222, 262, 265
PIP GLUCOSE CONTROL SOLUTION.....	134	PREMARIN.....	184, 205	<i>primaquine phosphate</i> .....	17
PIQRAY.....	39	PREMESISRX.....	141, 221, 261, 264	<i>primidone</i> .....	106
<i>pirfenidone</i> .....	226, 232	<i>premium lidocaine</i> .....	240	PRIORIX.....	47
<i>piroxicam</i> .....	121	PREMPHASE.....	184, 194	PRISMASOL B22GK 4/0.....	142
<i>pitavastatin calcium</i> .....	84	PREMPRO.....	184, 194	PRISMASOL BGK 0/2.5.....	142
PLAN B ONE-STEP.....	175, 194	PRENAISSANCE.....	66, 158, 221, 261, 265	PRISMASOL BGK 2/0.....	142
PLEGRIDY.....	217	<i>prenatal</i> .....	66, 261, 265	PRISMASOL BGK 2/3.5.....	142
PLEGRIDY STARTER PACK.....	217	<i>prenatal plus vitamin/mineral</i> .....	66, 262, 265	PRISMASOL BGK 4/0/1.2.....	142
PLENVU.....	158, 266	PRENATE.....	141, 262, 265	PRISMASOL BGK 4/2.5.....	142
<i>plerixafor</i> .....	61	PRENATE DHA.....	66, 141, 221, 262, 265	PRISMASOL BK 0/0/1.2.....	142
PLEXION.....	238, 250	PRENATE ELITE.....	66, 262, 265	<i>probenecid</i> .....	144, 203
PLEXION CLEANSER.....	238, 250	PRENATE ENHANCE.....	66, 141, 221, 262, 265	PROCENTRA.....	92
PLEXION CLEANSING CLOTH.....	238, 250	PRENATE ESSENTIAL.....	66, 141, 221, 262, 265	<i>prochlorperazine</i> .....	121, 155
PNEUMOVAX 23.....	47	PRENATE MINI.....	66, 141, 221, 262, 265	<i>prochlorperazine maleate</i> .....	121, 155
PODIATROLE.....	242, 250	PRENATE PIXIE.....	66, 141, 221, 262, 265	PROCORT.....	240, 247
PODOCON-25.....	257	PRENATE RESTORE.....	66, 141, 221, 262, 265	PROCTOCORT.....	247
<i>podofilox</i> .....	257	PRENATVITE COMPLETE.....	66, 142, 262, 265	PROCTOFOAM HC.....	241, 247
<i>polycin</i> .....	147	PRENATVITE PLUS.....	66, 142, 262, 265	<i>procto-med hc</i> .....	247
<i>polyethylene glycol 3350</i> .....	158	PRENATVITE RX.....	66, 142, 262, 265	<i>proctosol hc</i> .....	247
<i>polymyxin b-trimethoprim</i> .....	147	PREPIDIL.....	225	<i>proctozone-hc</i> .....	247
POLY-VI-FLOR.....	206, 261	PRETOMANID.....	19	PROCYSBI.....	222
POLY-VI-FLOR/IRON.....	66, 206, 261	<i>prevalite</i> .....	75	PROFILNINE.....	64
POMALYST.....	39, 217	PREVIDENT.....	207	<i>progesterone</i> .....	194, 195
<i>portia-28</i> .....	175, 184, 194	PREVIDENT 5000 BOOSTER PLUS.....	206	PROGESTERONE MICRONIZED.....	194
<i>posaconazole</i> .....	20	PREVIDENT 5000 DRY MOUTH.....	206	PROGLYCEM.....	168
<i>potassium chloride</i> .....	141	PREVIDENT 5000 ENAMEL PROTECT.....	128, 207	PROGRAF.....	219
<i>potassium chloride crys er</i> .....	141	PREVIDENT 5000 ORTHO DEFENSE.....	207	PROLATE.....	93, 117
<i>potassium chloride er</i> .....	141	PREVIDENT 5000 PLUS.....	207	PROLENSA.....	152
<i>potassium citrate er</i> .....	137			PROMACTA.....	61
<i>potassium citrate-citric acid</i> .....	137			<i>promethazine hcl</i> .....	12, 13, 104, 155, 229
<i>potassium iodide</i> .....	228			<i>promethazine vc</i> .....	13, 48
PRADAXA.....	60			<i>promethazine vc/codeine</i> .....	13, 48, 226
<i>pramipexole dihydrochloride</i> .....	113			<i>promethazine-codeine</i> .....	13, 226
PRAMOSONE.....	240, 247			<i>promethazine-dm</i> .....	13, 227
PRAMOTIC.....	151, 153			<i>promethegan</i> .....	13, 104, 155, 229
<i>prasugrel hcl</i> .....	68			PROMISEB.....	251
<i>pravastatin sodium</i> .....	84			PRONAL.....	242, 251
<i>praziquantel</i> .....	16			<i>propafenone hcl</i> .....	79
<i>prazosin hcl</i> .....	54, 69			<i>propafenone hcl er</i> .....	79
PRED MILD.....	150			<i>proparacaine hcl</i> .....	153



<i>propranolol hcl</i>	RADICAVA ORS.....	110	RIFAMPIN+SYRSPEND SF20, 31
..... 53, 73, 74, 75, 80, 103	RADICAVA ORS STARTER		<i>riluzole</i> .....
<i>propranolol hcl er</i>	KIT.....	110	<i>rimantadine hcl</i> .....
..... 53, 73, 74, 80, 103	RADIOGARDASE.....	139, 202	RINVOQ.....
<i>propylthiouracil</i> .....	RAGWITEK.....	43	<i>risedronate sodium</i> .....
169	<i>raloxifene hcl</i> .....	177, 205	<i>risperidone</i> .....
PROQUAD.....	<i>ramelteon</i> .....	104	<i>ritonavir</i> .....
47	<i>ramipril</i> .....	71, 72	<i>rivastigmine</i> .....
PROTONIX.....	<i>ranolazine er</i> .....	78	<i>rivastigmine tartrate</i> .....
163	RAPAMUNE.....	219	<i>rivelsa</i> .....
<i>protriptyline hcl</i> .....	<i>rasagiline mesylate</i> .....	113	175, 184, 195
127	RASUVO.....	211, 212	RIXUBIS.....
PROVERA.....	RAVICTI.....	138	<i>rizatriptan benzoate</i> .....
195	RAYA SURE PEN NEEDLE ...	134	125
PRUCLAIR.....	RAYASAL.....	251	ROCALTROL.....
257	<i>react</i> .....	175, 195	ROCKLATAN.....
PRUMYX.....	<i>reclipsen</i> .....	175, 184, 195	<i>roflumilast</i> .....
257	RECOMBINATE.....	64	<i>ropinirole hcl</i> .....
<i>pseudoephedrine-bromphen-</i>	RECOMBIVAX HB.....	47	<i>ropinirole hcl er</i> .....
<i>dm</i> .....	RECOTHROM.....	64	<i>rosuvastatin calcium</i> .....
13, 48, 227	RECOTHROM SPRAY KIT.....	64	84
PULMOSAL.....	RECTIV.....	257	ROSZET.....
230	REGLAN.....	162	78, 84
PULMOZYME.....	REGRANEX.....	257	ROTARIX.....
145, 230	RELENZA DISKHALER.....	28	47
PURE COMFORT SAFETY	RELISTOR.....	118, 161	ROTATEQ.....
PEN NEEDLE.....	RELNATE DHA .	66, 222, 262, 265	47
134	RELYVRIO.....	110	ROWASA.....
PURIXAN.....	REMIGEN.....	258	<i>roweepra</i> .....
39, 219	<i>repaglinide</i> .....	187	97
PYLERA.....	REPATHA.....	86	ROZLYTREK.....
16, 19, 32, 155, 156	REPATHA PUSHTRONEX		40
<i>pyrazinamide</i> .....	SYSTEM.....	86	RUBRACA.....
19	REPATHA SURECLICK.....	86	40
PYRIDIDIUM.....	RESTASIS.....	151	RUCONEST.....
241	RESTASIS MULTIDOSE.....	151	208, 220
<i>pyridostigmine bromide</i> .....	RESTORIL.....	108	<i>rufinamide</i> .....
55	RETACRIT.....	58, 61	97
<i>pyridostigmine bromide er</i> .....	RETEVMO.....	39	RUKOBIA.....
55	RETIN-A MICRO PUMP.....	243	24
<i>pyrimethamine</i> .....	RETROVIR.....	26	RYALTRIS 13, 146, 151, 166, 230
17	REVLIMID.....	39, 217	RYBELSUS.....
PYROGALLIC ACID225, 251, 257	REXULTI.....	105	186
PYRUKYND.....	REYATAZ.....	27	RYCLORA.....
59	REYVOW.....	125	13
PYRUKYND TAPER PACK.....	REZLIDHIA.....	39	RYDAPT.....
59	REZUROCK.....	222	40
QBRELIS.....	RHOFADE.....	258	SABRIL.....
72	RHOPRESSA.....	154	97
<i>qc magnesium citrate</i> .....	<i>ribavirin</i> .....	29	SAFETY PEN NEEDLES.....
158	RIDAURA.....	163, 212, 217	134
QINLOCK.....	<i>rifabutin</i> .....	19, 31	<i>sajazir</i> .....
39	<i>rifampin</i> .....	20, 31	205, 220
QNASL.....			SALAGEN.....
150, 230			55
QNASL CHILDRENS.....			SALICATE.....
150, 230			251
QSYMIA.....			<i>salicylic acid</i> .....
94			251
QUADRACEL.....			SALIMEZ.....
44, 47			251
QUALAQUIN.....			SALIVAMAX.....
17			152
QUESTRAN.....			<i>salsalate</i> .....
75			124
QUESTRAN LIGHT.....			SALVAX DUO PLUS.....
75			242, 251
<i>quetiapine fumarate</i> .....			SALYCIM.....
101, 105			251
<i>quetiapine fumarate er</i> ....			SAMSCA.....
100, 105			144
QUFLORA PEDIATRIC..			SANDIMMUNE.....
207, 262			212, 217, 219
QUICKVUE AT-HOME			SANDOSTATIN.....
COVID-19 TEST.....			161, 198
136			SANTYL.....
QUILLICHEW ER.....			145, 258
123			<i>sapropterin dihydrochloride</i> ....
QUILLIVANT XR.....			222
123			SAVAYSA.....
<i>quinapril hcl</i> .....			59
71, 72			SAVELLA.....
<i>quinapril-hydrochlorothiazide</i>			112, 124
.....			SAVELLA TITRATION PACK
72, 143			.....
<i>quinidine gluconate er</i> .....			112, 124
17, 79			<i>saxagliptin hcl</i> .....
<i>quinidine sulfate</i> .....			176
17, 79			
<i>quinine sulfate</i> .....			
17			
QVAR REDIHALER.....			
166, 231			
RABEPRAZOLE SODIUM.....			
163			
<i>rabeprazole sodium</i> .....			
163			

<i>saxagliptin-metformin er.</i> .....	169, 176	<i>sodium chloride</i> .....	230	STALEVO 125.....	109, 111
SAXENDA.....	186	<i>sodium fluoride</i> .....	207	STALEVO 150.....	109, 111
SCALACORT DK.....	247, 251	<i>sodium fluoride 5000 plus</i> .....	207	STALEVO 200.....	109, 111
SCARCIN.....	258	<i>sodium fluoride 5000 ppm</i> .....	207	STALEVO 50.....	109, 111
SCSEMBLIX.....	40	SODIUM OXYBATE.....	110	STALEVO 75.....	109, 112
<i>scopolamine</i> .....	50, 155	<i>sodium phenylbutyrate</i> .....	138	STELARA.....	258
SELECT-OB.....	66, 262, 265	<i>sodium polystyrene sulfonate</i> .....	139, 202	STENDRA.....	86
<i>selegiline hcl</i> .....	113	<i>sodium sulfacetamide</i> .....	238	STIOLTO RESPIMAT.....	50, 56
<i>selenium sulfide</i> .....	253	<i>sodium sulfacetamide wash</i> ....	238	STIVARGA.....	40
SELZENTRY.....	24	SODIUM SULFACETAMIDE- BAKUCHIOL.....	222, 238	STRATA CTX.....	258
SEREVENT DISKUS.....	56, 233	SODIUM SULFACETAMIDE- SOFOSBUVIR-VELPATASVIR .....	22, 23	STRATA XRT.....	258
SERNIVO.....	247	SOHONOS.....	222	STRATTERA.....	110
SEROQUEL XR.....	101, 105	<i>solifenacin succinate</i> .....	259	STRENSIQ.....	145
SEROSTIM.....	188, 198	SOLQUA.....	186, 187	STRIBILD.....	24, 26, 222
SERTRALINE HCL.....	126	SOLODYN.....	32, 258	STRIVERDI RESPIMAT...	56, 233
<i>sertraline hcl</i> .....	126	SOLOSEC.....	19	STROMECTOL.....	16
<i>setlakin</i> .....	175, 184, 195	SOLTAMOX.....	40, 177	SUBOXONE.....	118, 119
<i>sevelamer carbonate</i> .....	139, 202	SOMATULINE DEPOT.....	198	<i>subvenite</i> .....	97, 101
<i>sevelamer hcl</i> .....	139, 202	SOMAVERT.....	199	<i>subvenite starter kit-blue</i> ...	97, 101
SEVENFACT.....	64	SOOLANTRA.....	254	<i>subvenite starter kit-green</i>	97, 101
<i>sevoflurane</i> .....	112	<i>sorafenib tosylate</i> .....	40	<i>subvenite starter kit-orange</i> .....	97, 101
<i>sf</i> .....	207	<i>sotalol hcl</i> .....	53, 74, 75, 80	SUCRAID.....	145
<i>sf 5000 plus</i> .....	207	<i>sotalol hcl (af)</i> .....	53, 74, 75, 80	<i>sucralfate</i> .....	162
SFROWASA.....	156	SOTYKTU.....	258	SUFLAVE.....	158
<i>sharobel</i> .....	175, 195	SOTYLIZE.....	53, 74, 75, 80	SULAR.....	82, 83
SHARPS COLLECTOR.....	134	SOVALDI.....	22	SULCONAZOLE NITRATE.....	242
SHARPS CONTAINER.....	134	SPEEDY SWAB COVID-19 ANTIGEN.....	136	<i>sulfacetamide sodium</i> .....	147, 239
SHINGRIX.....	47	SPIKEVAX.....	47	<i>sulfacetamide sodium (acne)</i> ..	238
SIGNIFOR.....	198	<i>spinosad</i> .....	254	<i>sulfacetamide sodium (cleans)</i>	239
SILATRIX.....	258	SPIRIVA HANDIHALER....	50, 225	<i>sulfacetamide sodium-sulfur</i> .....	239, 251
<i>sildenafil citrate</i> .....	86, 231, 234, 260	SPIRIVA RESPIMAT.....	50, 225	<i>sulfacetamide sod-sulfur wash</i> .....	239, 251
SILENOR.....	127	<i>spironolactone</i> .....	85, 87, 140	<i>sulfacetamide-prednisolone</i> .....	147, 151
<i>silodosin</i> .....	55	<i>spironolactone-hctz</i> .....	85, 87, 143	<i>sulfacetamide-sulfur in urea</i> .....	239, 251
SILVADENE.....	253	SPORANOX.....	20	SULFACLEANSE 8/4.....	239, 251
<i>silver nitrate</i> .....	151	SPRAVATO (56 MG DOSE)....	99	<i>sulfadiazine</i> .....	31
<i>silver sulfadiazine</i> .....	253	SPRAVATO (84 MG DOSE)....	99	<i>sulfamethoxazole-trimethoprim</i> .....	19, 31, 33
SIMBRINZA.....	145, 149	<i>sprintec 28</i> .....	175, 184, 195	<i>sulfamez wash</i> .....	239, 251
<i>simliya</i> .....	175, 184, 195	SPRITAM.....	97	SULFAMYLON.....	253
<i>simpesse</i> .....	175, 184, 195	SPRIX.....	121	<i>sulfasalazine</i> .....	31, 156, 212, 217
SIMPONI.....	161, 212, 217	SPRYCEL.....	40	<i>sulfatrim pediatric</i> .....	19, 31, 33
<i>simvastatin</i> .....	84, 85	SPS.....	139, 202	<i>sulfurated lime</i> .....	254
SINEMET.....	111	<i>sronyx</i> .....	175, 184, 195	<i>sulindac</i> .....	121
SINGULAIR.....	229	<i>ssd</i> .....	253	<i>sumatriptan</i> .....	125
<i>sirolimus</i> .....	219	SSKI.....	228	<i>sumatriptan succinate</i> .....	125
SIRTURO.....	20	<i>sss 10-5</i> .....	238, 251	<i>sumatriptan succinate refill</i> <i>subcutaneous solution</i> <i>cartridge</i> .....	125
SIVEXTRO.....	30	SSS 10-5.....	238, 251		
SKYCLARYS.....	222	ST JOSEPH LOW DOSE .....	68, 69, 103, 124		
SKYRIZI.....	161, 249, 258	STALEVO 100.....	109, 111		
SKYRIZI PEN.....	249, 258				
SKYTROFA.....	188				
SLYND.....	175, 195				
SOAAZ.....	85, 139				
<i>sod citrate-citric acid</i> .....	137				

SUMAXIN.....	239, 251	TAZAROTENE .....	258	<i>thyroid</i> .....	200
SUMAXIN CP .....	239, 251	TAZORAC .....	258	<i>tiadylt er</i> .....	76, 77, 81, 89
<i>sunitinib malate</i> .....	40	<i>taztia xt</i> .....	76, 77, 81, 89	<i>tiagabine hcl</i> .....	97
SUNLENCA .....	19, 23	TAZVERIK.....	41	TIAZAC.....	76, 77, 81, 89
SUNOSI.....	128	TDVAX.....	44	TIBSOVO.....	41
SUPREP BOWEL PREP KIT..	158	TECHLITE LANCETS 26G .....	134	TIKOSYN.....	80
SUTAB.....	158	TEGLUTIK.....	110	<i>tilia fe</i> .....	175, 184, 195
<i>syeda</i> .....	175, 184, 195	TEGRETOL.....	97, 101	<i>timolol maleate</i>	
SYMBICORT.....	57, 166	TEGRETOL-XR.....	97, 101	.....	53, 74, 75, 80, 103, 148
SYMBYAX.....	105, 126	TEGSEDI.....	203	<i>timolol maleate (once-daily)</i> ...	148
SYMDEKO.....	227, 228	TEKTURNA .....	87	<i>timolol maleate pf</i> .....	148
SYMFI.....	25, 26	<i>telmisartan</i> .....	70	TIMOPTIC OCUDOSE.....	148
SYMFI LO.....	25, 26	<i>telmisartan-amlodipine</i> .....	70, 82	<i>tinidazole</i> .....	19
SYMLINPEN 120 .....	167	<i>telmisartan-hctz</i> .....	70, 143	<i>tiopronin</i> .....	222
SYMLINPEN 60 .....	167	<i>temazepam</i> .....	108	TIROSINT .....	200
SYMPAZAN.....	107, 108	TEMBEXA .....	29	TIROSINT-SOL.....	200
SYMPROIC.....	161	<i>temozolomide</i> .....	41	TISSEEL.....	258
SYMTUZA.....	26, 27, 222	TENCON .....	93, 106	TIVICAY.....	24
SYNALAR.....	248	TENIVAC.....	44	TIVICAY PD.....	24
SYNAPRYN FUSEPAQ.....	117	<i>tenofovir disoproxil fumarate</i> .....	26	<i>tizanidine hcl</i> .....	52
SYNAREL.....	186	TEPMETKO .....	41	TOBI PODHALER.....	15
SYNDROS.....	155	<i>terazosin hcl</i> .....	54, 69	TOBRADEX.....	147, 151
SYNJARDY.....	169, 197	<i>terbinafine hcl</i> .....	15	TOBRADEX ST .....	147, 151
SYNJARDY XR.....	169, 197, 198	<i>terbutaline sulfate</i> .....	57, 233	<i>tobramycin</i> .....	15, 147
TABLOID.....	40	<i>terconazole</i> .....	242	<i>tobramycin-dexamethasone</i>	
TABRADOL FUSEPAQ.....	52	<i>teriflunomide</i> .....	217	.....	147, 151
TABRECTA .....	40	TERIPARATIDE		TOBREX.....	147
TACLONEX .....	248, 258	(RECOMBINANT) .....	187, 203	TOLAK .....	258
<i>tacrolimus</i> .....	219, 249, 258	<i>terrell</i> .....	112	<i>tolcapone</i> .....	109
<i>tadalafil</i> .....	87, 231	TESTIM.....	167	<i>tolterodine tartrate</i> .....	259
<i>tadalafil (pah)</i> .....	86, 231, 234	<i>testosterone</i> .....	167	<i>tolterodine tartrate er</i> .....	259
TADLIQ.....	87, 231, 234	<i>testosterone cypionate</i> .....	167	<i>tolvaptan</i> .....	144
TAFINLAR .....	40	<i>testosterone enanthate</i> .....	167	TOPAMAX.....	97, 103
<i>tafluprost (pf)</i> .....	154	<i>tetrabenazine</i> .....	128	TOPAMAX SPRINKLE.....	97, 103
TAGRISSE.....	40	<i>tetracaine hcl</i> .....	153	TOPICORT .....	248
<i>take action</i> .....	175, 195	<i>tetracycline hcl</i> .....	17, 32, 157	<i>topiramate</i> .....	97, 103
TAKHZYRO.....	219, 220	TEXACORT .....	248	<i>toremifene citrate</i> .....	41, 177
TALZENNA .....	40	TEZSPIRE .....	232	<i>torsemide</i> .....	85, 139
<i>tamoxifen citrate</i> .....	40, 177	THALITONE .....	88, 144	TOSYMRA.....	125
<i>tamsulosin hcl</i> .....	55	THALOMID .....	217	TOUJEO MAX SOLOSTAR...	187
TAPERDEX 12-DAY.....	166	THEO-24...	83, 123, 138, 235, 260	TOUJEO SOLOSTAR.....	187
TAPERDEX 6-DAY.....	166	<i>theophylline</i>		<i>tovet</i> .....	248
TAPERDEX 7-DAY.....	166	.....	83, 123, 138, 235, 260	TPOXX.....	20
<i>tarina 24 fe</i> .....	175, 184, 195	<i>theophylline er</i>		TRACLEER.....	89, 228, 234
<i>tarina fe 1/20 eq</i> .....	175, 184, 195	.....	83, 123, 138, 235, 260	TRADJENTA .....	176
TARPEYO .....	166	THIOLA.....	222	<i>tramadol hcl</i> .....	117
TASIGNA.....	40	THIOLA EC.....	222	TRAMADOL HCL (ER	
<i>tasimelteon</i> .....	104	<i>thioridazine hcl</i> .....	121	BIPHASIC).....	117
<i>tavaborole</i> .....	253	<i>thiothixene</i> .....	127	<i>tramadol hcl (er biphasic)</i> .....	117
TAVALISSE.....	59	THROMBIN-JMI .....	64	<i>tramadol hcl er</i> .....	117
TAVNEOS.....	208, 220	THROMBIN-JMI EPISTAXIS....	64	<i>tramadol-acetaminophen</i> ..	93, 117
<i>taysofy</i> .....	175, 184, 195	THROMBOGEN.....	64	<i>trandolapril</i> .....	71, 72
<i>tazarotene</i> .....	258	THYQUIDITY.....	200	<i>trandolapril-verapamil hcl er</i>	72, 77

<i>tranexamic acid</i> .....	64	TRI-VI-FLORO	URELLE.....	33, 50, 93, 222
<i>tranylcypromine sulfate</i> .....	113	..... 207, 262, 263, 265, 266, 267	UREMEZ-40.....	252
<i>travoprost (bak free)</i> .....	154	<i>tri-vite/fluoride</i>	<i>uretron d/s</i> .....	33, 50, 93, 222
<i>trazodone hcl</i> .....	126	..... 207, 262, 263, 266, 267	URIMAR-T.....	33, 50, 93, 222
TRECTOR.....	20	<i>trivora (28)</i> .....	<i>urin ds</i> .....	33, 50, 94, 222
TRELEGY ELLIPTA ...	50, 57, 166	..... 175, 184, 195	UROCIT-K 10.....	137
TREMFYA.....	249, 258	<i>tri-vylibra</i> .....	UROCIT-K 15.....	137
<i>tretinoin</i> .....	41, 243	..... 175, 184, 195	UROCIT-K 5.....	137
<i>tretinoin microsphere</i> .....	243	<i>trospium chloride</i> .....	UROGESIC-BLUE.....	33, 51, 223
<i>tretinoin microsphere pump</i> ...	243	..... 259	<i>ursodiol</i> .....	158
TRETTEN.....	64	<i>trospium chloride er</i> .....	URSODIOL+SYRSPEND SF..	158
TREXALL.....	41, 212, 217, 219	..... 259	<i>valacyclovir hcl</i> .....	29
TREZIX.....	93, 117, 123	TRUE FOLIC ACID.....	VALCHLOR.....	259
<i>triamcinolone acetonide</i> .....	248	..... 265	<i>valganciclovir hcl</i> .....	29
<i>triamterene</i> .....	87, 140	TRUE METRIX LEVEL 1.....	<i>valproic acid</i> .....	98, 101, 103
<i>triamterene-hctz</i> .....	140, 143	..... 134	VALSARTAN.....	70, 71
<i>triazolam</i> .....	108	TRUE METRIX LEVEL 2.....	<i>valsartan</i> .....	70, 71
TRICITRASOL.....	58	TRUE METRIX LEVEL 3.....	<i>valsartan-hydrochlorothiazide</i>	..... 71, 143
<i>tricitrates</i> .....	137	TRULANCE.....	..... 71, 143	
<i>triderm</i> .....	248	TRULICITY.....	VALTOCO.....	107
<i>trientine hcl</i> .....	164	TRUMENBA.....	VANOCOCIN.....	21
<i>tri-estarylla</i> .....	175, 184, 195	TRUQAP.....	<i>vancomycin hcl</i> .....	21
<i>trifluoperazine hcl</i> .....	121	TRUVADA.....	VANCOMYCIN+SYRSPEND	
<i>trifluridine</i> .....	148	TUKYSA.....	SF.....	21
<i>trihexyphenidyl hcl</i> .....	51, 94	TURALIO.....	VANFLYTA.....	41
TRIJARDY XR.....	169, 177, 198	<i>turpentine</i> .....	VANISH.....	207
TRIKAFTA.....	227, 228	..... 242	VAQTA.....	47
<i>tri-legest fe</i> .....	175, 184, 195	<i>turqoz</i> .....	<i>vardefafil hcl</i> .....	87
TRILEPTAL.....	97	..... 175, 185, 195	<i>varenicline tartrate</i> .....	52
<i>tri-linyah</i> .....	175, 184, 195	TUXARIN ER.....	<i>varenicline tartrate (starter)</i> .....	52
<i>tri-lo-estarylla</i> .....	175, 184, 195	..... 13, 227	<i>varenicline tartrate(continue)</i> ....	52
<i>tri-lo-marzia</i> .....	175, 184, 195	TWINRIX.....	VARIVAX.....	47
<i>tri-lo-mili</i> .....	175, 184, 195	..... 47	VAXELIS.....	44, 47, 48
<i>tri-lo-sprintec</i> .....	175, 184, 195	TWIRLA.....	VAXNEUVANCE.....	48
<i>trimethobenzamide hcl</i> .....	155	..... 176, 185, 195	VCF VAGINAL	
<i>trimethoprim</i> .....	33	TWYNEO.....	CONTRACEPTIVE.....	224
<i>tri-mili</i> .....	175, 184, 195	..... 243, 253	VECAMYL.....	85
<i>trimipramine maleate</i> .....	128	TYBLUME.....	<i>velivet</i> .....	176, 185, 196
TRINATE.....	66, 262, 265	..... 176, 185, 196	VELPHORO.....	139
TRINTELLIX.....	127	TYBOST.....	VELTASSA.....	139
<i>tri-nymyo</i> .....	175, 184, 195	<i>tydemy</i> .....	VELTIN.....	239, 243, 259
TRIPLE COMPLEX FORMULA		..... 176, 185, 196, 265	VENCLEXTA.....	41
3 KIT.....	241, 253, 259	TYMLOS.....	VENCLEXTA STARTING	
TRIPLE PMB.....	147, 151, 153	..... 187, 203	PACK.....	41
TRIPLE PMK.....	148, 151, 153	TYRVAYA.....	VENELEX.....	259
<i>tri-sprintec</i> .....	175, 184, 195	..... 152	VENLAFAXINE BESYLATE	
TRISTART DHA		TYVASO.....	ER.....	124
..... 66, 142, 222, 262, 265		..... 90, 232, 234	<i>venlafaxine hcl</i> .....	125
TRIUMEQ.....	24, 26	TYVASO DPI MAINTENANCE	<i>venlafaxine hcl er</i> .....	124, 125
TRIUMEQ PD.....	24, 27	KIT.....	VENTAVIS.....	90, 232, 235
TRI-VI-FLOR		..... 90, 232, 234	VEOZAH.....	111
..... 207, 262, 263, 265, 266, 267		TYVASO DPI TITRATION KIT	<i>verapamil hcl</i> .....	76, 77, 81, 90
		..... 90, 232, 234	<i>verapamil hcl er</i> .....	76, 77, 81, 90
		TYVASO REFILL.....		
		..... 90, 232, 235		
		TYVASO STARTER ..		
		..... 90, 232, 235		
		UBRELVY.....		
		..... 109		
		UCERIS.....		
		..... 166		
		UDENYCA.....		
		..... 61		
		ULTANE.....		
		..... 113		
		UMECTA MOUSSE.....		
		..... 251		
		UNIFINE PROTECT PEN		
		NEEDLE.....		
		..... 134		
		UNISTRIP CONTROL.....		
		..... 134		
		<i>unithroid</i> .....		
		..... 200		
		UPNEEQ.....		
		..... 154		
		UPTRAVI.....		
		..... 235		
		UPTRAVI TITRATION.....		
		..... 235		
		URAMAXIN.....		
		..... 251		
		<i>urea</i> .....		
		..... 251		
		<i>urea nail</i> .....		
		..... 252		



VERDESO.....	248	VITAFOL-OB+DHA	67, 142, 223, 263, 266	WESTGEL DHA	67, 142, 223, 263, 266
VEREGEN.....	259	VITAMEDMD ONE		<i>wheat germ oil</i> .....	267
VERELAN.....	76, 77, 81, 90	RX/QUATREFOLIC	67, 142, 223, 263, 266	WIDE-SEAL DIAPHRAGM 60	224
VERELAN PM.....	76, 77, 81, 90	VITAMIN C BRIGHTENING		WIDE-SEAL DIAPHRAGM 65	224
VERIFINE INSULIN PEN		SERUM.....	242	WIDE-SEAL DIAPHRAGM 70	224
NEEDLE.....	134	<i>vitamin d (ergocalciferol)</i> .....	267	WIDE-SEAL DIAPHRAGM 75	224
VERIFINE INSULIN SYRINGE		<i>vitamins acd-fluoride</i>	207, 263, 266, 267	WIDE-SEAL DIAPHRAGM 80	224
.....	135	VITAPEARL.....	67, 223, 263, 266	WIDE-SEAL DIAPHRAGM 85	224
VERIFINE PLUS PEN		VITATHELY WITH GINGER	67, 263, 266	WIDE-SEAL DIAPHRAGM 90	224
NEEDLE.....	135	VITRAKVI.....	41	WIDE-SEAL DIAPHRAGM 95	224
VERIFINE SAFE LANCET		VIVJOA.....	21	WILATE.....	64
MINI 21G.....	135	VIZIMPRO.....	41	<i>wixela inhub</i> .....	57, 166
VERIFINE SAFE LANCET		VOCABRIA.....	24	<i>wymzya fe</i> .....	176, 185, 196
MINI 23G.....	135	<i>volnea</i> .....	176, 185, 196	XACIATO.....	239
VERIFINE SAFE LANCET		VONJO.....	42	XARELTO.....	59
MINI 28G.....	135	VONVENDI.....	64	XARELTO STARTER PACK.....	59
VERIFINE SAFE LANCET		<i>voriconazole</i> .....	21	XATMEP.....	42, 212, 217, 219
MINI 30G.....	135	VORTEX VALVED HOLDING		XCOPRI.....	98
VERIFINE SHARPS		CHAMBER.....	135	XELJANZ.....	212
CONTAINER.....	135	VOSEVI.....	22, 23	XELJANZ XR.....	213
VERQUVO.....	90	VOWST.....	223	XELPROS.....	154
VERSACLOZ.....	105	VOXZOGO.....	223	XELSTRYM.....	92
VERSAPENN (AL) ANHYD		VP FC KIT.....	52, 253, 259	XENICAL.....	161
LIPID.....	225	VP GKL KIT.....	241, 253, 259	XEPI.....	239
VERZENIO.....	41	VRAYLAR.....	105	XERMELO.....	155
VESICARE.....	260	VTAMA.....	239, 259	XIFAXAN.....	31
VESICARE LS.....	260	VUSION.....	241, 242, 249	XIIDRA.....	151
<i>vestura</i> .....	176, 185, 196	<i>vyfemla</i> .....	176, 185, 196	XOFLUZA (40 MG DOSE).....	20
VFEND.....	21	VYLEESI.....	111, 164	XOFLUZA (80 MG DOSE).....	20
VIBERZI.....	161	<i>vylibra</i> .....	176, 185, 196	XOLAIR.....	232, 233
VIBRAMYCIN.....	17, 18, 32	VYNDAMAX.....	78, 111, 223	XOLEGEL COREPAK.....	242, 248
VICTOZA.....	186, 187	VYNDAQEL.....	78, 223	XOLEGEL DUO/HEAD &	
<i>vienna</i> .....	176, 185, 196	VYTORIN.....	78, 85	SHOULDERS.....	242, 253
<i>vigabatrin</i> .....	98	VYVANSE.....	92	XOLEGEL DUO/XOLEX.....	242, 253
<i>vigadrone</i> .....	98	WAKIX.....	128	XOPENEX HFA.....	57, 233
VIGAMOX.....	148	<i>warfarin sodium</i> .....	59	XOSPATA.....	42
<i>vigpoder</i> .....	98	WEGOVI.....	187	XPHOZAH.....	139, 140, 161
VIJOICE.....	223	WELIREG.....	42	XPOVIO (100 MG ONCE	
<i>vilazodone hcl</i> .....	127	<i>wera</i> .....	176, 185, 196	WEEKLY).....	42
VILEVEV MB.....	33, 51, 94, 223	WESCAP-C DHA	67, 223, 263, 266	XPOVIO (40 MG ONCE	
VIMPAT.....	98	.....	67, 223, 263, 266	WEEKLY).....	42
VINATE ONE.....	67, 262, 265	WESCAP-PN DHA	67, 142, 223, 263, 266	XPOVIO (40 MG TWICE	
VIOKACE.....	145, 158	.....	67, 142, 223, 263, 266	WEEKLY).....	42
<i>viorele</i> .....	176, 185, 196	WESNATAL DHA COMPLETE	67, 142, 223, 263, 266	XPOVIO (60 MG ONCE	
VIRACEPT.....	27	.....	67, 142, 223, 263, 266	WEEKLY).....	42
VIRAZOLE.....	29	WESNATE DHA.....	67, 223, 263, 266	XPOVIO (80 MG ONCE	
VIREAD.....	27	<i>wes-phos 250 neutral</i> .....	142	WEEKLY).....	42
VISTARIL.....	13, 104			XPOVIO (80 MG TWICE	
VISTOGARD.....	202			WEEKLY).....	42
VITAFOL FE+				XTAMPZA ER.....	117
.....	67, 142, 223, 263, 265				
VITAFOL STRIPS.....	263				
VITAFOL-NANO.....	67, 263, 266				



XTANDI.....	42	ZONEGRAN.....	98
<i>xulane</i> .....	176, 185, 196	ZONISADE.....	98
XURIDEN.....	223	<i>zonisamide</i> .....	98
XYNTHA.....	64	ZONTIVITY.....	68
XYNTHA SOLOFUSE.....	64, 65	ZORYVE.....	259
XYWAV.....	111	<i>zovia 1/35 (28)</i> .....	176, 185, 196
YASMIN 28.....	176, 185, 196	ZOVIRAX.....	241
YAZ.....	176, 185, 196	ZTALMY.....	98
YUPELRI.....	51	ZTLIDO.....	200
<i>yuvafem</i> .....	185, 205	ZUBSOLV.....	118, 119
ZACARE.....	242, 253	<i>zumandimine</i> .....	176, 185, 196
ZACLIR CLEANSING.....	253	ZURZUVAE.....	99
<i>zafemy</i> .....	176, 185, 196	ZYDELIG.....	42
<i>zafirlukast</i> .....	229	ZYFLO.....	229
<i>zaleplon</i> .....	104	ZYLET.....	148, 151
ZANAFLEX.....	52	ZYPITAMAG.....	85
ZARONTIN.....	127	ZYVOX.....	30
ZARXIO.....	61		
ZAVZPRET.....	109		
ZEGALOGUE.....	186, 202		
ZEJULA.....	42		
ZELAPAR.....	113		
ZELBORAF.....	42		
ZEMBRACE SYMTOUCH.....	125		
ZEMPLAR.....	267		
<i>zenatane</i> .....	259		
ZENPEP.....	145, 159		
ZENPHOR WOUND PAD.....	259		
ZENZEDI.....	92		
ZEPATIER.....	23		
ZEPOSIA.....	218		
ZEPOSIA 7-DAY STARTER PACK.....	218		
ZEPOSIA STARTER KIT.....	218		
ZETONNA.....	151		
ZIAGEN.....	27		
<i>zidovudine</i> .....	27		
<i>zileuton er</i> .....	229		
ZILXI.....	239		
ZIMHI.....	118, 202		
ZIOPTAN.....	154		
<i>ziprasidone hcl</i> .....	101, 106		
ZIPSOR.....	121		
ZIRGAN.....	148		
ZITHROMAX.....	29, 30		
ZITHROMAX TRI-PAK.....	30		
ZITHROMAX Z-PAK.....	30		
ZOKINVY.....	223		
ZOLINZA.....	42		
<i>zolmitriptan</i> .....	125		
<i>zolpidem tartrate</i> .....	104		
<i>zolpidem tartrate er</i> .....	104		
ZOMIG.....	125		