



2024 California Large Group 4-Tier Essential HMO and PPO Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of May 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 All previous versions of this PDL are no longer in effect.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 > **Popular Forms** > **Pharmacy Benefits** > **Prescription Drug Lists** > **California plans** > **Large Group - Essential**. Plan-specific coverage documents may be accessed online at uhc.com/statedruglists > **Large Group Plans** > **California**.

If you are a UnitedHealthcare member, please register or log on to 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:

- Doctors Plan
- Select
- Select Plus
- Choice
- Choice Plus
- Core
- Core Essential
- Navigate
- Navigate Plus
- Options PPO
- Non-Differential PPO
- SignatureValue
- SignatureValue Advantage
- SignatureValue Alliance
- SignatureValue Focus
- SignatureValue Harmony

Please refer to your member ID card for plan type (HMO or PPO).

Updated 3/1/2024

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	13



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.

Enrollee is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

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 bold and italicized lowercase letters.

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 [applies to PPO plans **only**]); 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.

Subscriber means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

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 bold and 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 bold and 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>)	4	
<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 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.

Drug Tier 1	Your lowest cost medications	SP	Specialty medication
Drug Tier 2	Your mid-range cost medications	CM	Orally administered anti-cancer medication
Drug Tier 3	Your mid-range cost medications	M	May be covered under the medical benefit with prior authorization for HMO plans
Drug Tier 4	Your highest cost medications	SMCS	Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit)
PA	Prior authorization required	E	Excluded from coverage unless covered as part of health care reform preventive
SL	Supply Limit	SM	\$0 cost-share by state mandate when condition appropriate
ST	Step Therapy		
H	Part of health care reform preventive when age and/or condition appropriate		



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, 3 or 4, 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, Tier 2 or Tier 3 and may vary depending on the medication and the condition it treats.

\$	Drug Tier	Includes	Helpful Tips
\$	Tier 1 Your lowest cost	Medications that provide the highest overall value. Mostly generic drugs. Some preferred brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
\$\$	Tier 2 and 3 Your mid-range cost	Medications that provide good overall value. A mix of brand-name and generic drugs.	Use Tier 2 or Tier 3 drugs instead of Tier 4 to help reduce your out-of-pocket costs.
\$\$\$	Tier 4 Your highest cost	Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Many Tier 4 drugs have lower-cost options in Tier 1, 2 or 3. 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, or call the toll-free number on your member ID card for more information about your benefit plan. For HMO plans, please reference your Schedule of Benefits for costs associated with medications covered under the medical benefit. For information related to specialty medication cost share, please refer to the Specialty Medication Cost Share (SMCS) section below.

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 Advantage and Essential 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 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.

Specialty Medication Cost Share (SMCS)—Specialty medication cost share may apply. Please refer to the Pharmacy Schedule of Benefits for specific cost share. For HMO plans, does not apply to injectable medications covered under the medical benefit.

To learn more about a pharmacy program or to find out if it applies to you, please visit 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.

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. 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 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 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 member 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://www.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://www.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 or call the toll-free member phone number on your member ID card for more current information.

Log in to 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.



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
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 member 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 Managed Health Care:

DMHC
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219 (1-888-466-2219)
1-800-735-2929 or 1-888-877-5378 (TTY)
Internet Website: www.hmohelp.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 LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

Chinese

重要語言資訊：

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

Arabic

معلومات مهمة عن اللغة:

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 1-800-624-8822 / TTY: 711. وإذا احتجت لمزيد من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՅՈՒՆ՝

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանչության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալը համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիրը՝ UnitedHealthcare of California 1-800-624-8822 / TTY 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

Cambodian

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងស្នើរនៅខាងក្រោម។ អ្នកអាចទទួលបានអ្នកបកប្រែ ឬស្នើការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលបានជំនួយជាភាសា របស់អ្នក សូមទូរស័ព្ទទៅគម្រោងសុខភាពរបស់អ្នក តាមលេខ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។



Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 1-800-624-8822/TTY: 711 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ्त में उपलब्ध कराई जा सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

Hmong

COV NTAUB NTAUV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntauw pub dawb. Cov ntaub ntauw sau no muaj sau ua qee yam ntaub ntauw pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntauw sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntauw: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntauw tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ：

お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਰੱ ਤਵਪੂਰਨ ਭਾ,ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆਂ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾ,ਾਵਾਂ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾ,ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ:

UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।



Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия ТТТ: 711. Если вам все еще требуется помощь, позвоните в службу поддержки НМО по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

Thai

ข้อมูลสำคัญเกี่ยวกับภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังมีอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

State of California

Table of Contents of Prescription Drug List

Informational Section.....1
ANTI-HISTAMINE DRUGS - Drugs for Allergy14
ANTI-INFECTIVE AGENTS - Drugs for Infections16
ANTI-NEOPLASTIC AGENTS - Drugs for Cancer35
ANTITOXINS, IMMUNE GLOB, TOXOIDS, VACCINES - DRUGS FOR THE IMMUNE SYSTEM45
AUTONOMIC DRUGS50
AUTONOMIC DRUGS - Drugs for the Nervous System51
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood61
CARDIOVASCULAR DRUGS - Drugs for the Heart73
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System94
DENTAL AGENTS - Oral Care126
DEVICES - Medical Supplies and Durable Medical Equipment127
DIAGNOSTIC AGENTS134
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants136
ELECTROLYTIC, CALORIC, AND WATER BALANCE136
ENZYMES145
EYE, EAR, NOSE AND THROAT (EENT) PREPS.145
GASTROINTESTINAL DRUGS154
GASTROINTESTINAL DRUGS - Drugs for the Stomach154
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron163
HORMONES AND SYNTHETIC SUBSTITUTES164
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones164
LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing202
MISCELLANEOUS THERAPEUTIC AGENTS202
NONHORMONAL CONTRACEPTIVES - Drugs for Women226
OXYTOCICS - Drugs for Women227
PHARMACEUTICAL AIDS227
RESPIRATORY TRACT AGENTS - Drugs for the Lungs227
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin238
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles257
VITAMINS258

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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
VISTARIL ORAL CAPSULE 25 MG (hydroxyzine pamoate)	4	
OTHER ANTIHISTAMINES - Drugs for Allergy		
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
olopatadine hcl nasal solution 0.6 %	4	SL (30.5 grams (1 box) per prescription.)
VISTARIL ORAL CAPSULE 25 MG (hydroxyzine pamoate)	4	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
promethazine hcl oral solution 6.25 mg/5ml	1	
promethazine hcl oral syrup 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethazine vc oral syrup 6.25-5 mg/5ml	1	
promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml	1	PA; SL (360 ml per month.)
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA; SL (360 ml per month.)
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethegan rectal suppository 12.5 mg, 25 mg, 50 mg	1	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML (pseudoeph-bromphen-dm)	3	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	3	PA; SL (360 ml per month.)
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (chlorpheniramine-codeine)	3	PA; SL (10 tablets per prescription and 30 tablets per month.)
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (Iodoxamide tromethamine)	3	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
levocetirizine dihydrochloride oral tablet 5 mg	1	
ANTI-INFECTIVE AGENTS - Drugs for Infections		
1ST GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefadroxil oral capsule 500 mg	1	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	1	
cefadroxil oral tablet 1 gm	1	
cephalexin oral capsule 250 mg, 500 mg, 750 mg	1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cephalexin oral tablet 250 mg, 500 mg	1	
2ND GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefaclor er oral tablet extended release 12 hour 500 mg	1	
cefaclor oral capsule 250 mg, 500 mg	1	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefprozil oral tablet 250 mg, 500 mg	1	
cefuroxime axetil oral tablet 250 mg, 500 mg	1	
3RD GENERATION CEPHALOSPORIN ANTIBIOTICS - Antibiotics		
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefixime oral capsule 400 mg	3	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	3	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	1	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	1	
ADAMANTANE ANTIVIRALS - Drugs for Viral Infections		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
amantadine hcl oral tablet 100 mg	1	
rimantadine hcl oral tablet 100 mg	1	
ALLYLAMINE ANTIFUNGALS - Drugs for Fungus		
terbinafine hcl oral tablet 250 mg	1	
AMEBICIDES - Drugs for the Mouth and Throat		
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
HUMATIN ORAL CAPSULE 250 MG (paromomycin sulfate)	2	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	4	
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	2	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	4	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (amikacin sulfate liposome)	4	PA; SL (8.4 ml per day.); SMCS; SP
HUMATIN ORAL CAPSULE 250 MG (paromomycin sulfate)	2	
neomycin sulfate oral tablet 500 mg	1	
tobramycin inhalation nebulization solution 300 mg/4ml	3	PA; SL (224 ml per 56 days.); SMCS; SP
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (omadacycline tosylate)	4	SL (30 tablets per prescription.)
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
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	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
amoxicillin-potassium clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	1	
amoxicillin-potassium clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	1	
ampicillin oral capsule 500 mg	1	
OMECLAMOX-PAK ORAL 500-500-20 MG (amoxicillin-clarithro-omeprazole)	4	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
ANTHELMINTICS - Drugs for Parasites		
albendazole oral tablet 200 mg	3	PA; SL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (praziquantel)	4	
EGATEN ORAL TABLET 250 MG (triclabendazole)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (mebendazole)	4	PA; SL (6 tablets per 3 days.)
ivermectin oral tablet 3 mg	1	PA; SL (20 tablets per 3 months.)
praziquantel oral tablet 600 mg	2	
STROMECTOL ORAL TABLET 3 MG (ivermectin)	4	PA; SL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
griseofulvin microsize oral suspension 125 mg/5ml	1	
griseofulvin microsize oral tablet 500 mg	1	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	1	
ANTIMALARIALS - Drugs for the Mouth and Throat		
ARAKODA ORAL TABLET 100 MG (tafenoquine succinate)	4	SL (16 tablets per month.)
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	2	
avidoxy oral tablet 100 mg	1	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG (artemether-lumefantrine)	2	
DARAPRIM ORAL TABLET 25 MG (pyrimethamine)	4	PA; SMCS; SP
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	3	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
KRINTAFEL ORAL TABLET 150 MG (tafenoquine succinate)	1	SL (2 tablets per prescription.)
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (atovaquone-proguanil hcl)	4	
mefloquine hcl oral tablet 250 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
mondoxyne nl oral capsule 100 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	1	
pyrimethamine oral tablet 25 mg	3	PA; SMCS; SP
QUALAQUIN ORAL CAPSULE 324 MG (quinine sulfate)	4	
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
quinine sulfate oral capsule 324 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	3	
VIBRAMYCIN ORAL CAPSULE 100 MG (doxycycline hyclate)	4	
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML (doxycycline monohydrate)	4	
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
dapsone oral tablet 100 mg, 25 mg	2	
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (nitazoxanide)	2	SL (60 ml per prescription.)
atovaquone oral suspension 750 mg/5ml	2	
BACTRIM DS ORAL TABLET 800-160 MG (sulfamethoxazole-trimethoprim)	4	
BACTRIM ORAL TABLET 400-80 MG (sulfamethoxazole-trimethoprim)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
BENZNIDAZOLE ORAL TABLET 100 MG	2	PA; SL (240 tablets per 720 days.)
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	PA; SL (720 tablets per 720 days.)
dapsone oral tablet 100 mg, 25 mg	2	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
IMPAVIDO ORAL CAPSULE 50 MG (miltefosine)	2	PA; SL (3 capsules per day.)
LAMPIT ORAL TABLET 120 MG (nifurtimox)	4	PA; SL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (nifurtimox)	4	PA; SL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	4	
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
nitazoxanide oral tablet 500 mg	2	SL (6 tablets per prescription.)
pentamidine isethionate inhalation solution reconstituted 300 mg	2	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
tinidazole oral tablet 250 mg, 500 mg	3	
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (lenacapavir sodium)	4	PA; SL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (lenacapavir sodium)	4	PA; SL (5 tablets per 365 days.)
ANTITUBERCULOSIS AGENTS - Antibiotics		
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (ciprofloxacin)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (ciprofloxacin hcl)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	1	
cycloserine oral capsule 250 mg	1	
ethambutol hcl oral tablet 100 mg, 400 mg	1	
isoniazid oral syrup 50 mg/5ml	1	
isoniazid oral tablet 100 mg, 300 mg	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl oral tablet 400 mg	3	
MYAMBTOL ORAL TABLET 400 MG (ethambutol hcl)	4	
MYCOBUTIN ORAL CAPSULE 150 MG (rifabutin)	4	
PRETOMANID ORAL TABLET 200 MG	4	
PRIFTIN ORAL TABLET 150 MG (rifapentine)	2	
pyrazinamide oral tablet 500 mg	1	
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
SIRTURO ORAL TABLET 100 MG, 20 MG (bedaquiline fumarate)	2	
TRECTOR ORAL TABLET 250 MG (ethionamide)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (maribavir)	4	PA; SL (4 tablets per day.); SMCS; SP
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (nirmatrelvir-ritonavir)	3	SM
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (nirmatrelvir-ritonavir)	3	SM
PREVYMIS ORAL TABLET 240 MG, 480 MG (letermovir)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (baloxavir marboxil)	3	SL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (baloxavir marboxil)	3	SL (1 tablet per month.)
AZOLE ANTIFUNGALS - Drugs for Fungus		
CRESEMBA ORAL CAPSULE 186 MG (isavuconazonium sulfate)	3	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
itraconazole oral capsule 100 mg	1	SL (180 capsules per 365 days)
itraconazole oral solution 10 mg/ml	2	SL (1800 ml per 365 days)
ketoconazole oral tablet 200 mg	1	
NOXAFIL ORAL PACKET 300 MG (posaconazole)	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML (posaconazole)	4	SL (20 ml per day.)
posaconazole oral suspension 40 mg/ml	2	SL (20 ml per day.)
posaconazole oral tablet delayed release 100 mg	2	
SPORANOX ORAL CAPSULE 100 MG (itraconazole)	4	SL (180 capsules per 365 days)
SPORANOX ORAL SOLUTION 10 MG/ML (itraconazole)	4	SL (1800 ml per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (voriconazole)	4	SL (300 mL per prescription.)
VFEND ORAL TABLET 200 MG (voriconazole)	4	SL (62 tablets per prescription.)
VFEND ORAL TABLET 50 MG (voriconazole)	3	SL (124 tablets per prescription)
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (oteseconazole)	3	PA; SL (18 capsules per 84 days.)
voriconazole oral suspension reconstituted 40 mg/ml	1	SL (300 mL per prescription.)
voriconazole oral tablet 200 mg	1	SL (62 tablets per prescription.)
voriconazole oral tablet 50 mg	1	SL (124 tablets per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ERYTHROMYCIN ANTIBIOTICS - Antibiotics		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (erythromycin ethylsuccinate)	3	
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (erythromycin ethylsuccinate)	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (erythromycin ethylsuccinate)	4	
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG (erythromycin base)	4	
ERYTHROCIN STEARATE ORAL TABLET 250 MG (erythromycin stearate)	2	
erythromycin base oral capsule delayed release particles 250 mg	1	
erythromycin base oral tablet 250 mg, 500 mg	1	
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	3	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	1	
erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml	3	
erythromycin ethylsuccinate oral tablet 400 mg	1	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	3	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (vancomycin hcl)	4	
VANOCIN ORAL CAPSULE 250 MG (vancomycin hcl)	4	
vancomycin hcl oral capsule 125 mg, 250 mg	1	
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	1	
VANCOMYCIN+SYRSPEND SF ORAL SUSPENSION 50 MG/ML (vancomycin hcl)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (sofosbuvir-velpatasvir)	3	PA; SL (2 packets per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (sofosbuvir-velpatasvir)	3	PA; SL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (sofosbuvir-velpatasvir)	3	PA; SL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (sofosbuvir-velpatasvir)	3	PA; SL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.); SMCS
HARVONI ORAL TABLET 45-200 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (56 tablets per 720 days.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	3	PA; ST; SL (56 tablets per 720 days.); SMCS
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; SL (84 tablets per 720 days.); SMCS; SP
SOVALDI ORAL PACKET 150 MG, 200 MG (sofosbuvir)	4	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuvir-velpatasvir-voxilaprev)	3	PA; SL (84 tablets per 720 days.); SMCS; SP
HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
MAVYRET ORAL PACKET 50-20 MG (glecaprevir-pibrentasvir)	3	PA; SL (5 packets per day and 280 packets per 720 days.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (glecaprevir-pibrentasvir)	3	PA; SL (168 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuvir-velpatasvir-voxilaprev)	3	PA; SL (84 tablets per 720 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (elbasvir-grazoprevir)	3	PA; SL (84 tablets per 720 days (12 weeks).); SMCS; SP
HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections		
EPCLUSA ORAL PACKET 150-37.5 MG (sofosbuvir-velpatasvir)	3	PA; SL (2 packets per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL PACKET 200-50 MG (sofosbuvir-velpatasvir)	3	PA; SL (1 packet per day and 84 packets per 720 days.); SMCS; SP
EPCLUSA ORAL TABLET 200-50 MG (sofosbuvir-velpatasvir)	3	PA; SL (1 tablet per day.); SMCS; SP
EPCLUSA ORAL TABLET 400-100 MG (sofosbuvir-velpatasvir)	3	PA; SL (84 tablets per 720 days.); SMCS; SP
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (1 pellet per day and 84 pellets per 720 days.); SMCS
HARVONI ORAL TABLET 45-200 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (84 tablets per 720 days.); SMCS
HARVONI ORAL TABLET 90-400 MG (ledipasvir-sofosbuvir)	3	PA; ST; SL (56 tablets per 720 days.); SMCS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	3	PA; ST; SL (56 tablets per 720 days.); SMCS
MAVYRET ORAL PACKET 50-20 MG (glecaprevir-pibrentasvir)	3	PA; SL (5 packets per day and 280 packets per 720 days.); SMCS; SP
MAVYRET ORAL TABLET 100-40 MG (glecaprevir-pibrentasvir)	3	PA; SL (168 tablets per 720 days.); SMCS; SP
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; SL (84 tablets per 720 days.); SMCS; SP
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuvir-velpatasvir-voxilaprevir)	3	PA; SL (84 tablets per 720 days.); SMCS; SP
ZEPATIER ORAL TABLET 50-100 MG (elbasvir-grazoprevir)	3	PA; SL (84 tablets per 720 days (12 weeks).); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (lenacapavir sodium)	4	PA; SL (4 tablets per 365 days.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (lenacapavir sodium)	4	PA; SL (5 tablets per 365 days.)
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (enfuvirtide)	4	M; SMCS
maraviroc oral tablet 150 mg, 300 mg	2	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (fostemsavir tromethamine)	4	PA
SELZENTRY ORAL SOLUTION 20 MG/ML (maraviroc)	2	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (maraviroc)	4	PA
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (bictegravir-emtricitab-tenofovir)	3	SL (1 tablet per day.)
DOVATO ORAL TABLET 50-300 MG (dolutegravir-lamivudine)	2	SL (1 tablet per day.)
GENVOYA ORAL TABLET 150-150-200-10 MG (elviteg-cobic-emtricit-tenofaf)	2	SL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (raltegravir potassium)	2	
ISENTRESS ORAL PACKET 100 MG (raltegravir potassium)	2	
ISENTRESS ORAL TABLET 400 MG (raltegravir potassium)	2	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (raltegravir potassium)	2	
JULUCA ORAL TABLET 50-25 MG (dolutegravir-rilpivirine)	2	SL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (elviteg-cobic-emtricit-tenofdf)	2	SL (1 tablet per day.)
TIVICAY ORAL TABLET 50 MG (dolutegravir sodium)	3	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (dolutegravir sodium)	3	
TRIUMEQ ORAL TABLET 600-50-300 MG (abacavir-dolutegravir-lamivudine)	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (abacavir-dolutegravir-lamivud)	2	SL (6 tablets per day.)
HIV NONNUCLEOSIDE REV.TRANScriP. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (bictegravir-emtricitab-tenofov)	3	SL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (emtricitab-rilpivir-tenofovir)	3	SL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG (doravirin-lamivudin-tenofov df)	2	SL (1 tablet per day.)
EDURANT ORAL TABLET 25 MG (rilpivirine hcl)	2	
efavirenz oral capsule 200 mg, 50 mg	2	
efavirenz oral tablet 600 mg	2	
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	2	SL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	2	SL (1 tablet per day.)
etravirine oral tablet 100 mg, 200 mg	2	
INTELENCE ORAL TABLET 100 MG, 200 MG (etravirine)	4	
INTELENCE ORAL TABLET 25 MG (etravirine)	2	
JULUCA ORAL TABLET 50-25 MG (dolutegravir-rilpivirine)	2	SL (1 tablet per day.)
methocarbamol oral tablet 500 mg	1	
nevirapine er oral tablet extended release 24 hour 400 mg	3	
nevirapine oral suspension 50 mg/5ml	1	
nevirapine oral tablet 200 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitab-rilpivir-tenofov af)	3	SL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (doravirine)	3	
SYMFI LO ORAL TABLET 400-300-300 MG (efavirenz-lamivudine-tenofovir)	2	SL (1 tablet per day.)
SYMFI ORAL TABLET 600-300-300 MG (efavirenz-lamivudine-tenofovir)	2	SL (1 tablet per day.)
HIV NUCLEOSIDE, NUCLEOTIDE RT INHIBITORS - Drugs for Viral Infections		
abacavir sulfate oral solution 20 mg/ml	1	
abacavir sulfate oral tablet 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
abacavir sulfate-lamivudine oral tablet 600-300 mg	2	SL (1 tablet per day.)
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (bictegravir-emtricitab-tenofov)	3	SL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (lamivudine-tenofovir)	2	SL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (emtricitab-rilpivir-tenofovir)	3	SL (1 tablet per day.)
DELSTRIGO ORAL TABLET 100-300-300 MG (doravirin-lamivudin-tenofov df)	2	SL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (emtricitabine-tenofovir af)	3	SL (1 tablet per day.)
DESCOVY ORAL TABLET 200-25 MG (emtricitabine-tenofovir af)	3	SL (1 tablet per day.); H
DOVATO ORAL TABLET 50-300 MG (dolutegravir-lamivudine)	2	SL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	2	SL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	2	SL (1 tablet per day.)
emtricitabine oral capsule 200 mg	2	
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	SL (1 tablet per day.)
emtricitabine-tenofovir df oral tablet 200-300 mg	1	SL (1 tablet per day.); H
EMTRIVA ORAL SOLUTION 10 MG/ML (emtricitabine)	2	
GENVOYA ORAL TABLET 150-150-200-10 MG (elviteg-cobic-emtricit-tenofaf)	2	SL (1 tablet per day.)
lamivudine oral solution 10 mg/ml	1	
lamivudine oral tablet 100 mg, 150 mg, 300 mg	1	
lamivudine-zidovudine oral tablet 150-300 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitab-rilpivir-tenofov af)	3	SL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (zidovudine)	4	
RETROVIR ORAL SYRUP 50 MG/5ML (zidovudine)	3	
STRIBILD ORAL TABLET 150-150-200-300 MG (elviteg-cobic-emtricit-tenofdf)	2	SL (1 tablet per day.)
SYMFI LO ORAL TABLET 400-300-300 MG (efavirenz-lamivudine-tenofovir)	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SYMFI ORAL TABLET 600-300-300 MG (efavirenz-lamivudine-tenofovir)	2	SL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (darun-cobic-emtricit-tenofaf)	3	SL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	2	H
TRIUMEQ ORAL TABLET 600-50-300 MG (abacavir-dolutegravir-lamivud)	2	SL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG (abacavir-dolutegravir-lamivud)	2	SL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (emtricitabine-tenofovir df)	4	SL (1 tablet per day.)
VIREAD ORAL POWDER 40 MG/GM (tenofovir disoproxil fumarate)	3	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	2	
zidovudine oral capsule 100 mg	1	
zidovudine oral syrup 50 mg/5ml	1	
zidovudine oral tablet 300 mg	1	
HIV PROTEASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
APTIVUS ORAL CAPSULE 250 MG (tipranavir)	2	
atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg	2	
darunavir oral tablet 600 mg, 800 mg	1	
EVOTAZ ORAL TABLET 300-150 MG (atazanavir-cobicistat)	2	
fosamprenavir calcium oral tablet 700 mg	2	
KALETRA ORAL SOLUTION 400-100 MG/5ML (lopinavir-ritonavir)	4	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (lopinavir-ritonavir)	4	
lopinavir-ritonavir oral solution 400-100 mg/5ml	2	
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	2	
NORVIR ORAL PACKET 100 MG (ritonavir)	2	
PREZCOBIX ORAL TABLET 800-150 MG (darunavir-cobicistat)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (darunavir)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
PREZISTA ORAL TABLET 150 MG, 75 MG (darunavir)	2	
REYATAZ ORAL PACKET 50 MG (atazanavir sulfate)	2	
ritonavir oral tablet 100 mg	2	
SYMTUZA ORAL TABLET 800-150-200-10 MG (darun-cobic-emtricit-tenofaf)	3	SL (1 tablet per day.)
VIRACEPT ORAL TABLET 250 MG, 625 MG (nelfinavir mesylate)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML (interferon alfa-n3)	3	M
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	3	M; SMCS; SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (peginterferon alfa-2a)	3	M; SMCS; SP
LINCOMYCIN ANTIBIOTICS - Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (clindamycin hcl)	4	
CLEOCIN ORAL CAPSULE 75 MG (clindamycin hcl)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (clindamycin palmitate hcl)	4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	2	
MONOCLONAL ANTIBODY ANTIVIRALS - Drugs for Viral Infections		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (nirsevimab-alip)	3	H
NATURAL PENICILLIN ANTIBIOTICS - Antibiotics		
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	
NEURAMINIDASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	2	SL (180 ml per month.)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (zanamivir)	3	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
adefovir dipivoxil oral tablet 10 mg	3	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (entecavir)	2	
entecavir oral tablet 0.5 mg, 1 mg	2	
famciclovir oral tablet 125 mg, 500 mg	2	
famciclovir oral tablet 250 mg	2	SL (62 tablets per prescription.)
LAGEVRIO ORAL CAPSULE 200 MG (molnupiravir)	3	SM
ribavirin inhalation solution reconstituted 6 gm	3	
ribavirin oral capsule 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (brincidofovir)	4	
TEMBEXA ORAL TABLET 100 MG (brincidofovir)	4	
valacyclovir hcl oral tablet 1 gm	1	SL (31 tablets per prescription)
valacyclovir hcl oral tablet 500 mg	1	SL (62 tablets per prescription.)
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
VIRAZOLE INHALATION SOLUTION RECONSTITUTED 6 GM (ribavirin)	4	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
azithromycin oral packet 1 gm	1	
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (fidaxomicin)	4	SL (136 mL per 10 days.)
DIFICID ORAL TABLET 200 MG (fidaxomicin)	4	SL (20 tablets per 7 days)
OMECLAMOX-PAK ORAL 500-500-20 MG (amoxicill-clarithro-omeprazole)	4	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
ZITHROMAX ORAL PACKET 1 GM (azithromycin)	4	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (azithromycin)	4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (azithromycin)	4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (azithromycin)	4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (azithromycin)	4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
linezolid oral suspension reconstituted 100 mg/5ml	2	
linezolid oral tablet 600 mg	2	
ZYVOX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (linezolid)	4	
PENICILLINASE-RESISTANT PENICILLINS - Antibiotics		
dicloxacillin sodium oral capsule 250 mg, 500 mg	1	
POLYENE ANTIFUNGALS - Drugs for Fungus		
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
POLYMYXIN ANTIBIOTICS - Antibiotics		
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	M
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (colistimethate sodium)	4	M
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (flucytosine)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANCOBON ORAL CAPSULE 500 MG (flucytosine)	3	
flucytosine oral capsule 250 mg, 500 mg	1	
QUINOLONE ANTIBIOTICS - Antibiotics		
BAXDELA ORAL TABLET 450 MG (delafloxacin meglumine)	4	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (ciprofloxacin)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (ciprofloxacin hcl)	4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl oral tablet 400 mg	3	
ofloxacin oral tablet 300 mg, 400 mg	1	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
MYCOBUTIN ORAL CAPSULE 150 MG (rifabutin)	4	
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
SULFONAMIDE ANTIBIOTICS (SYSTEMIC) - Antibiotics		
BACTRIM DS ORAL TABLET 800-160 MG (sulfamethoxazole-trimethoprim)	4	
BACTRIM ORAL TABLET 400-80 MG (sulfamethoxazole-trimethoprim)	4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline-sunscreen-sal acid)	3	
avidoxy oral tablet 100 mg	1	
demeclocycline hcl oral tablet 150 mg, 300 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg	2	
doxycycline hyclate oral tablet 20 mg	1	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	3	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
mondoxyne nl oral capsule 100 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	3	
VIBRAMYCIN ORAL CAPSULE 100 MG (doxycycline hyclate)	4	
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML (doxycycline monohydrate)	4	
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (sulfamethoxazole-trimethoprim)	4	
BACTRIM ORAL TABLET 400-80 MG (sulfamethoxazole-trimethoprim)	4	
fosfomycin tromethamine oral packet 3 gm	3	
HIPREX ORAL TABLET 1 GM (methenamine hippurate)	4	
MACROBID ORAL CAPSULE 100 MG (nitrofurantoin monohyd macro)	4	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (nitrofurantoin macrocrystal)	4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methenamine hippurate oral tablet 1 gm	1	
methenamine mandelate oral tablet 0.5 gm, 1 gm	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	1	
nitrofurantoin monohydrate macrocrystals oral capsule 100 mg	1	
nitrofurantoin oral suspension 25 mg/5ml	3	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
sulfatrim pediatric oral suspension 200-40 mg/5ml	1	
trimethoprim oral tablet 100 mg	1	
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
uretron d/s oral tablet 81.6 mg	4	
URIMAR-T ORAL CAPSULE 120 MG (meth-hyo-m bl-na phos-ph sal)	4	
urin ds oral tablet 81.6 mg	4	
UROGESIC-BLUE ORAL TABLET 81.6 MG (methen-hyosc-meth blue-na phos)	2	
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	3	PA; SL (4 tablets per day.); SP; CM
ALECENSA ORAL CAPSULE 150 MG (alectinib hcl)	3	PA; SL (8 capsules per day.); SMCS; SP; CM
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML (interferon alfa-n3)	3	M
ALUNBRIG ORAL TABLET 180 MG, 90 MG (brigatinib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
ALUNBRIG ORAL TABLET 30 MG (brigatinib)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (brigatinib)	3	PA; SL (30 packs per year.); SMCS; SP; CM
anastrozole oral tablet 1 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (avapritinib)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
bexarotene oral capsule 75 mg	3	SMCS; CM
bicalutamide oral tablet 50 mg	1	CM
BOSULIF ORAL CAPSULE 100 MG (bosutinib)	3	PA; ST; SL (3 Capsules per day.); SMCS; SP; CM
BOSULIF ORAL CAPSULE 50 MG (bosutinib)	3	PA; ST; SL (1 Capsule per day.); SMCS; SP; CM
BRUKINSA ORAL CAPSULE 80 MG (zanubrutinib)	4	PA; ST; SL (4 capsules per day.); SMCS; SP; CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (cabozantinib s-malate)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
CALQUENCE ORAL TABLET 100 MG (acalabrutinib maleate)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
capecitabine oral tablet 150 mg	2	SL (84 tablets per prescription.); SMCS; SP; CM
capecitabine oral tablet 500 mg	2	SL (140 tablets per prescription.); SMCS; SP; CM
CAPRELSA ORAL TABLET 100 MG (vandetanib)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
CAPRELSA ORAL TABLET 300 MG (vandetanib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
CASODEX ORAL TABLET 50 MG (bicalutamide)	4	CM
COMETRIQ ORAL KIT 20 MG (cabozantinib s-malate)	3	PA; SL (93 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (cabozantinib s-malate)	3	PA; SL (124 capsules per month.); SMCS; SP; CM
COMETRIQ ORAL KIT 80 & 20 MG (cabozantinib s-malate)	3	PA; SL (62 capsules per month.); SMCS; SP; CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (duvelisib)	4	PA; SL (2 capsules per day.); SMCS; SP; CM
COTELLIC ORAL TABLET 20 MG (cobimetinib fumarate)	4	PA; SL (63 tablets per 21 days); SMCS; SP; CM
cyclophosphamide oral capsule 25 mg, 50 mg	3	CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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	3	CM
DAURISMO ORAL TABLET 100 MG, 25 MG (glasdegib maleate)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (hydroxyurea)	3	CM
EMCYT ORAL CAPSULE 140 MG (estramustine phosphate sodium)	3	CM
ERIVEDGE ORAL CAPSULE 150 MG (vismodegib)	3	PA; SL (1 capsule per day.); SMCS; SP; CM
ERLEADA ORAL TABLET 240 MG (apalutamide)	3	PA; SL (1 tablet per year.); SMCS
ERLEADA ORAL TABLET 60 MG (apalutamide)	3	PA; SL (3 tablets per day.); SMCS; SP; CM
erlotinib hcl oral tablet 100 mg, 150 mg	3	PA; SL (1 tablet per day.); SMCS; SP; CM
erlotinib hcl oral tablet 25 mg	3	PA; SL (2 tablets per day.); SMCS; SP; CM
etoposide oral capsule 50 mg	1	SMCS; SP; CM
everolimus oral tablet 10 mg, 7.5 mg	3	PA; SL (2 tablets per day.); SMCS; SP; CM
everolimus oral tablet 2.5 mg, 5 mg	3	PA; SL (1 tablet per day.); SMCS; SP; CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	3	PA; SL (1 tablet per day.); SMCS; SP; CM
exemestane oral tablet 25 mg	2	H
EXKIVITY ORAL CAPSULE 40 MG (mobocertinib succinate)	4	PA; SL (4 capsules per day.); SMCS; SP; CM
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (degarelix acetate)	4	M; SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (degarelix acetate)	4	M; SMCS; SP
FRUZAQLA ORAL CAPSULE 1 MG (fruquintinib)	4	PA; SL (84 capsules per 21 days.); SMCS; SP; CM
FRUZAQLA ORAL CAPSULE 5 MG (fruquintinib)	4	PA; SL (21 capsules per 21 days.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
GAVRETO ORAL CAPSULE 100 MG (pralsetinib)	4	PA; SL (4 capsules per day.); SMCS; SP; CM
gefitinib oral tablet 250 mg	4	PA; SL (2 tablets per day.); SMCS; SP; CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (afatinib dimaleate)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (lomustine)	3	SMCS; SP; CM
HYCAMTIN ORAL CAPSULE 0.25 MG (topotecan hcl)	3	PA; SL (15 capsules per 15 days.); SMCS; SP; CM
HYCAMTIN ORAL CAPSULE 1 MG (topotecan hcl)	3	PA; SL (305 capsules per 15 days.); SMCS; SP; CM
HYDREA ORAL CAPSULE 500 MG (hydroxyurea)	4	CM
hydroxyurea oral capsule 500 mg	1	CM
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (palbociclib)	3	PA; SL (21 capsules per month.); SMCS; SP; CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (palbociclib)	3	PA; SL (0.75 tablets per day.); SMCS; SP; CM
ICLUSIG ORAL TABLET 10 MG, 30 MG (ponatinib hcl)	4	PA; SL (1 tablet per day.); SMCS; CM
ICLUSIG ORAL TABLET 15 MG, 45 MG (ponatinib hcl)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
IDHIFA ORAL TABLET 100 MG, 50 MG (enasidenib mesylate)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
imatinib mesylate oral tablet 100 mg	1	PA; SL (6 tablets per day.); SMCS; SP; CM
imatinib mesylate oral tablet 400 mg	1	PA; SL (1 tablet per day.); SMCS; SP; CM
IMBRUVICA ORAL CAPSULE 140 MG (ibrutinib)	3	PA; SL (4 capsules per day.); SMCS; SP; CM
IMBRUVICA ORAL CAPSULE 70 MG (ibrutinib)	3	PA; SL (1 capsule per day.); SMCS; SP; CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (ibrutinib)	3	PA; SL (7.2 ml per day.); SMCS; SP; CM
IMBRUVICA ORAL TABLET 420 MG (ibrutinib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
INLYTA ORAL TABLET 1 MG (axitinib)	4	PA; SL (6 tablets per day.); SMCS; SP; CM
INLYTA ORAL TABLET 5 MG (axitinib)	4	PA; SL (124 tablets per 30 days.); SMCS; SP; CM
INQOVI ORAL TABLET 35-100 MG (decitabine-cedazuridine)	4	PA; SL (5 tablets per month.); SMCS; SP; CM
IRESSA ORAL TABLET 250 MG (gefitinib)	4	PA; SL (2 tablets per day.); SMCS; SP; CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (ruxolitinib phosphate)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
JAYPIRCA ORAL TABLET 100 MG (pirtobrutinib)	4	PA; SL (3 tablets per day.); SMCS; SP; CM
JAYPIRCA ORAL TABLET 50 MG (pirtobrutinib)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
KISQALI FEMARA ORAL TABLET THERAPY PACK 200 & 2.5 MG (ribociclib-letrozole)	4	PA; ST; SMCS; CM
KOSELUGO ORAL CAPSULE 10 MG (selumetinib sulfate)	3	PA; SL (8 capsules per day.); SMCS; SP; CM
KOSELUGO ORAL CAPSULE 25 MG (selumetinib sulfate)	3	PA; SL (4 capsules per day.); SMCS; SP; CM
KRAZATI ORAL TABLET 200 MG (adagrasib)	4	PA; SL (6 tablets per day.); SMCS; SP; CM
lapatinib ditosylate oral tablet 250 mg	3	PA; SL (186 tablets per prescription); SMCS; SP; CM
lenalidomide oral capsule 10 mg, 2.5 mg, 5 mg	3	PA; SL (28 capsules per 21 days.); SMCS; SP; CM
lenalidomide oral capsule 15 mg, 20 mg, 25 mg	3	PA; SL (21 capsules per 21 days.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (lenvatinib mesylate)	4	PA; SL (2 capsules per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG (lenvatinib mesylate)	4	PA; SL (1 capsule per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG (lenvatinib mesylate)	4	PA; SL (3 capsules per day.); SMCS; SP; CM
LENVIMA ORAL CAPSULE THERAPY PACK 3 X 4 MG (lenvatinib mesylate)	3	PA; SL (3 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
LENVIMA ORAL CAPSULE THERAPY PACK 4 MG (lenvatinib mesylate)	3	PA; SL (1 capsule per day.); SMCS; SP; CM
letrozole oral tablet 2.5 mg	1	H
LEUKERAN ORAL TABLET 2 MG (chlorambucil)	3	CM
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; M; SMCS
LORBRENA ORAL TABLET 100 MG, 25 MG (lorlatinib)	4	PA; ST; SMCS; SP; CM
LUMAKRAS ORAL TABLET 120 MG (sotorasib)	4	PA; SL (4 tablets per day.); SMCS; SP; CM
LUMAKRAS ORAL TABLET 320 MG (sotorasib)	4	PA; SL (3 tablets per day.); SMCS; SP; CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (olaparib)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
LYSODREN ORAL TABLET 500 MG (mitotane)	3	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (futibatinib)	4	PA; SL (84 tablets per month.); SMCS; SP; CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (futibatinib)	4	PA; SL (112 tablets per month.); SMCS; SP; CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (futibatinib)	4	PA; SL (140 tablets per month.); SMCS; SP; CM
MATULANE ORAL CAPSULE 50 MG (procarbazine hcl)	3	SMCS; SP; CM
megestrol acetate oral suspension 40 mg/ml	1	
megestrol acetate oral suspension 625 mg/5ml	3	
megestrol acetate oral tablet 20 mg, 40 mg	1	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (trametinib dimethyl sulfoxide)	4	ST; SL (17.4 ml per day.); SMCS; SP; CM
MEKINIST ORAL TABLET 0.5 MG (trametinib dimethyl sulfoxide)	4	PA; ST; SL (2 tablets per day.); SMCS; SP; CM
MEKINIST ORAL TABLET 2 MG (trametinib dimethyl sulfoxide)	4	PA; ST; SL (1 tablet per day.); SMCS; SP; CM
melphalan oral tablet 2 mg	3	SMCS; CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
MYLERAN ORAL TABLET 2 MG (busulfan)	3	CM
NERLYNX ORAL TABLET 40 MG (neratinib maleate)	3	PA; SL (6 tablets per day.); SMCS; SP; CM
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (ixazomib citrate)	3	PA; SL (3 capsules per prescription.); SMCS; SP; CM
NUBEQA ORAL TABLET 300 MG (darolutamide)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
ODOMZO ORAL CAPSULE 200 MG (sonidegib phosphate)	3	PA; SL (1 capsule per day.); SMCS; SP; CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (momelotinib dihydrochloride)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
ONUREG ORAL TABLET 200 MG, 300 MG (azacitidine)	3	PA; SL (14 tablets per 24 days.); SMCS; SP; CM
ORGOVYX ORAL TABLET 120 MG (relugolix)	4	PA; SL (1 tablet per day); SMCS; SP; CM
ORSERDU ORAL TABLET 345 MG (elacestrant hydrochloride)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
ORSERDU ORAL TABLET 86 MG (elacestrant hydrochloride)	3	PA; SL (3 tablets per day.); SMCS; SP; CM
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (pemigatinib)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (alpelisib)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (alpelisib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	4	PA; SL (21 capsules per prescription.); SMCS; SP; CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (mercaptopurine)	4	SMCS; SP; CM
RETEVMO ORAL CAPSULE 40 MG (selpercatinib)	4	PA; SL (6 capsules per day.); SMCS; SP; CM
RETEVMO ORAL CAPSULE 80 MG (selpercatinib)	4	PA; SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (lenalidomide)	3	PA; SL (28 capsules per 21 days.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 15 MG, 20 MG, 25 MG (lenalidomide)	3	PA; SL (21 capsules per 21 days.); SMCS; SP; CM
REZLIDHIA ORAL CAPSULE 150 MG (olutasidenib)	3	PA; SL (2 capsules per day.); SMCS; CM
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (entrectinib)	3	PA; SL (3 capsules per day.); SMCS; SP; CM
ROZLYTREK ORAL PACKET 50 MG (entrectinib)	2	SL (3 pellet packets per day.); SMCS; SP; CM
RYDAPT ORAL CAPSULE 25 MG (midostaurin)	3	PA; SL (8 capsules per day.); SMCS; SP; CM
sorafenib tosylate oral tablet 200 mg	3	PA; SL (4 tablets per day.); SMCS; SP; CM
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (dasatinib)	4	PA; ST; SL (1 tablet per day.); SMCS; SP; CM
SPRYCEL ORAL TABLET 20 MG (dasatinib)	4	PA; ST; SL (2 tablets per day.); SMCS; SP; CM
STIVARGA ORAL TABLET 40 MG (regorafenib)	3	PA; SL (84 tablets per 21 days.); SMCS; SP; CM
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	3	PA; SL (1 capsule per day.); SMCS; SP; CM
TABLOID ORAL TABLET 40 MG (thioguanine)	3	SMCS; SP; CM
TABRECTA ORAL TABLET 150 MG, 200 MG (capmatinib hcl)	4	PA; SL (4 tablets per day.); SMCS; SP; CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (dabrafenib mesylate)	4	PA; ST; SL (4 capsules per day.); SMCS; SP; CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (dabrafenib mesylate)	4	ST; SL (12 tablets per day.); SMCS; SP; CM
TAGRISO ORAL TABLET 40 MG, 80 MG (osimertinib mesylate)	4	PA; SL (1 tablet per day.); SMCS; SP; CM
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (nilotinib hcl)	3	PA; ST; SL (4 capsules per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (tazemetostat hbr)	4	PA; SL (8 tablets per day.); SMCS; SP; CM
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	PA; SMCS; SP; CM
TIBSOVO ORAL TABLET 250 MG (ivosidenib)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
toremifene citrate oral tablet 60 mg	3	CM
tretinoin oral capsule 10 mg	3	SL (279 capsules per prescription.); SMCS; SP; CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
TUKYSA ORAL TABLET 150 MG (tucatinib)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
TUKYSA ORAL TABLET 50 MG (tucatinib)	3	PA; SL (10 tablets per day.); SMCS; SP; CM
TURALIO ORAL CAPSULE 125 MG (pexidartinib hcl)	3	PA; SL (4 capsules per day.); SMCS; SP; CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (quizartinib dihydrochloride)	4	PA; SL (2 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 10 MG, 100 MG (venetoclax)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
VENCLEXTA ORAL TABLET 50 MG (venetoclax)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (venetoclax)	3	PA; SL (42 tablets per year.); SMCS; SP; CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (abemaciclib)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 100 MG (larotrectinib sulfate)	3	PA; SL (2 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL CAPSULE 25 MG (larotrectinib sulfate)	3	PA; SL (6 capsules per day.); SMCS; SP; CM
VITRAKVI ORAL SOLUTION 20 MG/ML (larotrectinib sulfate)	3	PA; SL (10 mL per day.); SMCS; SP; CM
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (dacomitinib)	4	PA; SL (1 tablet per day.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (pacritinib citrate)	4	PA; SL (4 capsules per day.); SMCS; SP; CM
WELIREG ORAL TABLET 40 MG (belzutifan)	4	PA; SL (3 tablets day.); SMCS; SP; CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	4	PA; SL (4 ml per day.); CM
XOSPATA ORAL TABLET 40 MG (gilteritinib fumarate)	4	PA; SL (3 tablets per day.); SMCS; SP; CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (selinexor)	4	PA; SL (0.26 tablet per day.); SMCS; SP; CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (selinexor)	4	PA; SL (0.14 tablet per day.); SMCS; SP; CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (selinexor)	4	PA; SL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (selinexor)	4	PA; SL (0.14 tablet per day.); SMCS; SP; CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (selinexor)	4	PA; SL (0.86 tablets per day.); SMCS; SP; CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (selinexor)	4	PA; SL (0.29 tablet per day.); SMCS; SP; CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (selinexor)	4	PA; SL (1.15 tablets per day.); SMCS; SP; CM
XTANDI ORAL CAPSULE 40 MG (enzalutamide)	3	PA; SL (4 capsules per day.); SMCS; SP; CM
XTANDI ORAL TABLET 40 MG (enzalutamide)	3	PA; SL (4 tablets per day.); SMCS; SP; CM
XTANDI ORAL TABLET 80 MG (enzalutamide)	3	PA; SL (2 tablets per day.); SMCS; SP; CM
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (niraparib tosylate)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
ZELBORAF ORAL TABLET 240 MG (vemurafenib)	3	PA; SL (8 tablets per day.); SMCS; SP; CM
ZOLINZA ORAL CAPSULE 100 MG (vorinostat)	3	PA; SL (4 capsules per day.); SMCS; SP; CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (idelalisib)	4	PA; SL (60 tablets per month.); SMCS; SP; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS (THERAPEUTIC) - DRUGS FOR THE IMMUNE SYSTEM		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (timothy grass pollen allergen)	4	PA; SL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (dust mite mixed allergen ext)	4	PA; SL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (grass mix pollens allergen ext)	4	PA; SL (1 tablet per day.)
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (grass mix pollens allergen ext)	4	PA; SL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (grass mix pollens allergen ext)	4	PA; SL (1 tablet per day.)
PALFORZIA ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (peanut powder-dnfp)	4	PA; SL (13 capsules per year.); SMCS; SP
PALFORZIA ORAL 2 X 1 MG & 10 MG, 3 X 1 MG (peanut powder-dnfp)	4	PA; SL (45 capsules per 13 days.); SMCS; SP
PALFORZIA ORAL 2 X 100 MG, 2 X 20 MG, 20 MG & 100 MG (peanut powder-dnfp)	4	PA; SL (30 capsules per 13 days.); SMCS; SP
PALFORZIA ORAL 2 X 20 MG & 2 X 100 MG, 4 X 20 MG (peanut powder-dnfp)	4	PA; SL (60 capsules per 13 days.); SMCS; SP
PALFORZIA ORAL 20 MG (peanut powder-dnfp)	4	PA; SL (15 capsules per 13 days.); SMCS; SP
PALFORZIA ORAL 3 X 20 MG & 100 MG (peanut powder-dnfp)	4	PA; SL (60 capsule per 13 days.); SMCS; SP
PALFORZIA ORAL 6 X 1 MG (peanut powder-dnfp)	4	PA; SL (90 capsules per 13 days.); SMCS; SP
PALFORZIA ORAL PACKET 300 MG (peanut powder-dnfp)	4	PA; SL (1 capsule per day.); SMCS; SP
PALFORZIA ORAL PACKET 300 MG (peanut powder-dnfp)	4	PA; SL (15 capsules per 13 days.); SMCS; SP
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (short ragweed pollen ext)	4	PA; SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TOXOIDS - Vaccines		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	2	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	2	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (diphth-acell pertussis-tetanus)	2	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (diphth-acell pertussis-tetanus)	2	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (diphth-acell pertussis-tetanus)	3	M; H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (dtap-hepatitis b recomb-ipv)	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (dtap-ipv-hib vaccine)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (dtap-ipv vaccine)	3	H
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML (tetanus-diphtheria toxoids td)	3	H
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (tetanus-diphtheria toxoids td)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION (dtap-ipv-hib-hepatitis b recmb)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (dtap-ipv-hib-hepatitis b recmb)	3	H
VACCINES - Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (rsv pre-fusion f a&b vac rcmb)	3	H
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (haemophilus b polysac conj vac)	2	M; H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	3	H
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION (influenza vac split quad)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (influenza vac split quad)	3	H
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (rsvpref3 vac recomb adjuvanted)	3	H
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (meningococcal b recomb omv adj)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	2	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (tetanus-diphth-acell pertussis)	2	H
COMIRNATY INTRAMUSCULAR SUSPENSION 30 MCG/0.3ML (covid-19 mrna virus vaccine)	3	H
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (covid-19 mrna virus vaccine)	3	H
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (diphth-acell pertussis-tetanus)	2	M; H
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (dengue virus vaccine live tetr)	3	H
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (hepatitis b vac recombinant)	2	H
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (hepatitis b vac recombinant)	2	H
FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML (influenza vac a&b sa adj quad)	3	H
FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (influenza vac split quad)	3	H
FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (influenza vac recomb ha quad)	3	H
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION (influenza vac subunit quad)	3	H
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (influenza vac subunit quad)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (influenza vac split quad)	3	H
FLUMIST QUADRIVALENT NASAL SUSPENSION (influenza virus vac live quad)	3	H
FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.7 ML (influenza vac high-dose quad)	3	H
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION (influenza vac split quad)	3	H
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (influenza vac split quad)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION (hpv 9-valent recomb vaccine)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (hpv 9-valent recomb vaccine)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML (hepatitis a vaccine)	3	H
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (hepatitis b vac recomb adj)	3	H
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (haemophilus b polysac conj vac)	3	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (diphth-acell pertussis-tetanus)	2	M; H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (diphth-acell pertussis-tetanus)	3	M; H
IPOL INJECTION INJECTABLE (poliovirus vaccine inactivated)	2	H
MENQUADFI INTRAMUSCULAR SOLUTION (mening acy&w-135 tetanus conj)	3	H
MENVEO INTRAMUSCULAR SOLUTION (meningococcal a c y&w-135 olig)	3	H
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (meningococcal a c y&w-135 olig)	3	H
M-M-R II INJECTION SOLUTION RECONSTITUTED (measles, mumps & rubella vac)	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION 25 MCG/0.25ML (covid-19 mrna virus vaccine)	3	H
NOVAVAX COVID-19 VACCINE INTRAMUSCULAR SUSPENSION 5 MCG/0.5ML	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (dtap-hepatitis b recomb-ipv)	3	H
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (haemophilus b polysac conj vac)	2	M; H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (mening acyw(tet conj)-b(rcmb))	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (dtap-ipv-hib vaccine)	3	H
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (covid-19 mrna virus vaccine)	3	H
PFIZER COVID-19 VAC-TRIS 6M-4Y INTRAMUSCULAR SUSPENSION 3 MCG/0.3ML	3	H
PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML (pneumococcal vac polyvalent)	2	H
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML (hepatitis b vac 3-antigen rcmb)	3	M; H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (pneumococcal 20-val conj vacc)	3	M; H
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (measles, mumps & rubella vac)	3	H
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (measles-mumps-rubella-varicell)	3	H
QUADRACEL INTRAMUSCULAR SUSPENSION (dtap-ipv vaccine)	3	H
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (hepatitis b vac recombinant)	2	H
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (hepatitis b vac recombinant)	2	H
ROTARIX ORAL SUSPENSION (rotavirus vaccine live oral)	3	H
ROTATEQ ORAL SOLUTION (rotavirus vac live pentavalent)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (zoster vac recomb adjuvanted)	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION 50 MCG/0.5ML (covid-19 mrna virus vaccine)	3	H
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (covid-19 mrna virus vaccine)	3	H
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (meningococcal b vac (recomb))	3	H
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (hepatitis a-hep b recomb vac)	3	H
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (hepatitis a vaccine)	2	H
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML (varicella virus vaccine live)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION (dtap-ipv-hib-hepatitis b recmb)	3	H
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (dtap-ipv-hib-hepatitis b recmb)	3	H
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (pneumococcal 15-val conj vacc)	3	M; H
AUTONOMIC DRUGS		
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat gum 2 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG (nicotine polacrilex)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (nicotine polacrilex)	4	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (nicotine polacrilex)	2	H
nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine polacrilex mini mouth/throat lozenge 2 mg	1	H
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	1	H
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine step 1 transdermal patch 24 hour 21 mg/24hr	1	H
nicotine step 2 transdermal patch 24 hour 14 mg/24hr	1	H
nicotine step 3 transdermal patch 24 hour 7 mg/24hr	1	H
nicotine transdermal kit 21-14-7 mg/24hr	1	H
nicotine transdermal patch 24 hour 21 mg/24hr	1	H
NICOTROL INHALATION INHALER 10 MG (nicotine)	4	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (nicotine)	4	H
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	3	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	3	H
varenicline tartrate(continue) oral tablet 1 mg	3	H
AUTONOMIC DRUGS - Drugs for the Nervous System		
ALPHA- AND BETA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
ADRENALIN NASAL SOLUTION 0.1 % (epinephrine hcl (nasal))	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (epinephrine)	2	SL (2 pens per prescription.)
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (epinephrine)	2	SL (2 injections per prescription.)
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML (pseudoeph-bromphen-dm)	3	
epinephrine hcl (nasal) nasal solution 0.1 %	1	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml	1	SL (2 injections per prescription.)
epinephrine injection solution auto-injector 0.15 mg/0.3ml	1	SL (4 injections per prescription.)
LETS KIT	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
ALPHA-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	3	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	3	
METHYLDOPA ORAL TABLET 250 MG, 500 MG	4	PA; ST
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
promethazine vc oral syrup 6.25-5 mg/5ml	1	
promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml	1	PA; SL (360 ml per month.)
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANASPAZ ORAL TABLET DISPERSIBLE 0.125 MG (hyoscyamine sulfate)	2	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (umeclidinium-vilanterol)	3	SL (2 blisters per day.)
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (ipratropium bromide hfa)	3	SL (0.87 grams per day.)
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (glycopyrrolate-formoterol)	2	SL (0.36 grams per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	SL (0.36 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (ipratropium-albuterol)	4	SL (0.28 grams per day.)
CUVPOSA ORAL SOLUTION 1 MG/5ML (glycopyrrolate)	4	
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	1	
dicyclomine hcl oral tablet 20 mg	1	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
glycopyrrolate oral solution 1 mg/5ml	3	
glycopyrrolate oral tablet 1 mg, 2 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA; SL (120 mL per prescription and 360 ml per month.)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	1	PA; SL (120 mL per prescription and 360 ml per month.)
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sl sublingual tablet sublingual 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
hyosyne oral elixir 0.125 mg/5ml	1	
hyosyne oral solution 0.125 mg/ml	1	
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (hyoscyamine sulfate)	4	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (hyoscyamine sulfate)	4	
LOMOTIL ORAL TABLET 2.5-0.025 MG (diphenoxylate-atropine)	4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (hyoscyamine sulfate)	4	
OSCIMIN ORAL TABLET 0.125 MG	4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	4	
scopolamine transdermal patch 72 hour 1 mg/3days	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (tiotropium bromide monohydrate)	2	SL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (tiotropium bromide monohydrate)	2	SL (0.15 grams per day.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (tiotropium bromide-olodaterol)	2	SL (0.15 grams per day.)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	SL (2 blisters per day.)
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
uretron d/s oral tablet 81.6 mg	4	
URIMAR-T ORAL CAPSULE 120 MG (meth-hyo-m bl-na phos-ph sal)	4	
urin ds oral tablet 81.6 mg	4	
UROGESIC-BLUE ORAL TABLET 81.6 MG (methen-hyosc-meth blue-na phos)	2	
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
YUPELRI INHALATION SOLUTION 175 MCG/3ML (revefenacin)	4	PA; SL (3 ml per day.)
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (diphenhydramine hcl)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
AUTONOMIC DRUGS, MISCELLANEOUS - Drugs for the Nervous System		
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat gum 2 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG (nicotine polacrilex)	2	H
NICORETTE MOUTH/THROAT GUM 2 MG (nicotine polacrilex)	4	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (nicotine polacrilex)	2	H
nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine polacrilex mini mouth/throat lozenge 2 mg	1	H
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	1	H
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	1	H
nicotine step 1 transdermal patch 24 hour 21 mg/24hr	1	H
nicotine step 2 transdermal patch 24 hour 14 mg/24hr	1	H
nicotine step 3 transdermal patch 24 hour 7 mg/24hr	1	H
nicotine transdermal kit 21-14-7 mg/24hr	1	H
nicotine transdermal patch 24 hour 21 mg/24hr	1	H
NICOTROL INHALATION INHALER 10 MG (nicotine)	4	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (nicotine)	4	H
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	3	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	3	H
varenicline tartrate(continue) oral tablet 1 mg	3	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles		
carisoprodol oral tablet 350 mg	1	
chlorzoxazone oral tablet 500 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
ENOVARX-CYCLOBENZAPRINE HCL TRANSDERMAL CREAM 20 MG/GM	3	PA
metaxalone oral tablet 400 mg, 800 mg	3	
methocarbamol oral tablet 500 mg, 750 mg	1	
TABRADOL FUSEPAQ ORAL SUSPENSION 1 MG/ML (cyclobenzaprine hcl-msm)	3	PA
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tizanidine hcl oral tablet 2 mg, 4 mg	1	
VP FC KIT EXTERNAL CREAM	3	PA
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (tizanidine hcl)	4	
ZANAFLEX ORAL TABLET 4 MG (tizanidine hcl)	4	
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (dantrolene sodium)	4	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	1	
GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
BACLOFEN ORAL SOLUTION 10 MG/5ML	4	
BACLOFEN ORAL SOLUTION 5 MG/5ML	4	PA
baclofen oral suspension 25 mg/5ml	3	PA
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	
ENOVARX-BACLOFEN EXTERNAL CREAM 1 %	3	PA
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (baclofen)	4	PA
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)	4	
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	
NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	4	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
CORGARD ORAL TABLET 20 MG, 40 MG (nadolol)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	2	
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)	4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	4	
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	
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (prazosin hcl)	4	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
dihydroergotamine mesylate injection solution 1 mg/ml	1	M
ergoloid mesylates oral tablet 1 mg	1	
ergotamine-caffeine oral tablet 1-100 mg	3	SL (10 tablets per prescription.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (ergotamine-caffeine)	3	
phenoxybenzamine hcl oral capsule 10 mg	2	
PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS) - Drugs for Bladder Incontinence		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	1	
cevimeline hcl oral capsule 30 mg	1	
donepezil hcl oral tablet 10 mg, 5 mg	1	
donepezil hcl oral tablet 23 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
FIRDAPSE ORAL TABLET 10 MG (amifampridine phosphate)	3	PA; SL (8 tablets per day.); SMCS; SP
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	
galantamine hydrobromide oral solution 4 mg/ml	1	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
MESTINON ORAL SOLUTION 60 MG/5ML (pyridostigmine bromide)	4	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
pyridostigmine bromide er oral tablet extended release 180 mg	1	
pyridostigmine bromide oral solution 60 mg/5ml	3	
pyridostigmine bromide oral tablet 60 mg	1	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	1	
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	3	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (pilocarpine hcl)	4	
SELECTIVE ALPHA-1-ADRENERGIC BLOCK.AGENT - Drugs for the Heart		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
silodosin oral capsule 4 mg, 8 mg	3	
tamsulosin hcl oral capsule 0.4 mg	1	
SELECTIVE BETA-2-ADRENERGIC AGONISTS - Drugs for Heart and Lungs		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (fluticasone-salmeterol)	3	SL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	SL (10.7 grams per prescription.)
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (1 inhaler per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (6.7 grams per prescription.)
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (8.5 grams per prescription.)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	3	PA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (umeclidinium-vilanterol)	3	SL (2 blisters per day.)
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	4	SL (2 nebulizers per day)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (glycopyrrolate-formoterol)	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 (fluticasone furoate-vilanterol)	3	SL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	SL (0.36 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (ipratropium-albuterol)	4	SL (0.28 grams per day.)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	SL (2 blisters per day)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	SL (0.04 mcg per day.)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	3	SL (90 ml per prescription.)
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	3	SL (30 vials per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SL (15 grams per prescription.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (salmeterol xinafoate)	2	SL (2 blisters per day.)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (tiotropium bromide-olodaterol)	2	SL (0.15 grams per day.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (olodaterol hcl)	2	SL (0.14 grams per day.)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	SL (0.35 grams per day.)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	SL (2 blisters per day.)
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	SL (2 blisters per day)
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (levalbuterol tartrate)	3	SL (15 grams per prescription.)
SELECTIVE BETA-ADRENERGIC BLOCKING AGENT - Drugs for the Heart		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (atenolol)	3	PA
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	4	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 25 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood		
ANTIANEMIA DRUGS - Vitamins and Minerals		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (darbepoetin alfa)	3	M; SL (2 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (darbepoetin alfa)	3	M; SL (4 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (darbepoetin alfa)	3	M; SL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (darbepoetin alfa)	3	M; SL (1 prefill syringe per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (darbepoetin alfa)	3	M; SL (2 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (darbepoetin alfa)	3	M; SL (4 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (darbepoetin alfa)	3	M; SL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (darbepoetin alfa)	3	M; SL (2 syringes per month); SMCS; SP
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG (daprodustat)	4	PA; SL (1 tablet per day.); SMCS; SP
JESDUVROQ ORAL TABLET 6 MG (daprodustat)	4	PA; SL (2 tablets per day.); SMCS; SP
JESDUVROQ ORAL TABLET 8 MG (daprodustat)	4	PA; SL (3 tablets per day.); SMCS; SP
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (8 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (12 ml per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (epoetin alfa-epbx)	3	M; SMCS
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (4 ml per 21 days.); SMCS; SP
ANTICOAGULANTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (anticoagulant cit dext soln a)	3	
ANTICOAGULANT SODIUM CITRATE IN VITRO SOLUTION 4 %, 4 GM/100ML	3	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml	2	M; SL (24 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	2	M; SL (15 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 5 mg/0.4ml	2	M; SL (12 ml (30 syringes) per prescription)
fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml	2	M; SL (18 ml (30 syringes) per prescription)
TRICITRASOL IN VITRO CONCENTRATE 46.7 % (anticoagulant sodium citrate)	3	
ANTITHROMBOTIC AGENTS, MISCELLANEOUS - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (caplacizumab-yhdp)	3	PA; M; SL (1 vial per day and 58 vials per 120 days.); SMCS; SP
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (mitapivat sulfate)	4	PA; SL (56 tablets per 28 days.); SMCS; SP; CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (mitapivat sulfate)	4	PA; SL (7 tablets per 365 days.); SMCS; 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 (mitapivat sulfate)	4	PA; SL (14 tablets per 365 days.); SMCS; SP; CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (fostamatinib disodium)	4	PA; SL (2 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
DIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (apixaban)	2	SL (2.5 tablets per day.)
ELIQUIS ORAL TABLET 2.5 MG (apixaban)	2	SL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG (apixaban)	2	SL (2.5 tablets per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (rivaroxaban)	2	SL (20 ml per day.)
XARELTO ORAL TABLET 10 MG (rivaroxaban)	2	SL (1 tablet per day.)
XARELTO ORAL TABLET 15 MG (rivaroxaban)	2	SL (52 tablets per month initial 1 tablet per day for maintenance.)
XARELTO ORAL TABLET 2.5 MG (rivaroxaban)	2	SL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG (rivaroxaban)	2	SL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (rivaroxaban)	2	SL (51 tablets per year.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
dabigatran etexilate mesylate oral capsule 110 mg	2	SL (2 tablets per day.)
dabigatran etexilate mesylate oral capsule 150 mg, 75 mg	2	SL (62 capsules per 31 days.)
PRADAXA ORAL CAPSULE 110 MG (dabigatran etexilate mesylate)	2	SL (2 tablets per day.)
PRADAXA ORAL CAPSULE 150 MG, 75 MG (dabigatran etexilate mesylate)	2	SL (62 capsules per 31 days.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (darbepoetin alfa)	3	M; SL (2 syringes per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (darbepoetin alfa)	3	M; SL (4 syringes per month); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 PREFILLED SYRINGE 10 MCG/0.4ML (darbepoetin alfa)	3	M; SL (1.6 ml per month.); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (darbepoetin alfa)	3	M; SL (1 prefill syringe per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (darbepoetin alfa)	3	M; SL (2 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (darbepoetin alfa)	3	M; SL (4 vials per month); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (darbepoetin alfa)	3	M; SL (2 vials per prescription); SMCS; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (darbepoetin alfa)	3	M; SL (2 syringes per month); SMCS; SP
DOPTELET ORAL TABLET 20 MG (avatrombopag maleate)	4	PA; SL (15 tablets per month.); SMCS; SP
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG (daprodustat)	4	PA; SL (1 tablet per day.); SMCS; SP
JESDUVROQ ORAL TABLET 6 MG (daprodustat)	4	PA; SL (2 tablets per day.); SMCS; SP
JESDUVROQ ORAL TABLET 8 MG (daprodustat)	4	PA; SL (3 tablets per day.); SMCS; SP
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (sargramostim)	3	M; SMCS
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (plerixafor)	4	M; SMCS; SP
MULPLETA ORAL TABLET 3 MG (lusutrombopag)	3	PA; SL (7 tablets per prescription.); SMCS; SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (pegfilgrastim)	4	M; SMCS
plerixafor subcutaneous solution 24 mg/1.2ml	3	M; SMCS; SP
PROMACTA ORAL PACKET 12.5 MG (eltrombopag olamine)	4	PA; SL (6 packets per day.); SMCS; SP
PROMACTA ORAL PACKET 25 MG (eltrombopag olamine)	4	PA; SL (6 packets per day.); SMCS
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG (eltrombopag olamine)	4	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (8 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (12 ml per 21 days.); SMCS; SP
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (epoetin alfa-epbx)	3	M; SMCS
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (epoetin alfa-epbx)	3	M; SL (4 ml per 21 days.); SMCS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (pegfilgrastim-cbqv)	3	SMCS
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (pegfilgrastim-cbqv)	3	M; SMCS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (filgrastim-sndz)	3	M; SMCS; SP
HEMORRHOLOGIC AGENTS - Drugs for Blood Flow		
pentoxifylline er oral tablet extended release 400 mg	1	
HEMOSTATICS - Drugs to Prevent Bleeding		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (antihemophil factor (rahf-pfm))	3	M; SMCS; SP
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	4	PA; M; SMCS; SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (antihemophil fact single chain)	4	PA; M; SMCS; SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (antihemophilic factor-vwf)	3	M; SMCS; SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (coagulation factor ix)	3	M; SMCS
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 500 UNIT (coagulation factor ix)	3	M; SMCS; SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (coagulation factor ix (rfixfc))	4	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT (coagulation factor ix (rfixfc))	3	M; SMCS; SP
ALTUVIIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (antihem fact fc-vwf-xten-eh1l)	4	PA; M; SMCS; SP
aminocaproic acid oral solution 0.25 gm/ml	3	
aminocaproic acid oral tablet 1000 mg, 500 mg	3	
ASTRINGYN EXTERNAL SOLUTION 259 MG/GM (ferric subsulfate)	3	
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (coagulation factor ix (recomb))	3	M; SMCS; SP
COAGADDEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (coagulation factor x (human))	3	M; SMCS; SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (factor xiii concentrate human)	3	M; SMCS; SP
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	M
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	M
desmopressin acetate spray nasal solution 0.01 %	1	
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (antiinhibitor coagulant cmplx)	3	M; SMCS; SP
GELFILM OPHTHALMIC FILM (gelatin adsorbable)	2	
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (emicizumab-kxwh)	3	PA; M; SMCS; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (antihemophilic factor)	3	M; SMCS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1700 UNIT (antihemophilic factor)	3	M; SMCS; SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (antihemophilic factor-vwf)	3	M; SMCS; SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (coagulation factor ix (rix-fp))	4	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (ahf (bdd-rfviii peg-aucl))	4	PA; M; SMCS; SP
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (antihemophilic factor)	3	M; SMCS
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 500 UNIT (antihemophilic factor)	3	M; SMCS
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (antihem factor recomb (rfviii))	3	M; SMCS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (antihemophil factor (rahf-pfm))	3	M; SMCS; SP
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG (desmopressin acetate)	3	PA; SL (1 tablet per day.)
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (antihemophil fact bd truncated)	3	M; SMCS
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT (antihemophil fact bd truncated)	3	M; SMCS; SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (coagulation factor viia recomb)	3	M; SMCS; SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (antihem fact (bdd-rfviii,sim))	3	M; SMCS; SP
NUWIQ INTRAVENOUS KIT 1500 UNIT (antihem fact (bdd-rfviii,sim))	3	M; SMCS
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (antihem fact (bdd-rfviii,sim))	3	M; SMCS; SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT (antihem fact (bdd-rfviii,sim))	3	M; SMCS
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (factor ix complex)	3	M; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (antihem factor recomb (rfviii))	3	M; SMCS; SP
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED 5000 UNIT (thrombin (recombinant))	3	
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED 20000 UNIT (thrombin (recombinant))	3	
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	3	M; SMCS
THROMBIN-JMI EPISTAXIS EXTERNAL KIT 5000 UNIT (thrombin)	3	
THROMBIN-JMI EXTERNAL KIT 20000 UNIT, 5000 UNIT (thrombin)	3	
THROMBOGEN EXTERNAL KIT 10000 UNIT (thrombin)	3	
THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED 1000 UNIT, 10000 UNIT (thrombin)	3	
tranexamic acid oral tablet 650 mg	2	SL (30 tablets per 5 days.)
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (coagulation factor xiii a-sub)	4	M; SMCS; SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (von willebrand factor (recomb))	3	M; SMCS; SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (antihemophilic factor-vwf)	3	M; SMCS; SP
HEPARINS - Drugs to Prevent Blood Clots		
enoxaparin sodium injection solution 300 mg/3ml	2	M; SL (42 ml (14 vials) per prescription)
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml	2	M; SL (30 syringes per prescription)
enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml	2	M; SL (24 ml (30 syringes) per prescription)
enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml	2	M; SL (9 ml (30 syringes) per prescription)
enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml	2	M; SL (12 ml (30 syringes) per prescription)
enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml	2	M; SL (18 ml (30 syringes) per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml	1	M
heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml	1	M
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	1	M
heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml	1	M
heparin sodium (porcine) pf injection solution 5000 unit/0.5ml, 5000 unit/ml	1	M
IRON PREPARATIONS - Vitamins and Minerals		
ATABEX OB ORAL TABLET 29-1 MG (prenatal vit w/ fe bisg-fa)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (prenat-fecb-fefum-fa-dha w/o a)	3	
ELITE-OB ORAL TABLET 50-1.25 MG (prenatal vit-iron carbonyl-fa)	3	
ENBRACE HR ORAL CAPSULE (prenat vit-fe gly cys-fa-omega)	3	
hematinic/folic acid oral tablet 324-1 mg	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	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	
NEONATAL PLUS ORAL TABLET 27-1 MG (prenatal vit-fe fumarate-fa)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (prenat-fe-methylfol-dha w/o a)	3	
NESTABS ORAL TABLET 32-1 MG (prenat-fe bisgly-fa-w/o vit a)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (ped multivitamins-fl-iron)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (ped multivitamins-fl-iron)	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral oral tablet 27-1 mg	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (prenatal-feaspgly-methylfol-fa)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fecfn-feasp-meth-fa-dha)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	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 (pren-fe-meth-fa-omeg w/o a)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (prenatal vit-fe psac cmplx-fa)	4	
TRINATE ORAL TABLET (prenatal vit-fe fumarate-fa)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VINATE ONE ORAL TABLET 60-1 MG (prenatal vit-fe fumarate-fa)	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (prenat-fe poly-methfol-fa-dha)	3	
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG (prenatal-fe fum-methf-fa w/o a)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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-OB+DHA ORAL 65-1 & 250 MG (prenatal mv-min-fe fum-fa-dha)	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG (prenat w/o a-fe-methfol-fa-dha)	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG (prenat-fefum-fered-fa-dha w/oa)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (prenatal vit-fe fumarate-fa)	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	4	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
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	
LIVER AND STOMACH PREPARATIONS - Vitamins and Minerals		
cyanocobalamin injection solution 1000 mcg/ml	1	M
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	M
cyanocobalamin nasal solution 500 mcg/0.1ml	3	M
DODEX INJECTION SOLUTION 1000 MCG/ML (cyanocobalamin)	4	M
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (cyanocobalamin)	4	M
PLATELET-AGGREGATION INHIBITORS - Drugs to Prevent Blood Clots		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
aspirin regimen oral tablet delayed release 81 mg	E	H
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	3	
BRILINTA ORAL TABLET 60 MG, 90 MG (ticagrelor)	4	SL (2 tablets per day.)
cilostazol oral tablet 100 mg, 50 mg	1	
clopidogrel bisulfate oral tablet 300 mg, 75 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
ft aspirin low dose oral tablet delayed release 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
prasugrel hcl oral tablet 10 mg, 5 mg	3	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (aspirin)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (aspirin)	E	H
ZONTIVITY ORAL TABLET 2.08 MG (vorapaxar sulfate)	4	SL (1 tablet per day.)
PLATELET-REDUCING AGENTS - Drugs to Prevent Blood Clots		
anagrelide hcl oral capsule 0.5 mg, 1 mg	1	
THROMBOLYTIC AGENTS - Drugs to Prevent Blood Clots		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (aspirin)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (aspirin)	E	H
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for High Blood Pressure		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (doxazosin mesylate)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (prazosin hcl)	4	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	4	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (doxazosin mesylate)	3	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG (prazosin hcl)	4	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN) - Drugs for High Blood Pressure & Angina		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	3	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	2	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	2	
VALSARTAN ORAL SOLUTION 4 MG/ML	4	PA
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	2	
ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs for the Heart		
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	2	
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	3	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	3	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (sacubitril-valsartan)	4	PA; SL (2 tablets per day.)
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	2	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	2	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	2	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	
VALSARTAN ORAL SOLUTION 4 MG/ML	4	PA
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	2	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANGIOTENSIN-CONVERT.ENZYME INHIB(HYPOTN) - Drugs for High Blood Pressure & Angina		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
enalapril maleate oral solution 1 mg/ml	3	PA
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
EPANED ORAL SOLUTION 1 MG/ML (enalapril maleate)	4	PA
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (benazepril hcl)	4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG (quinapril-hydrochlorothiazide)	4	
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	1	
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
enalapril maleate oral solution 1 mg/ml	3	PA
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
EPANED ORAL SOLUTION 1 MG/ML (enalapril maleate)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (benazepril-hydrochlorothiazide)	4	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (benazepril hcl)	4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	
QBRELIS ORAL SOLUTION 1 MG/ML (lisinopril)	4	PA
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg	2	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	3	
ANTIARRHYTHMICS, MISCELLANEOUS - Drugs for Angina		
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (digoxin)	3	
LANOXIN ORAL TABLET 62.5 MCG (digoxin)	4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (bempedoic acid)	2	PA; ST; SL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (bempedoic acid-ezetimibe)	2	PA; ST; SL (1 tablet per day.)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	3	
omega-3-acid ethyl esters oral capsule 1 gm	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
BETA-ADRENERGIC BLOCKING AGENTS - Drugs for Abnormal Heart Rhythms		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (atenolol)	3	PA
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
CORGARD ORAL TABLET 20 MG, 40 MG (nadolol)	4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 25 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 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	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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)	4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
BETA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (atenolol)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
CORGARD ORAL TABLET 20 MG, 40 MG (nadolol)	4	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 25 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 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	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol hcl)	4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
BILE ACID SEQUESTRANTS - Drugs for Cholesterol		
cholestyramine light oral packet 4 gm	1	
cholestyramine light oral powder 4 gm/dose	1	
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	1	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (clindamycin-tretinoin-cholesty)	3	PA
colesevelam hcl oral packet 3.75 gm	2	
colesevelam hcl oral tablet 625 mg	2	
COLESTID FLAVORED ORAL PACKET 5 GM (colestipol hcl)	4	
COLESTID ORAL GRANULES 5 GM (colestipol hcl)	3	
COLESTID ORAL PACKET 5 GM (colestipol hcl)	4	
COLESTID ORAL TABLET 1 GM (colestipol hcl)	4	
colestipol hcl oral granules 5 gm	1	
colestipol hcl oral packet 5 gm	1	
colestipol hcl oral tablet 1 gm	1	
prevalite oral packet 4 gm	1	
prevalite oral powder 4 gm/dose	1	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (cholestyramine light)	4	
QUESTRAN ORAL PACKET 4 GM (cholestyramine)	4	
QUESTRAN ORAL POWDER 4 GM/DOSE (cholestyramine)	4	
CALCIUM-CHANNEL BLOCK.AGT,MISC(HYPOTEN) - Drugs for High Blood Pressure & Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	2	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem hcl er beads)	4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	3	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (verapamil hcl)	4	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (verapamil hcl)	4	
CALCIUM-CHANNEL BLOCKING AGENTS, MISC. - Drugs for High Blood Pressure & Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	2	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem hcl er beads)	4	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	3	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	3	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (verapamil hcl)	4	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (verapamil hcl)	4	
CARBONIC ANHYDRASE INHIBITORS(HYPOTEN) - Drugs for High Blood Pressure & Angina		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
methazolamide oral tablet 25 mg, 50 mg	1	
CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina		
ASPRUZYO SPRINKLE ORAL PACKET 1000 MG, 500 MG (ranolazine)	4	PA
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (mavacamten)	4	PA; SL (1 capsule per day.); SMCS; SP
CORLANOR ORAL SOLUTION 5 MG/5ML (ivabradine hcl)	3	PA; SL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (ivabradine hcl)	3	PA; SL (2 tablets per day.)
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	2	
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	3	PA; SL (1 capsule per day.); SMCS; SP
VYNDAQEL ORAL CAPSULE 20 MG (tafamidis meglumine (cardiac))	3	PA; SL (4 capsules per day.); SMCS; SP
CARDIOTONIC AGENTS - Drugs for Angina		
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (digoxin)	3	
LANOXIN ORAL TABLET 62.5 MCG (digoxin)	4	
CENTRAL ALPHA-AGONISTS - Drugs for High Blood Pressure & Angina		
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	3	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	3	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
METHYLDOPA ORAL TABLET 250 MG, 500 MG	4	PA; ST
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
ezetimibe oral tablet 10 mg	2	
NEXLIZET ORAL TABLET 180-10 MG (bempedoic acid-ezetimibe)	2	PA; ST; SL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
disopyramide phosphate oral capsule 100 mg, 150 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (disopyramide phosphate)	2	
NORPACE ORAL CAPSULE 100 MG, 150 MG (disopyramide phosphate)	4	
quinidine gluconate er oral tablet extended release 324 mg	1	
quinidine sulfate oral tablet 200 mg, 300 mg	1	
CLASS IB ANTIARRHYTHMICS - Drugs for Angina		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (phenytoin)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (phenytoin sodium extended)	3	
DILANTIN ORAL SUSPENSION 125 MG/5ML (phenytoin)	3	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	1	
phenytek oral capsule 200 mg	1	
phenytek oral capsule 300 mg	4	
phenytoin infatabs oral tablet chewable 50 mg	1	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
CLASS IC ANTIARRHYTHMICS - Drugs for Angina		
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	4	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	1	
CLASS II ANTIARRHYTHMICS - Drugs for Angina		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
ATENOLOL+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (atenolol)	3	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 50 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 25 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 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	2	
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)	4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
CLASS III ANTIARRHYTHMICS - Drugs for Angina		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol hcl af)	4	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	2	
PACERONE ORAL TABLET 100 MG, 400 MG (amiodarone hcl)	3	
PACERONE ORAL TABLET 200 MG (amiodarone hcl)	4	
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)	4	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (dofetilide)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	2	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem hcl er beads)	4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	3	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (verapamil hcl)	4	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (verapamil hcl)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (amlodipine besylate)	3	PA
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
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	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	2	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (amlodipine besylate)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (nimodipine)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (nisoldipine)	4	
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (amlodipine besylate)	3	PA
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
nicardipine hcl oral capsule 20 mg, 30 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (amlodipine besylate)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (nimodipine)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (nisoldipine)	4	
DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	2	
minoxidil oral tablet 10 mg, 2.5 mg	1	
DIURETICS, MISCELLANEOUS (HYPOTENSIVE) - Drugs for High Blood Pressure & Angina		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (theophylline)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
FIBRIC ACID DERIVATIVES - Drugs for Cholesterol		
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	2	
fenofibrate oral capsule 134 mg, 200 mg, 67 mg	2	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	2	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
gemfibrozil oral tablet 600 mg	1	
LOPID ORAL TABLET 600 MG (gemfibrozil)	4	
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (atorvastatin calcium)	4	PA
atorvastatin calcium oral tablet 10 mg, 20 mg	1	H
atorvastatin calcium oral tablet 40 mg, 80 mg	1	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (rosuvastatin calcium)	3	PA
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	4	PA
fluvastatin sodium oral capsule 20 mg, 40 mg	1	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	H
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	2	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	H
simvastatin oral tablet 80 mg	1	
HYPOTENSIVE AGENTS, MISCELLANEOUS - Drugs for High Blood Pressure & Angina		
phenoxybenzamine hcl oral capsule 10 mg	2	
VECAMYL ORAL TABLET 2.5 MG (mecamylamine hcl)	4	PA
LOOP DIURETICS (HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (bumetanide)	3	
ethacrynic acid oral tablet 25 mg	4	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (furosemide)	4	
torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (spironolactone)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
eplerenone oral tablet 25 mg, 50 mg	2	
spironolactone oral suspension 25 mg/5ml	3	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
MINERALOCORTICOID(ALDOSTER.)ANTAG(HYPOT) - Drugs for High Blood Pressure & Angina		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (spironolactone)	4	PA
eplerenone oral tablet 25 mg, 50 mg	2	
spironolactone oral suspension 25 mg/5ml	3	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
NITRATES AND NITRITES - Drugs for the Heart		
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	2	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 % (nitroglycerin)	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 (nitroglycerin)	3	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (nitroglycerin)	4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (nitroglycerin)	3	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (evolocumab)	2	PA; ST; M; SL (3.5 ml (1 cartridge) per month.)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (evolocumab)	2	PA; ST; M; SL (2 syringes per 28 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (evolocumab)	2	PA; ST; M; SL (2 ml per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
cilostazol oral tablet 100 mg, 50 mg	1	
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; SL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	2	SL (0.5 tablet per day.)
sildenafil citrate oral tablet 20 mg	1	SL (0.5 tablet per day.); SMCS
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (avanafil)	4	PA; SL (3 tablets per month.)
tadalafil oral tablet 10 mg, 20 mg	2	SL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	2	SL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (tadalafil (pah))	4	PA; SL (10 ml per day.); SMCS; SP
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	3	SL (3 tablets per month.)
vardenafil hcl oral tablet dispersible 10 mg	3	SL (3 tablets per month.)
POTASSIUM-SPARING DIURETICS (HYPOTEN) - Drugs for High Blood Pressure & Angina		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (spironolactone)	4	PA
eplerenone oral tablet 25 mg, 50 mg	2	
spironolactone oral suspension 25 mg/5ml	3	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
triamterene oral capsule 100 mg, 50 mg	3	
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (sacubitril-valsartan)	4	PA; SL (2 tablets per day.)
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (spironolactone)	4	PA
eplerenone oral tablet 25 mg, 50 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
spironolactone oral suspension 25 mg/5ml	3	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
DIURIL ORAL SUSPENSION 250 MG/5ML (chlorothiazide)	2	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
THIAZIDE-LIKE DIURETICS(HYPOTENSIVE AGT) - Drugs for High Blood Pressure & Angina		
chlorthalidone oral tablet 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
ambrisentan oral tablet 10 mg, 5 mg	3	PA; SL (1 tablet per day.); SMCS; SP
AMLODIPINE BES+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (amlodipine besylate)	3	PA
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bosentan oral tablet 125 mg, 62.5 mg	3	PA; SL (2 tablets per day.); SMCS; SP
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	2	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (alprostadil (vasodilator))	3	M; SL (6 units per month.)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (alprostadil (vasodilator))	3	M; SL (6 units per month.)
CORLANOR ORAL SOLUTION 5 MG/5ML (ivabradine hcl)	3	PA; SL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (ivabradine hcl)	3	PA; SL (2 tablets per day.)
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (alprostadil (vasodilator))	3	M; SL (6 units per month.)
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
MUSE URETHRAL PELLETT 1000 MCG, 250 MCG, 500 MCG (alprostadil (vasodilator))	3	SL (6 units per month.)
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (amlodipine besylate)	4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (nimodipine)	2	
OPSUMIT ORAL TABLET 10 MG (macitentan)	3	PA; SL (1 tablet per day.); SMCS; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (336 tablets per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (treprostinil diolamine)	4	PA; SL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	4	PA; SL (6 tablets per day.); SMCS; SP
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	2	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem hcl er beads)	4	
TRACLEER ORAL TABLET 125 MG, 62.5 MG (bosentan)	3	PA; SL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (bosentan)	2	PA; SL (4 tablets per day.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (treprostinil)	3	PA; SL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG (treprostinil)	3	PA; SL (196 cartridges per 365 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (treprostinil)	3	PA; SL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (iloprost)	3	PA; SMCS; SP
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	3	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 360 MG (verapamil hcl)	4	
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (verapamil hcl)	4	
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System		
ADAMANTANES (CNS) - Drugs for Parkinson		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral solution 50 mg/5ml	1	
amantadine hcl oral tablet 100 mg	1	
AMPHETAMINE DERIVATIVES - Drugs for the Nervous System		
ADIPEX-P ORAL TABLET 37.5 MG (phentermine hcl)	4	PA
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	1	PA
diethylpropion hcl oral tablet 25 mg	1	PA
LOMAIRA ORAL TABLET 8 MG (phentermine hcl)	3	PA
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	1	PA
phendimetrazine tartrate oral tablet 35 mg	1	PA
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	1	PA
phentermine hcl oral tablet 37.5 mg	1	PA
AMPHETAMINES - Drugs for the Nervous System		
amphetamine sulfate oral tablet 10 mg, 5 mg	2	
amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	2	SL (2 capsules per day.)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	
benzphetamine hcl oral tablet 50 mg	1	PA
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	2	SL (5 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	3	SL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	2	SL (10 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	2	
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	3	SL (2 capsules per day.)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	3	SL (1 capsule per day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	3	SL (2 tablets per day.)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	3	SL (1 tablet per day.)
methamphetamine hcl oral tablet 5 mg	1	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (dextroamphetamine)	4	PA; SL (1 patch per day.)
ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	
bac oral tablet 50-325-40 mg	1	SL (6 tablets per day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg	3	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-325-40 mg	1	SL (6 capsules per day)
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	SL (6 tablets per day)
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	
ESGIC ORAL CAPSULE 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 tablets per day)
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (gabapentin)	3	PA
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	2	
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	
NEURAPTINE EXTERNAL CREAM 10 % (gabapentin)	3	PA
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	
TENCON ORAL TABLET 50-325 MG (butalbital-acetaminophen)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	SL (40 tablets per prescription.)
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
uretron d/s oral tablet 81.6 mg	4	
URIMAR-T ORAL CAPSULE 120 MG (meth-hyo-m bl-na phos-ph sal)	4	
urin ds oral tablet 81.6 mg	4	
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System		
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (phentermine-topiramate)	3	PA; SL (1 capsule per day.)
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (naltrexone-bupropion hcl)	3	PA; SL (4 tablets per day.)
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (setmelanotide acetate)	3	PA; M; SMCS; SP
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (diphenhydramine hcl)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
ANTICONVULSANTS, MISCELLANEOUS - Drugs for Seizures		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	2	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	3	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	4	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (cannabidiol)	4	PA; SMCS; SP
epitol oral tablet 200 mg	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (carbamazepine (antipsychotic))	3	
FANATREX FUSEPAQ ORAL SUSPENSION 25 MG/ML (gabapentin)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
felbamate oral suspension 600 mg/5ml	1	
felbamate oral tablet 400 mg, 600 mg	1	
FELBATOL ORAL TABLET 400 MG, 600 MG (felbamate)	4	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (perampanel)	4	PA
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
lacosamide oral solution 10 mg/ml	3	PA
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	PA
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (lamotrigine)	4	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (lamotrigine)	4	PA
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 42 x 50 mg & 14x100 mg	3	PA
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	2	
levetiracetam oral solution 100 mg/ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	3	PA
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (lacosamide)	4	
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	2	
pregabalin oral solution 20 mg/ml	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
roweepra oral tablet 500 mg	1	
rufinamide oral suspension 40 mg/ml	3	
rufinamide oral tablet 200 mg, 400 mg	3	PA
SABRIL ORAL TABLET 500 MG (vigabatrin)	4	PA; SL (6 tablets per day.); SMCS; SP
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
subvenite starter kit-blue oral kit 35 x 25 mg	1	
subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
topiramate oral capsule sprinkle 15 mg, 25 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	3	PA; SL (6 packets per day.); SMCS
vigabatrin oral tablet 500 mg	3	PA; SL (6 tablets per day.); SMCS; SP
vigadrone oral packet 500 mg	3	PA; SL (6 packets per day.); SMCS
vigadrone oral tablet 500 mg	3	PA; SL (6 tablets per day.); SMCS; SP
vigpoder oral packet 500 mg	3	PA; SL (6 packets per day.); SMCS
VIMPAT ORAL SOLUTION 10 MG/ML (lacosamide)	4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (zonisamide)	4	PA
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (ganaxolone)	4	PA; SMCS; SP
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	1	
bupropion hcl oral tablet 100 mg, 75 mg	1	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (esketamine hcl)	4	PA; SL (8 devices (4 kits) per month.); SMCS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (esketamine hcl)	4	PA; SL (12 devices (4 kits) per month.); SMCS
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (zuranolone)	3	PA; SL (28 capsules per year.); SMCS; SP
ZURZUVAE ORAL CAPSULE 30 MG (zuranolone)	3	PA; SL (14 capsules per year.); SMCS; SP
ANTIMANIC AGENTS - Drugs for Personality Disorder		
aripiprazole oral solution 1 mg/ml	4	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	2	
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	2	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	3	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	4	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
epitol oral tablet 200 mg	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (carbamazepine (antipsychotic))	3	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (lamotrigine)	4	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (lamotrigine)	4	PA
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 42 x 50 mg & 14x100 mg	3	PA
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium oral solution 8 meq/5ml	1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (lithium carbonate)	4	PA
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	2	
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	3	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	1	
risperidone oral solution 1 mg/ml	1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
subvenite starter kit-blue oral kit 35 x 25 mg	1	
subvenite starter kit-green oral kit 84 x 25 mg & 14x100 mg	1	
subvenite starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	1	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	
ANTIMIGRAINE AGENTS, MISCELLANEOUS - Migraine Treatment		
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
butorphanol tartrate nasal solution 10 mg/ml	2	SL (7.5 ml (3 bottles) per prescription.)
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (divalproex sodium)	4	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (divalproex sodium)	4	PA
dihydroergotamine mesylate injection solution 1 mg/ml	1	M
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG (naproxen)	3	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 500 MG (naproxen)	4	
ec-naproxen oral tablet delayed release 375 mg, 500 mg	1	
ergotamine-caffeine oral tablet 1-100 mg	3	SL (10 tablets per prescription.)
ft aspirin low dose oral tablet delayed release 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
KIPROFEN ORAL CAPSULE 25 MG (ketoprofen)	3	ST; SL (4 capsules per day.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (ergotamine-caffeine)	3	
mm aspirin oral tablet delayed release 81 mg	E	H
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	2	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	2	
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	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (aspirin)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (aspirin)	E	H
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
topiramate oral capsule sprinkle 15 mg, 25 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (loxapine)	3	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	3	
pimozide oral tablet 1 mg, 2 mg	2	
ANXIOLYTICS, SEDATIVES, AND HYPNOTICS, MISC - Drugs for Anxiety & Sleep Disorder		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (diphenhydramine hcl)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	2	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (tasimelteon)	4	PA; SL (5.1 mL per day.); SMCS; SP
HETLIOZ ORAL CAPSULE 20 MG (tasimelteon)	4	PA; SL (1 capsule per day.); SMCS; SP
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
meprobamate oral tablet 200 mg, 400 mg	1	
promethazine hcl oral solution 6.25 mg/5ml	1	
promethazine hcl oral syrup 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethegan rectal suppository 12.5 mg, 25 mg, 50 mg	1	
ramelteon oral tablet 8 mg	4	ST; SL (1 tablet per day)
tasimelteon oral capsule 20 mg	4	PA; SL (1 capsule per day.); SMCS; SP
VISTARIL ORAL CAPSULE 25 MG (hydroxyzine pamoate)	4	
zaleplon oral capsule 10 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	2	
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
aripiprazole oral solution 1 mg/ml	4	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	2	
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (lumateperone tosylate)	4	PA; ST; SL (1 capsule per day.)
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	1	
CLOZARIL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (clozapine)	4	
lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg	3	SL (1 tablet per day.)
lurasidone hcl oral tablet 40 mg	3	SL (1 tablet per day)
lurasidone hcl oral tablet 80 mg	3	SL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (pimavanserin tartrate)	4	PA
NUPLAZID ORAL TABLET 10 MG (pimavanserin tartrate)	4	PA
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	2	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	2	SL (1 capsule per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	3	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	1	
risperidone oral solution 1 mg/ml	1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (olanzapine-fluoxetine hcl)	4	SL (1 capsule per day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (cariprazine hcl)	4	SL (1 capsule per day.)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG (cariprazine hcl)	4	SL (7 capsules per year.)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	
BARBITURATES (ANTICONSULSANTS) - Drugs for Seizures		
phenobarbital oral elixir 20 mg/5ml	1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	
primidone oral tablet 125 mg	1	PA
primidone oral tablet 250 mg, 50 mg	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
ascomp-codeine oral capsule 50-325-40-30 mg	1	
bac oral tablet 50-325-40 mg	1	SL (6 tablets per day)
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg	3	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-325-40 mg	1	SL (6 capsules per day)
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	SL (6 tablets per day)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
ESGIC ORAL CAPSULE 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 tablets per day)
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day.)
phenobarbital oral elixir 20 mg/5ml	1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TENCON ORAL TABLET 50-325 MG (butalbital-acetaminophen)	3	
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
clobazam oral suspension 2.5 mg/ml	3	PA
clobazam oral tablet 10 mg, 20 mg	2	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	SL (1 box (2 doses/box) per prescription)
lorazepam intensol oral concentrate 2 mg/ml	1	
lorazepam oral concentrate 2 mg/ml	1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (midazolam (anticonvulsant))	3	PA; SL (1 box per prescription.)
ONFI ORAL SUSPENSION 2.5 MG/ML (clobazam)	4	PA
ONFI ORAL TABLET 10 MG, 20 MG (clobazam)	4	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (clobazam)	4	PA
VALTOCO NASAL LIQUID 10 MG/0.1ML, 5 MG/0.1ML (diazepam)	3	PA; SL (2 devices per prescription.)
VALTOCO NASAL LIQUID THERAPY PACK 10 MG/0.1ML, 7.5 MG/0.1ML (diazepam)	3	PA; SL (2 devices per prescription.)
BENZODIAZEPINES (ANXIOLYTIC, SEDATIV/HYP) - Drugs for Anxiety & Sleep Disorder		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
alprazolam intensol oral concentrate 1 mg/ml	1	
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg	1	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
clobazam oral suspension 2.5 mg/ml	3	PA
clobazam oral tablet 10 mg, 20 mg	2	PA
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	1	
diazepam intensol oral concentrate 5 mg/ml	1	
diazepam oral concentrate 5 mg/ml	1	
diazepam oral solution 5 mg/5ml	1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	1	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	1	SL (1 box (2 doses/box) per prescription)
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
HALCION ORAL TABLET 0.25 MG (triazolam)	4	
lorazepam intensol oral concentrate 2 mg/ml	1	
lorazepam oral concentrate 2 mg/ml	1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	
midazolam hcl oral syrup 2 mg/ml	1	
MIDAZOLAM+SYRSPEND SF ORAL SUSPENSION 1 MG/ML (midazolam)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (clobazam)	4	PA
ONFI ORAL TABLET 10 MG, 20 MG (clobazam)	4	PA
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (temazepam)	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (clobazam)	4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	1	
triazolam oral tablet 0.125 mg, 0.25 mg	1	
BUTYROPHENONES - Drugs for Depression & Psychosis		
haloperidol lactate oral concentrate 2 mg/ml	1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	
CALCITONIN GENE-RELATED PEPTIDE ANTAG. - Migraine Treatment		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (erenumab-aooe)	3	PA; ST; M; SL (1 ml per 21 days.)
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML (erenumab-aooe)	3	PA; ST; M
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (galcanezumab-gnlm)	3	PA; ST; M; SL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (galcanezumab-gnlm)	3	PA; ST; M; SL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (galcanezumab-gnlm)	3	PA; ST; M; SL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (rimegepant sulfate)	3	PA; ST; SL (0.27 tablets per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG (ubrogepant)	3	PA; ST; SL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (zavegepant hcl)	4	PA; ST; SL (6 mg per prescription.)
CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB. - Drugs for Parkinson		
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	1	
entacapone oral tablet 200 mg	1	
STALEVO 150 ORAL TABLET 37.5-150-200 MG (carbidopa-levodopa-entacapone)	4	
CENTRAL NERVOUS SYSTEM AGENTS, MISC. - Drugs for Attention Deficit Disorder		
acamprosate calcium oral tablet delayed release 333 mg	1	
ADDYI ORAL TABLET 100 MG (flibanserin)	4	PA; SL (1 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
atomoxetine hcl oral capsule 10 mg, 25 mg	4	SL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	4	SL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	4	SL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	4	SL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (trofinetide)	3	PA; SL (120 ml per day.); SMCS; SP
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	2	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	3	
memantine hcl oral solution 2 mg/ml	4	
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
NUDEXTA ORAL CAPSULE 20-10 MG (dextromethorphan-quinidine)	2	PA; SL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (edaravone)	4	PA; SL (150 ml per 84 days.); SMCS; SP
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (edaravone)	4	PA; SL (70 ml per 365 days.); SMCS; SP
RELYVRIO ORAL PACKET 3-1 GM (phenylbutyrate- taurursodiol)	4	PA; SL (2 packets per day.); SMCS; SP
riluzole oral tablet 50 mg	1	SMCS
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (riluzole)	4	PA; SMCS; SP
VEOZAH ORAL TABLET 45 MG (fezolinetant)	4	PA; SL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (bremelanotide acetate)	4	PA; M; SL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	3	PA; SL (1 capsule per day.); SMCS; SP
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
celecoxib oral capsule 100 mg, 200 mg, 50 mg	2	SL (2 capsules per day)
celecoxib oral capsule 400 mg	2	SL (31 capsules per 31 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
DOPAMINE PRECURSORS - Drugs for Parkinson		
carbidopa oral tablet 25 mg	1	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	1	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	1	
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	1	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (carbidopa-levodopa)	4	PA
INBRIJA INHALATION CAPSULE 42 MG (levodopa)	3	PA; SL (10 tablets per day.); SMCS; SP
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (carbidopa-levodopa)	4	
STALEVO 150 ORAL TABLET 37.5-150-200 MG (carbidopa-levodopa-entacapone)	4	
ERGOT-DERIV. DOPAMINE RECEPTOR AGONISTS - Drugs for Parkinson		
bromocriptine mesylate oral capsule 5 mg	1	
bromocriptine mesylate oral tablet 2.5 mg	1	
cabergoline oral tablet 0.5 mg	2	
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	2	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	3	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	2	
pregabalin oral solution 20 mg/ml	3	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran hcl)	4	SL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (milnacipran hcl)	4	SL (1 pack per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HYDANTOINS - Drugs for Seizures		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (phenytoin)	3	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (phenytoin sodium extended)	3	
DILANTIN ORAL SUSPENSION 125 MG/5ML (phenytoin)	3	
phenytek oral capsule 200 mg	1	
phenytek oral capsule 300 mg	4	
phenytoin infatabs oral tablet chewable 50 mg	1	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
INHALATION ANESTHETICS - Anesthetics		
FORANE INHALATION SOLUTION (isoflurane)	2	
isoflurane inhalation solution	1	
sevoflurane inhalation solution	1	
terrell inhalation solution	1	
ULTANE INHALATION SOLUTION (sevoflurane)	3	
MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson		
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis		
NARDIL ORAL TABLET 15 MG (phenelzine sulfate)	4	
PARNATE ORAL TABLET 10 MG (tranylcypromine sulfate)	4	
phenelzine sulfate oral tablet 15 mg	1	
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
tranylcypromine sulfate oral tablet 10 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson		
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
OPIATE AGONISTS - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	
ascomp-codeine oral capsule 50-325-40-30 mg	1	
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG	3	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	SL (6 capsules per day.)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
codeine sulfate oral tablet 30 mg, 60 mg	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	2	PA; SL (4 lozenges per day)
fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	PA; SL (0.34 patches per day.)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	2	PA; SL (15 patches per 31 days.)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	3	PA; SL (2 capsules per day.)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	3	PA; SL (0 tablets per 100 days, diagnosis review required.)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	3	PA; SL (1 tablet per day.)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	2	
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	3	PA; SL (2 tablets per day.)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg	3	PA; SL (1 tablet per day.)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	3	PA; SL (0 tablet per 100 days, diagnosis review required.)
hydromorphone hcl oral liquid 1 mg/ml	1	
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	
hydromorphone hcl rectal suppository 3 mg	1	
meperidine hcl oral solution 50 mg/5ml	1	
meperidine hcl oral tablet 50 mg	1	
methadone hcl intensol oral concentrate 10 mg/ml	1	SL (6 ml per day.)
methadone hcl oral concentrate 10 mg/ml	1	SL (6 ml per day.)
methadone hcl oral solution 10 mg/5ml	1	PA; SL (11.3 ml per day.)
methadone hcl oral solution 5 mg/5ml	1	PA; SL (22.6 ml per day.)
methadone hcl oral tablet 10 mg	1	PA; SL (2 tablets per day.)
methadone hcl oral tablet 5 mg	1	PA; SL (4 tablets per day.)
methadone hcl oral tablet soluble 40 mg	1	SL (1.5 tablets per day.)
METHADOSE ORAL CONCENTRATE 10 MG/ML (methadone hcl)	3	SL (6 ml per day.)
methadose oral tablet soluble 40 mg	1	SL (1.5 tablets per day.)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (methadone hcl)	3	SL (6 ml per day.)
morphine sulfate (concentrate) oral solution 10 mg/0.5ml, 100 mg/5ml, 20 mg/ml	1	
morphine sulfate er beads oral capsule extended release 24 hour 120 mg	3	PA; SL (0 capsule per 100 days, diagnosis review required.)
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	3	PA; SL (1 capsule per day.)
morphine sulfate er oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg	3	PA; SL (62 capsules per 31 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
morphine sulfate er oral capsule extended release 24 hour 100 mg	3	PA; SL (0 capsule per 100 days, diagnosis review required.)
morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg, 80 mg	3	PA; SL (1 capsule per day.)
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	1	PA; SL (0 capsules per 100 days, diagnosis review required.)
morphine sulfate er oral tablet extended release 15 mg, 30 mg	1	PA; SL (93 tablets per 31 days.)
morphine sulfate oral solution 10 mg/5ml	1	
morphine sulfate oral tablet 15 mg, 30 mg	1	
morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	1	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (tapentadol hcl)	3	PA; SL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (tapentadol hcl)	3	PA; SL (0 capsules per 100 days, diagnosis review required.)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (tapentadol hcl)	4	SL (6 tablets per day)
oxycodone hcl oral capsule 5 mg	1	
oxycodone hcl oral concentrate 100 mg/5ml	1	
oxycodone hcl oral solution 5 mg/5ml	1	
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg	1	
oxycodone hcl oral tablet 5 mg	1	SL (12 tablets per day.)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	3	PA; SL (2 tablets per day.)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg	3	PA; SL (0 tablet per 100 days.)
oxymorphone hcl oral tablet 10 mg, 5 mg	2	SL (6 tablets per day.)
SYNAPRYN FUSEPAQ ORAL SUSPENSION RECONSTITUTED 10 MG/ML (tramadol hcl)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	2	SL (1 tablet per day)
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	2	SL (1 tablet per day)
tramadol hcl oral tablet 50 mg	1	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	SL (40 tablets per prescription.)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (oxycodone)	4	PA; SL (2 tablets per day.)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (oxycodone)	4	PA; SL (0 capsules per 100 days, diagnosis review required.)
OPIATE ANTAGONISTS - Drugs for Overdose or Poisoning		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1	SL (2 films per day.)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg	1	SL (1 film per day.)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1	SL (3 films per day.)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	SL (3 tablets per day.)
KLOXXADO NASAL LIQUID 8 MG/0.1ML (naloxone hcl)	2	SL (2 devices per prescription.)
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 2 mg/2ml	1	
naloxone hcl nasal liquid 4 mg/0.1ml	1	SL (2 auto-injectors per prescription.)
naltrexone hcl oral tablet 50 mg	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (naloxone hcl)	2	SL (2 auto-injectors per prescription.)
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (nalmefene hcl)	2	SL (2 spray bottles per prescription.)
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (methylnaltrexone bromide)	4	PA; M; SL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (methylnaltrexone bromide)	4	PA; M; SL (0.4 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SUBOXONE SUBLINGUAL FILM 12-3 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (2 films per day.)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 8-2 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (3 films per day.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (naloxone hcl)	2	SL (1 ml per prescription.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (buprenorphine hcl-naloxone hcl)	1	SL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (buprenorphine hcl-naloxone hcl)	1	SL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (buprenorphine hcl-naloxone hcl)	1	SL (2 tablets per day.)
OPIATE PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 900 MCG (buprenorphine hcl)	3	PA; SL (2 Films per day.)
BELBUCA BUCCAL FILM 750 MCG (buprenorphine hcl)	3	PA; SL (2 films per day.)
buprenorphine hcl sublingual tablet sublingual 2 mg	1	SL (3 sublingual tablets per day.)
buprenorphine hcl sublingual tablet sublingual 8 mg	1	SL (3 tablets per day.)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1	SL (2 films per day.)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg	1	SL (1 film per day.)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1	SL (3 films per day.)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	SL (3 tablets per day.)
buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr	3	PA; SL (4 patches per 28 days.)
buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr	3	PA; SL (4 patches per month.)
butorphanol tartrate nasal solution 10 mg/ml	2	SL (7.5 ml (3 bottles) per prescription.)
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	
SUBOXONE SUBLINGUAL FILM 12-3 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (2 films per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (1 film per day.)
SUBOXONE SUBLINGUAL FILM 8-2 MG (buprenorphine hcl-naloxone hcl)	4	PA; ST; SL (3 films per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 2.9-0.71 MG (buprenorphine hcl-naloxone hcl)	1	SL (1 tablet per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG (buprenorphine hcl-naloxone hcl)	1	SL (3 tablets per day.)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG, 8.6-2.1 MG (buprenorphine hcl-naloxone hcl)	1	SL (2 tablets per day.)
OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Pain		
DAYPRO ORAL TABLET 600 MG (oxaprozin)	4	
diclofenac potassium oral tablet 50 mg	2	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	3	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	3	
diflunisal oral tablet 500 mg	3	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG (naproxen)	3	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 500 MG (naproxen)	4	
ec-naproxen oral tablet delayed release 375 mg, 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	3	
etodolac oral capsule 200 mg, 300 mg	2	
etodolac oral tablet 400 mg, 500 mg	2	
FELDENE ORAL CAPSULE 10 MG, 20 MG (piroxicam)	4	
flurbiprofen oral tablet 100 mg, 50 mg	1	
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
INDOCIN RECTAL SUPPOSITORY 50 MG (indomethacin)	4	PA
indomethacin er oral capsule extended release 75 mg	2	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin rectal suppository 50 mg	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	3	PA
ketorolac tromethamine oral tablet 10 mg	1	
KIPROFEN ORAL CAPSULE 25 MG (ketoprofen)	3	ST; SL (4 capsules per day.)
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
mefenamic acid oral capsule 250 mg	3	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	4	PA
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	2	
oxaprozin oral tablet 600 mg	2	
piroxicam oral capsule 10 mg, 20 mg	2	
sulindac oral tablet 150 mg, 200 mg	1	
PHENOTHIAZINES - Drugs for Depression & Psychosis		
chlorpromazine hcl oral tablet 10 mg, 25 mg	1	SL (6 tablets per day.)
chlorpromazine hcl oral tablet 100 mg, 50 mg	1	SL (4 tablets per day.)
chlorpromazine hcl oral tablet 200 mg	1	SL (2 tablets per day.)
compro rectal suppository 25 mg	1	
fluphenazine hcl oral concentrate 5 mg/ml	1	
fluphenazine hcl oral elixir 2.5 mg/5ml	1	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	1	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	1	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	1	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	1	
RESPIRATORY AND CNS STIMULANTS - Drugs for the Nervous System		
ascomp-codeine oral capsule 50-325-40-30 mg	1	
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (serdexmethylphen-dexmethylphen)	3	ST; SL (1 capsule per day.)
bac oral tablet 50-325-40 mg	1	SL (6 tablets per day)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-300-40 mg	3	SL (6 capsules per day.)
butalbital-apap-caffeine oral capsule 50-325-40 mg	1	SL (6 capsules per day)
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	SL (6 tablets per day)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	2	SL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	2	SL (31 capsules per 31 days.)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
elixophyllin oral elixir 80 mg/15ml	3	
ergotamine-caffeine oral tablet 1-100 mg	3	SL (10 tablets per prescription.)
ESGIC ORAL CAPSULE 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day)
ESGIC ORAL TABLET 50-325-40 MG (butalbital-apap-caffeine)	4	SL (6 tablets per day)
FIORICET ORAL CAPSULE 50-300-40 MG (butalbital-apap-caffeine)	4	SL (6 capsules per day.)
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (methylphenidate hcl)	3	ST; SL (1 capsule per day.)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
methylphenidate hcl er (cd) oral capsule extended release 60 mg	2	SL (31 capsules per 31 days.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	2	SL (5 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg	2	SL (5capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	2	SL (3 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg	2	SL (2 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg	2	
methylphenidate hcl er (osm) oral tablet extended release 18 mg	2	SL (2 tablets per day.)
methylphenidate hcl er oral tablet extended release 10 mg	2	SL (10 tablets per day.)
methylphenidate hcl er oral tablet extended release 20 mg	2	SL (5 tablets per day.)
METHYLPHENIDATE HCL ER TABLET EXTENDED RELEASE 24 HOUR 27 MG ORAL	2	SL (1 tablet per day.)
METHYLPHENIDATE HCL ER TABLET EXTENDED RELEASE 24 HOUR 36 MG ORAL	2	SL (2 tablets per day.)
METHYLPHENIDATE HCL ER TABLET EXTENDED RELEASE 24 HOUR 54 MG ORAL	2	SL (1 tablet per day.)
methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml	1	
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	3	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (ergotamine-caffeine)	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (theophylline)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SALICYLATES - Drugs for Pain		
ascomp-codeine oral capsule 50-325-40-30 mg	1	
aspirin 81 oral tablet delayed release 81 mg	E	H
aspirin adult low dose oral tablet delayed release 81 mg	E	H
aspirin adult low strength oral tablet delayed release 81 mg	E	H
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec low dose oral tablet delayed release 81 mg	E	H
aspirin ec low strength oral tablet delayed release 81 mg	E	H
aspirin low dose oral tablet chewable 81 mg	E	H
aspirin low dose oral tablet delayed release 81 mg	E	H
aspirin oral tablet chewable 81 mg	E	H
aspirin oral tablet delayed release 81 mg	E	H
aspirin regimen oral tablet delayed release 81 mg	E	H
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	3	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
ft aspirin low dose oral tablet delayed release 81 mg	E	H
goodsense aspirin low dose oral tablet delayed release 81 mg	E	H
mm aspirin oral tablet delayed release 81 mg	E	H
salsalate oral tablet 500 mg, 750 mg	1	
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (aspirin)	E	H
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (aspirin)	E	H
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 50 mg	3	SL (1 tablet per day)
desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg	3	SL (1 tablet per day.)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran hcl)	4	SL (2 tablets per day)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (milnacipran hcl)	4	SL (1 pack per 365 days.)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
SELECTIVE SEROTONIN AGONISTS - Migraine Treatment		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	4	SL (4 tablets per prescription)
eletriptan hydrobromide oral tablet 20 mg, 40 mg	3	SL (4 tablets per prescription)
frovatriptan succinate oral tablet 2.5 mg	3	SL (4 tablets per prescription)
naratriptan hcl oral tablet 1 mg, 2.5 mg	1	SL (10 per prescription.)
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	SL (10 tablets per prescription.)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	SL (10 per prescription.)
sumatriptan nasal solution 20 mg/act, 5 mg/act	2	SL (6 spray bottles per prescription)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	SL (10 tablets per prescription.)
sumatriptan succinate refill subcutaneous solution cartridge subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	1	M; SL (2 kits per prescription)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	M; SL (2 kits per prescription)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	1	M; SL (2 kits per prescription)
zolmitriptan oral tablet 2.5 mg, 5 mg	2	SL (4 tablets per prescription)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	3	SL (4 tablets per prescription)
ZOMIG NASAL SOLUTION 2.5 MG (zolmitriptan)	3	SL (6 units per prescription.)
ZOMIG NASAL SOLUTION 5 MG (zolmitriptan)	2	SL (1 box per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
citalopram hydrobromide oral solution 10 mg/5ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
escitalopram oxalate oral solution 5 mg/5ml	3	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	3	SL (4 capsules per 28 days.)
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg	3	SL (1 tablet per day.)
fluoxetine hcl oral tablet 20 mg, 60 mg	3	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	4	SL (2 capsules per day)
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	2	SL (1 capsule per day)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg	3	SL (1 tablet per day)
paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg	3	SL (2 tablets per day)
paroxetine hcl oral suspension 10 mg/5ml	3	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
PAXIL ORAL SUSPENSION 10 MG/5ML (paroxetine hcl)	4	
sertraline hcl oral concentrate 20 mg/ml	1	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	1	
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (olanzapine-fluoxetine hcl)	4	SL (1 capsule per day)
SEROTONIN MODULATORS - Drugs for Depression & Psychosis		
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	1	
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	1	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (methsuximide)	4	
ethosuximide oral capsule 250 mg	1	
ethosuximide oral solution 250 mg/5ml	1	
methsuximide oral capsule 300 mg	2	
ZARONTIN ORAL CAPSULE 250 MG (ethosuximide)	4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (ethosuximide)	4	
THIOXANTHENES - Drugs for Depression & Psychosis		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
TRICYCLICS, OTHER NOREPI-RU INHIBITORS - Drugs for Depression & Psychosis		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	1	
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	1	
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	3	
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl oral concentrate 10 mg/ml	1	
ENOVARX-AMITRIPTYLINE EXTERNAL KIT 2 %	3	PA
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (desipramine hcl)	4	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	
nortriptyline hcl oral solution 10 mg/5ml	1	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	1	
protriptyline hcl oral tablet 10 mg, 5 mg	1	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (deutetrabenazine)	3	PA; SL (4 tablets per day.); SMCS; SP
AUSTEDO ORAL TABLET 6 MG (deutetrabenazine)	3	PA; SL (2 tablets per day.); SMCS; SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 6 MG (deutetrabenazine)	3	SL (2 tablets per day.); SMCS; SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG (deutetrabenazine)	3	SL (42 tablets per 365 days.); SMCS; SP
tetrabenazine oral tablet 12.5 mg	3	PA; SMCS
tetrabenazine oral tablet 25 mg	3	PA; SMCS; SP
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
armodafinil oral tablet 150 mg, 250 mg	2	SL (1 tablet per day)
armodafinil oral tablet 200 mg, 50 mg	2	SL (1 tablet per day.)
diclofenac sodium oral tablet delayed release 75 mg	1	
modafinil oral tablet 100 mg, 200 mg	2	SL (1 tablet per day)
SUNOSI ORAL TABLET 150 MG, 75 MG (solriamfetol hcl)	2	PA; SL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (pitolisant hcl)	4	PA; SL (2 tablets per day.); SMCS; SP
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % (sod fluoride-potassium nitrate)	3	
FLUORIMAX 5000 SENSITIVE DENTAL PASTE 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
DEVICES - Medical Supplies and Durable Medical Equipment		
DEVICES - Medical Supplies and Durable Medical Equipment		
ACCU-CHEK AVIVA IN VITRO SOLUTION (blood glucose calibration)	1	
ACCU-CHEK FASTCLIX LANCET KIT KIT (lancets misc.)	1	
ACCU-CHEK GUIDE CONTROL IN VITRO LIQUID (blood glucose calibration)	3	
ACCU-CHEK GUIDE KIT W/DEVICE (blood glucose monitoring suppl)	3	M
ACCU-CHEK GUIDE ME KIT W/DEVICE (blood glucose monitoring suppl)	3	M
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (blood glucose calibration)	1	
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT (lancets misc.)	1	
ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM (insulin pen needle)	2	SL (10 pen needles per day.)
AEROCHAMBER HOLDING CHAMBER DEVICE (spacer/aero-holding chambers)	3	
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (spacer/aero-holding chambers)	3	
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (spacer/aero-holding chambers)	3	
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (spacer/aero-holding chambers)	3	
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (spacer/aero-holding chambers)	3	
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (spacer/aero-holding chambers)	3	
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.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (insulin pen needle)	2	SL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (insulin pen needle)	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.)
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 (insulin pen needle)	2	SL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (insulin pen needle)	2	SL (10 pen needles per day.)
AUTOLET LANCING DEVICE (lancet devices)	3	SL (1 device per prescription.)
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (insulin pen needle)	2	SL (10 pen needles per day.)
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (needle (disp))	2	
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1-1/2" , 25G X 5/8" (needle (disp))	2	
BD SHARPS COLLECTOR (sharps container)	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 (insulin syringe-needle u-100)	2	SL (10 syringes per day.)
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (insulin syringe/needle u-500)	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 (insulin pen needle)	2	SL (10 pen needles per day.)
BREATHE COMFORT CHAMBER/ADULT DEVICE	3	
BREATHE COMFORT CHAMBER/CHILD DEVICE	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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 (blood glucose calibration)	2	
CARESENS LANCETS 30G (lancets)	3	SL (1 device per prescription.)
CARETOUCH CONTROL SOL LEVEL 2 IN VITRO LIQUID (blood glucose calibration)	3	
CARETOUCH HYPODERMIC NEEDLE 22G X 1" , 27G X 1-1/2" (needle (disp))	2	
CARETOUCH LANCING/EJECTOR (lancet devices)	3	SL (1 device per prescription.)
CEQUR SIMPLICITY 2U DEVICE (injection device for insulin)	3	
CHEMSTRIP BG LOG BOOK (blood glucose monitoring suppl)	1	M
CLEVER CHOICE COMFORT EZ (lancets)	3	SL (1 device per prescription.)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (insulin pen needle)	2	SL (10 pen needles per day.)
CONTOUR CONTROL IN VITRO LIQUID HIGH (blood glucose calibration)	3	
CONTOUR CONTROL IN VITRO LIQUID LOW , NORMAL (blood glucose calibration)	2	
CONTOUR NEXT CONTROL IN VITRO SOLUTION LOW , NORMAL (blood glucose calibration)	2	
CONTOUR NEXT MONITOR KIT W/DEVICE (blood glucose monitoring suppl)	2	M
CONTOUR NEXT ONE KIT (blood glucose monitoring suppl)	2	M
DEXCOM G6 RECEIVER DEVICE (continuous glucose receiver)	3	PA; M; SL (1 kit per 999 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
DEXCOM G6 SENSOR (continuous glucose sensor)	3	PA; M; SL (3 sensors per month.)
DEXCOM G6 TRANSMITTER (continuous glucose transmitter)	3	PA; M; SL (Benefit maximum quantity 1 transmitter per 3 months for Dexcom G6 Transmitter.)
DEXCOM G7 RECEIVER DEVICE (continuous glucose receiver)	3	PA; M; SL (1 kit per 999 days.)
DEXCOM G7 SENSOR (continuous glucose sensor)	3	PA; M; 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 (insulin syringe-needle u-100)	2	SL (10 syringes per day.)
DROPSAFE SICURA 25G X 1" (needle (disp))	2	
EASIVENT (spacer/aero-holding chambers)	3	
EASY COMFORT SHARPS CONTAINER	3	
EASYMAX 15 LEVEL 2-3 CONTROL IN VITRO LIQUID (blood glucose calibration)	3	
EASYMAX CONTROL IN VITRO SOLUTION NORMAL (blood glucose calibration)	3	
EASYMAX CONTROL NORMAL/HIGH IN VITRO LIQUID (blood glucose calibration)	3	
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	SL (10 pen needles per day.)
ENLITE GLUCOSE SENSOR (continuous glucose sensor)	3	PA; M
FLEXICHAMBER ADULT MASK/SMALL (spacer/aero-hold chamber mask)	2	
FLEXICHAMBER CHILD MASK/LARGE (spacer/aero-hold chamber mask)	2	
FLEXICHAMBER CHILD MASK/SMALL (spacer/aero-hold chamber mask)	2	
FLEXICHAMBER DEVICE (spacer/aero-holding chambers)	3	
FORA TEST N' GO ADVANCE DEVICE (blood glucose/ketone monitor)	3	M
FORTISCARE CONTROL IN VITRO SOLUTION HIGH , LOW , NORMAL (blood glucose calibration)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
FREESTYLE LIBRE 14 DAY READER DEVICE (continuous glucose receiver)	3	PA; M; SL (1 receiver per 999 days.)
FREESTYLE LIBRE 14 DAY SENSOR (continuous glucose sensor)	3	PA; M; SL (2 sensors per 21 days.)
FREESTYLE LIBRE 2 READER DEVICE (continuous glucose receiver)	3	PA; M; SL (1 receiver per 999 days.)
FREESTYLE LIBRE 2 SENSOR (continuous glucose sensor)	3	PA; M; SL (2 sensors per 21 days.)
FREESTYLE LIBRE 3 READER DEVICE (continuous glucose receiver)	3	PA; M
FREESTYLE LIBRE 3 SENSOR (continuous glucose sensor)	3	PA; M; SL (2 sensors per 21 days.)
FREESTYLE LIBRE READER DEVICE (continuous glucose receiver)	3	PA; M; SL (1 kit per 999 days.)
GUARDIAN 4 GLUCOSE SENSOR (continuous glucose sensor)	3	PA; M
GUARDIAN 4 TRANSMITTER (continuous glucose transmitter)	3	PA; M
GUARDIAN CONNECT TRANSMITTER (continuous glucose transmitter)	3	PA; M; SL (1 transmitter per 365 days.)
GUARDIAN LINK 3 TRANSMITTER (continuous glucose transmitter)	3	PA; M; SL (1 transmitter kit per 365 days.)
GUARDIAN SENSOR (3) (continuous glucose sensor)	3	PA; M; SL (5 sensors per 24 days.)
GUARDIAN SENSOR 3	3	PA; M; SL (5 sensors per 24 days.)
INPEN 100-BLUE-LILLY-HUMALOG DEVICE (injection device for insulin)	3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE (injection device for insulin)	3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE (injection device for insulin)	3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE (injection device for insulin)	3	
INPEN 100-PINK-LILLY-HUMALOG DEVICE (injection device for insulin)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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-PINK-NOVOLOG-FIASP DEVICE (injection device for insulin)	3	
INSPIREASE RESERVOIR BAGS (spacer/aero-hold chamber bags)	2	
INSULIN PEN NEEDLES 29G X 12.7MM , 29G X 12MM , 29G X 5MM , 29G X 8MM , 31G X 4 MM , 31G X 8 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 (insulin pen needle)	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 , 32G X 4 MM	2	SL (10 pen needles per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (OTC)	2	SL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)	2	SL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (OTC)	2	SL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)	2	SL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (OTC)	2	SL (10 syringes per day.)
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)	2	SL (10 syringes per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML, 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 (insulin syringe-needle u-100)	2	SL (10 syringes per day.)
INSULIN SYRINGES 28G X 1/2" 0.5 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.)
LANCETS (lancets)	1	SL (1 device per prescription.)
LANCETS (lancets)	3	SL (1 device per prescription.)
MICROLET NEXT LANCING DEVICE (lancet devices)	3	SL (1 device per prescription.)
NORDIPEN 5 INJECTION DEVICE (injection device)	3	
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM (insulin pen needle)	2	SL (10 pen needles per day.)
NOVOFINE PEN NEEDLE 32G X 6 MM (insulin pen needle)	2	SL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (insulin pen needle)	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NOVOPEN ECHO DEVICE (injection device for insulin)	3	
OMNIPOD 5 G6 INTRO (GEN 5) KIT (insulin disposable pump)	2	PA; SL (1 kit per 180 days.)
OMNIPOD 5 G6 PODS (GEN 5) (insulin disposable pump)	2	PA; SL (10 pods per prescription.)
ONETOUCH DELICA PLUS LANCING (lancet devices)	1	SL (1 device per prescription.)
ONETOUCH DELICA SAFETY LANCING (lancets)	1	SL (1 device per prescription.)
ONETOUCH ULTRA 2 KIT W/DEVICE (blood glucose monitoring suppl)	1	M
ONETOUCH ULTRA IN VITRO LIQUID (blood glucose calibration)	1	
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE (blood glucose monitoring suppl)	1	M
ONETOUCH VERIO IN VITRO LIQUID HIGH (blood glucose calibration)	1	
ONETOUCH VERIO REFLECT KIT W/DEVICE (blood glucose monitoring suppl)	1	M
PARI VORTEX ADULT MASK (spacer/aero-hold chamber mask)	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (blood glucose calibration)	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 (lancets)	3	SL (1 device per prescription.)
TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (blood glucose calibration)	2	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (blood glucose calibration)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (blood glucose calibration)	2	
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM (insulin pen needle)	2	SL (10 pen needles per day.)
UNISTRIP CONTROL IN VITRO SOLUTION LOW (blood glucose calibration)	3	
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (insulin pen needle)	2	SL (10 pen needles per day.)
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 (insulin syringe-needle u-100)	2	SL (10 syringes per day.)
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (insulin pen needle)	2	SL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G (lancets)	3	SL (1 device per prescription.)
VERIFINE SAFE LANCET MINI 23G (lancets)	3	SL (1 device per prescription.)
VERIFINE SAFE LANCET MINI 28G (lancets)	3	SL (1 device per prescription.)
VERIFINE SAFE LANCET MINI 30G (lancets)	3	SL (1 device per prescription.)
VERIFINE SHARPS CONTAINER (sharps container)	3	
VORTEX VALVED HOLDING CHAMBER DEVICE (spacer/aero-holding chambers)	2	
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (cosyntropin)	4	M
cosyntropin injection solution reconstituted 0.25 mg	1	M
CARDIAC FUNCTION		
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
DIABETES MELLITUS		
ACCU-CHEK GUIDE IN VITRO STRIP (glucose blood)	3	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CONTOUR NEXT TEST IN VITRO STRIP (glucose blood)	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 (ketone blood test)	3	
ONETOUCH ULTRA IN VITRO STRIP (glucose blood)	1	SL (51 strips per prescription without history 204 strips per prescription with history.)
ONETOUCH VERIO IN VITRO STRIP (glucose blood)	1	SL (51 strips per prescription without history 204 strips per prescription with history.)
DIAGNOSTIC AGENTS		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (covid-19 at home test)	3	SM
CARESTART COVID-19 HOME TEST IN VITRO KIT (covid-19 at home test)	3	SM
CLEARDETECT COVID-19 AG HOME IN VITRO KIT (covid-19 at home test)	3	SM
CLINITEST RAPID COVID-19 TEST IN VITRO KIT (covid-19 at home test)	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 (covid-19 at home test)	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 (covid-19 at home test)	3	SM
IHEALTH COVID-19 RAPID TEST IN VITRO KIT (covid-19 at home test)	3	SM
INDICAID COVID-19 RAPID TEST IN VITRO KIT (covid-19 at home test)	3	SM
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT (covid-19 at home test)	3	SM
ON/GO COVID-19 ANTIGEN TEST IN VITRO KIT (covid-19 at home test)	3	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ON/GO ONE COVID-19 HOME TEST IN VITRO KIT (covid-19 at home test)	3	SM
PILOT COVID-19 AT-HOME TEST IN VITRO KIT (covid-19 at home test)	3	SM
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (covid-19 at home test)	3	SM
SPEEDY SWAB COVID-19 ANTIGEN IN VITRO KIT (covid-19 at home test)	3	SM
KETONES		
CHEMSTRIP K IN VITRO STRIP (acetone (urine) test)	2	
KETONE TEST IN VITRO STRIP	2	
KETOSTIX IN VITRO STRIP (acetone (urine) test)	2	
PHEOCHROMOCYTOMA		
DEMSEER ORAL CAPSULE 250 MG (metyrosine)	4	
metyrosine oral capsule 250 mg	3	
URINE AND FECES CONTENTS		
CHEMSTRIP UGK IN VITRO STRIP (urine glucose-ketones test)	3	
CVS KETONE CARE IN VITRO STRIP (urine glucose-ketones test)	2	
KETO-DIASTIX IN VITRO STRIP (urine glucose-ketones test)	3	
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
formaldehyde external solution 10 %, 37 %	1	
glutaraldehyde external solution 25 %	1	
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
ACIDIFYING AGENTS		
K-PHOS NO 2 ORAL TABLET 305-700 MG (pot & sod ac phosphates)	2	
ALKALINIZING AGENTS		
cytra k crystals oral packet 3300-1002 mg	1	
ORACIT ORAL SOLUTION 490-640 MG/5ML (sod citrate-citric acid)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ORAL CITRATE ORAL SOLUTION 490-640 MG/5ML	2	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	1	
potassium citrate-citric acid oral solution 1100-334 mg/5ml	1	
sod citrate-citric acid oral solution 500-334 mg/5ml	1	
tricitrates oral solution 550-500-334 mg/5ml	1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (potassium citrate)	4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (potassium citrate)	4	
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE 5 MEQ (540 MG) (potassium citrate)	4	
AMMONIA DETOXICANTS		
carglumic acid oral tablet soluble 200 mg	3	PA; SMCS; SP
constulose oral solution 10 gm/15ml	1	
enulose oral solution 10 gm/15ml	1	
generlac oral solution 10 gm/15ml	1	
KRISTALOSE ORAL PACKET 10 GM (lactulose)	4	
KRISTALOSE ORAL PACKET 20 GM (lactulose)	3	
lactulose encephalopathy oral solution 10 gm/15ml	1	
lactulose oral solution 10 gm/15ml, 20 gm/30ml	1	
LITHOSTAT ORAL TABLET 250 MG (acetohydroxamic acid)	3	
RAVICTI ORAL LIQUID 1.1 GM/ML (glycerol phenylbutyrate)	4	PA; ST; SL (17.5 ml per day.); SMCS; SP
sodium phenylbutyrate oral powder 3 gm/tsp	1	PA; SMCS
sodium phenylbutyrate oral tablet 500 mg	4	PA; SMCS
CALORIC AGENTS - Drugs for Nutrition		
CAMINO PRO COMPLETE/GLYTACTIN ORAL BAR (nutritional supplements)	3	M
DOJOLVI ORAL LIQUID 100 % (triheptanoin)	4	PA; SMCS; SP
ENSURE PLUS ORAL LIQUID (nutritional supplements)	3	
GLYTACTIN BETTERMILK 15 ORAL PACKET (nutritional supplements)	3	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
GLYTACTIN BETTERMILK DE-LITE ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN BUILD 10PE ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN BUILD 20/20 ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN BUILD 20/20 PKU ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN BURST ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN COMPLETE 10PE ORAL BAR (nutritional supplements)	3	M
GLYTACTIN RESTORE 10 ORAL LIQUID (nutritional supplements)	3	M
GLYTACTIN RESTORE 5 ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN RESTORE LITE 10 ORAL LIQUID (nutritional supplements)	3	M
GLYTACTIN RESTORE LITE 10PE ORAL PACKET (nutritional supplements)	3	M
GLYTACTIN RTD 10 ORAL LIQUID (nutritional supplements)	3	M
GLYTACTIN RTD 15 ORAL LIQUID (nutritional supplements)	3	M
GLYTACTIN RTD LITE 15 ORAL LIQUID (nutritional supplements)	3	M
GLYTACTIN SWIRL 15 ORAL PACKET (nutritional supplements)	3	
GLYTACTIN SWIRL 15PE ORAL PACKET (nutritional supplements)	3	M
L-ISOLEUCINE POWDER	3	PA
PKU EASY MICROTABS ORAL TABLET DELAYED RELEASE (nutritional supplements)	3	
PKU EASY SHAKE & GO ORAL POWDER (nutritional supplements)	3	
PREKUNIL ORAL TABLET (nutritional supplements)	3	
PRO-STAT/FIBER ORAL LIQUID (amino acids-protein hydrolys)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CARBONIC ANHYDRASE INHIBITORS - Drugs for Water Balance		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
DIURETICS, MISCELLANEOUS - Drugs for Water Balance		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (theophylline)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
LOOP DIURETICS - Drugs for Water Balance		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (bumetanide)	3	
ethacrynic acid oral tablet 25 mg	4	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (furosemide)	4	
torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OTHER ION-REMOVING AGENTS		
RADIOGARDASE ORAL CAPSULE 0.5 GM (prussian blue insoluble)	3	
PHOSPHATE-REMOVING AGENTS		
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
calcium acetate oral tablet 667 mg	1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (lanthanum carbonate)	3	ST
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	3	ST

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	2	PA
sevelamer carbonate oral tablet 800 mg	2	
sevelamer hcl oral tablet 400 mg, 800 mg	3	
VELPHORO ORAL TABLET CHEWABLE 500 MG (sucroferric oxyhydroxide)	2	
POTASSIUM-REMOVING AGENTS		
LOKELMA ORAL PACKET 10 GM (sodium zirconium cyclosilicate)	3	PA; SL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM (sodium zirconium cyclosilicate)	3	PA; SL (3 packets per day.)
sodium polystyrene sulfonate oral powder	1	
SPS ORAL SUSPENSION 15 GM/60ML (sodium polystyrene sulfonate)	3	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (patiromer sorbitex calcium)	3	PA; SL (1 Packet per day.)
POTASSIUM-SPARING DIURETICS - Drugs for Water Balance		
amiloride hcl oral tablet 5 mg	1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (spironolactone)	4	PA
eplerenone oral tablet 25 mg, 50 mg	2	
MAXZIDE ORAL TABLET 75-50 MG (triamterene-hctz)	4	
spironolactone oral suspension 25 mg/5ml	3	PA
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
triamterene oral capsule 100 mg, 50 mg	3	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
REPLACEMENT PREPARATIONS		
CALCIFOL ORAL WAFER 1342-1.6 MG (ca carb-fa-d-b6-b12-boron-mg)	3	
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
calcium acetate oral tablet 667 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
EFFER-K ORAL TABLET EFFERVESCENT 10 MEQ, 20 MEQ (potassium bicarb-citric acid)	2	
effer-k oral tablet effervescent 25 meq	1	
GALZIN ORAL CAPSULE 25 MG, 50 MG (zinc acetate (oral))	3	
klor-con 10 oral tablet extended release 10 meq	1	
klor-con m10 oral tablet extended release 10 meq	1	
klor-con m15 oral tablet extended release 15 meq	1	
klor-con m20 oral tablet extended release 20 meq	1	
klor-con oral packet 20 meq	1	
klor-con oral tablet extended release 8 meq	1	
klor-con/ef oral tablet effervescent 25 meq	1	
K-PHOS ORAL TABLET 500 MG (potassium phosphate monobasic)	2	
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (k phos mono-sod phos di & mono)	2	
k-prime oral tablet effervescent 25 meq	1	
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ (potassium chloride)	3	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (insulin regular(human) in nacl)	3	
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (k phos mono-sod phos di & mono)	2	
phosphorous oral tablet 155-852-130 mg	1	
phospho-trin 250 neutral oral tablet 155-852-130 mg	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	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq	1	
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
potassium chloride oral packet 20 meq	1	
potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)	1	
PREMESISRX ORAL TABLET 1 MG (prenatal ca-b6-b12-fa-ginger)	3	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fecbn-feasp-meth-fa-dha)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (prenat mv-min-methylfolate-fa)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
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 (bicarb-dextrose-k (crrt))	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION 32-2.5 MEQ/L (bicarb-dextrose-ca (crrt))	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION 32-2 MEQ/L (bicarb-dextrose-k (crrt))	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION 32-2-3.5 MEQ/L (bicarb-dextrose-k-ca (crrt))	3	
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION 32-4-1.2 MEQ/L (bicarb-dextrose-k-mg (crrt))	3	
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION 32-4-2.5 MEQ/L (bicarb-dextrose-k-ca (crrt))	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION 32-1.2 MEQ/L (bicarb-mg (crrt))	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (prenat-fe poly-methfol-fa-dha)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (prenatal mv-min-fe fum-fa-dha)	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG (prenat w/o a-fe-methfol-fa-dha)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
WESNATAL DHA COMPLETE ORAL 29-1-200 & 200 MG	2	
wes-phos 250 neutral oral tablet 155-852-130 mg	1	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
THIAZIDE DIURETICS - Drugs for Water Balance		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG (quinapril-hydrochlorothiazide)	4	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	3	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
DIURIL ORAL SUSPENSION 250 MG/5ML (chlorothiazide)	2	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (benazepril-hydrochlorothiazide)	4	
MAXZIDE ORAL TABLET 75-50 MG (triamterene-hctz)	4	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	2	
quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg	2	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
THIAZIDE-LIKE DIURETICS - Drugs for Water Balance		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
URICOSURIC AGENTS		
colchicine-probenecid oral tablet 0.5-500 mg	1	
probenecid oral tablet 500 mg	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
JYNARQUE ORAL TABLET 15 MG, 30 MG (tolvaptan)	3	PA; SL (2 tablets per day.); SMCS; SP
JYNARQUE ORAL TABLET THERAPY PACK 15 MG, 45 & 15 MG, 60 & 30 MG, 90 & 30 MG (tolvaptan)	3	PA; SL (2 tablets per day.); SMCS; SP
JYNARQUE ORAL TABLET THERAPY PACK 30 & 15 MG (tolvaptan)	3	PA; SL (2 tablets per day.); SMCS
tolvaptan oral tablet 15 mg	3	PA; SMCS; SP
tolvaptan oral tablet 30 mg	3	PA; SL (2 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ENZYMES		
ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (pancrelipase (lip-prot-amyl))	2	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (pancrelipase (lip-prot-amyl))	4	ST
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (dornase alfa)	3	PA; SL (5 ml per day.); SMCS; SP
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (collagenase)	4	SL (90 grams per prescription.)
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML (asfotase alfa)	3	PA; M; SL (5.4 ml per month.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7ML (asfotase alfa)	3	PA; M; SL (8.4 ml per month.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML (asfotase alfa)	3	PA; M; SL (12 ml tablets per month.); SMCS; SP
STRENSIQ SUBCUTANEOUS SOLUTION 80 MG/0.8ML (asfotase alfa)	3	PA; M; SL (9.6 ml (12 vials) per month.); SMCS; SP
SUCRAID ORAL SOLUTION 8500 UNIT/ML (sacrosidase)	3	PA; SMCS; SP
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (pancrelipase (lip-prot-amyl))	4	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 (pancrelipase (lip-prot-amyl))	2	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
ALPHA-ADRENERGIC AGONISTS (EENT) - Drugs for the Eye		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (brimonidine tartrate)	2	SL (10 ml per prescription)
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (brimonidine tartrate)	4	SL (10 ml per prescription)
brimonidine tartrate ophthalmic solution 0.15 %	2	SL (10 ml per prescription)
brimonidine tartrate ophthalmic solution 0.2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (brimonidine tartrate-timolol)	2	SL (5 ml per prescription)
ANTIALLERGIC AGENTS - Drugs for Allergy		
ALOCRIAL OPHTHALMIC SOLUTION 2 % (nedocromil sodium)	3	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (Iodoxamide tromethamine)	3	
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	3	
azelastine hcl ophthalmic solution 0.05 %	1	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	
cromolyn sodium ophthalmic solution 4 %	1	
epinastine hcl ophthalmic solution 0.05 %	4	SL (5 ml per prescription)
olopatadine hcl nasal solution 0.6 %	4	SL (30.5 grams (1 box) per prescription.)
ANTIBACTERIALS (EENT) - Drugs for Infections		
AZASITE OPHTHALMIC SOLUTION 1 % (azithromycin)	3	
bacitracin ophthalmic ointment 500 unit/gm	1	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (besifloxacin hcl)	3	
CETRAXAL OTIC SOLUTION 0.2 % (ciprofloxacin hcl)	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (ciprofloxacin hcl)	3	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
ciprofloxacin hcl otic solution 0.2 %	1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	4	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin-colist-hc-thonzonium)	3	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
erythromycin ophthalmic ointment 5 mg/gm	1	H
gatifloxacin ophthalmic solution 0.5 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
gentamicin sulfate ophthalmic solution 0.3 %	1	SL (15 ml per prescription.)
levofloxacin ophthalmic solution 1.5 %	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (neomycin-polymyxin-dexameth)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (neomycin-polymyxin-dexameth)	4	
MITOSOL OPHTHALMIC KIT 0.2 MG (mitomycin)	3	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	3	
moxifloxacin hcl ophthalmic solution 0.5 %	3	
neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000	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-gramicidin ophthalmic solution 1.75-10000-.025	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	
neo-polycin ophthalmic ointment 3.5-400-10000	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (ofloxacin)	4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin otic solution 0.3 %	2	
polycin ophthalmic ointment 500-10000 unit/gm	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sulfacetamide sodium ophthalmic ointment 10 %	1	
sulfacetamide sodium ophthalmic solution 10 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tobramycin ophthalmic solution 0.3 %	1	SL (5 ml per prescription.)
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
TOBREX OPHTHALMIC OINTMENT 0.3 % (tobramycin)	3	SL (3.5 grams per prescription.)
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (loteprednol-tobramycin)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (natamycin)	4	
ANTIVIRALS (EENT) - Drugs for Infections		
trifluridine ophthalmic solution 1 %	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (ganciclovir)	4	
BETA-ADRENERGIC BLOCKING AGENTS (EENT) - Drugs for the Eye		
betaxolol hcl ophthalmic solution 0.5 %	1	
BETIMOL OPHTHALMIC SOLUTION 0.25 % (timolol hemihydrate)	2	SL (5 ml per prescription)
BETIMOL OPHTHALMIC SOLUTION 0.5 % (timolol hemihydrate)	2	SL (5 ml per prescription.)
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (betaxolol hcl)	3	
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (brimonidine tartrate-timolol)	2	SL (5 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (dorzolamide hcl-timolol mal)	4	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	2	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (timolol maleate)	4	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	2	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (timolol maleate)	4	
CARBONIC ANHYDRASE INHIBITORS (EENT) - Drugs for the Eye		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
brinzolamide ophthalmic suspension 1 %	2	SL (10 ml per prescription)
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (dorzolamide hcl-timolol mal)	4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	2	
methazolamide oral tablet 25 mg, 50 mg	1	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	SL (10.7 grams per prescription.)
ALREX OPHTHALMIC SUSPENSION 0.2 % (loteprednol etabonate)	4	SL (5 ml per prescription)
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	4	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin-colist-hc-thonzonium)	3	
DERMOTIC OTIC OIL 0.01 % (fluocinolone acetonide)	4	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	3	
DOUBLE PM OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5 %	3	PA
DUREZOL OPHTHALMIC EMULSION 0.05 % (difluprednate)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (loteprednol etabonate)	4	SL (8.3 mL per prescription)
flac otic oil 0.01 %	1	
FLAREX OPHTHALMIC SUSPENSION 0.1 % (fluorometholone acetate)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluocinolone acetonide otic oil 0.01 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
fluticasone propionate nasal suspension 50 mcg/act	2	SL (16 grams (1 bottle) per prescription)
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (fluorometholone)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (fluorometholone)	4	
hydrocortisone-acetic acid otic solution 1-2 %	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (loteprednol etabonate)	3	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (loteprednol etabonate)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (loteprednol etabonate)	3	SL (5 grams per prescription.)
loteprednol etabonate ophthalmic suspension 0.2 %	3	SL (5 ml per prescription)
loteprednol etabonate ophthalmic suspension 0.5 %	3	SL (5 ml per prescription.)
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (dexamethasone)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (neomycin-polymyxin-dexameth)	4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (neomycin-polymyxin-dexameth)	4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
neo-polycin hc ophthalmic ointment 1 %	1	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (prednisolone acetate)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (tobramycin-dexamethasone)	3	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
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 (ciclesonide)	3	SL (6.1 grams per prescription.)
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (loteprednol-tobramycin)	3	
EENT ANTI-INFECTIVES, MISCELLANEOUS - Drugs for Infections		
ARZOL SILVER NIT APPLICATORS EXTERNAL 75-25 % (silver nitrate-pot nitrate)	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % (povidone-iodine)	3	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (chlorhexidine gluconate)	4	
periogard mouth/throat solution 0.12 %	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (pramoxine-chloroxylenol)	3	
silver nitrate external solution 0.5 %	1	
XDEMVIY OPHTHALMIC SOLUTION 0.25 % (lotilaner)	4	PA; SL (10 ml per 63 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS OPHTHALMIC EMULSION 0.05 % (cyclosporine)	4	PA; SL (60 vials per prescription.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (cyclosporine)	4	PA
XIIDRA OPHTHALMIC SOLUTION 5 % (lifitegrast)	4	PA; SL (60 vials per prescription.)
EENT DRUGS, MISCELLANEOUS		
acetic acid otic solution 2 %	1	
apraclonidine hcl ophthalmic solution 0.5 %	1	
AQUORAL MOUTH/THROAT SOLUTION (artificial saliva)	3	
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (cysteamine hcl)	4	PA; SL (20 mL per 21 days); SMCS
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (cysteamine hcl)	3	PA; SL (60 ml (4 bottles) per month.); SMCS; SP
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (sulfuric acid-sulf phenolics)	2	
hydrocortisone-acetic acid otic solution 1-2 %	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (apraclonidine hcl)	3	
LACRISERT OPHTHALMIC INSERT 5 MG (artificial tear insert)	2	
MUCOSITISRX MOUTH/THROAT PACKET (artificial saliva)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (cenegermin-bkbj)	4	PA; SL (1 ml per day and 56 ml per 365 days.); SMCS; SP
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (ketorolac tromethamine)	4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (ketorolac tromethamine)	4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	3	
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (nepafenac)	4	
TRIPLE PMB OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.09 %	3	PA
TRIPLE PMK OPHTHALMIC SOLUTION RECONSTITUTED 1-0.5-0.5 %	3	PA
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (lidocaine hcl)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (proparacaine hcl)	3	
ALTACAIN OPHTHALMIC SOLUTION 0.5 % (tetracaine hcl)	3	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
lidocaine hcl mouth/throat solution 4 %	1	
lidocaine viscous hcl mouth/throat solution 2 %	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (pramoxine-chloroxylenol)	3	
proparacaine hcl ophthalmic solution 0.5 %	1	
tetracaine hcl ophthalmic solution 0.5 %	1	
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (echothiophate iodide)	2	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
VUITY OPHTHALMIC SOLUTION 1.25 % (pilocarpine hcl)	4	PA; SL (0.09 ml per day.)
MYDRIATICS - Drugs for the Eye		
altafrin ophthalmic solution 10 %, 2.5 %	1	
atropine sulfate ophthalmic ointment 1 %	1	
atropine sulfate ophthalmic solution 1 %	1	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (cyclopentolate hcl)	4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (cyclopentolate-phenylephrine)	3	
cyclopentolate hcl ophthalmic solution 1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
bimatoprost ophthalmic solution 0.03 %	2	SL (2.5 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
LATANOPROST OIL	3	PA
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (bimatoprost)	2	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (netarsudil-latanoprost)	3	SL (2.5 mL per prescription.)
tafluprost (pf) ophthalmic solution 0.0015 %	3	ST; SL (30 unit of use droppers per prescription.)
XELPROS OPHTHALMIC EMULSION 0.005 % (latanoprost)	3	SL (2.5 ml per prescription.)
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (tafluprost)	3	ST; SL (30 unit of use droppers per prescription.)
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (netarsudil dimesylate)	3	SL (2.5 ml per prescription.)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (netarsudil-latanoprost)	3	SL (2.5 mL per prescription.)
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (epinephrine hcl (nasal))	2	
altafrin ophthalmic solution 10 %, 2.5 %	1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (cyclopentolate-phenylephrine)	3	
epinephrine hcl (nasal) nasal solution 0.1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
GASTROINTESTINAL DRUGS		
ANTACIDS AND ADSORBENTS		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
IMMUNOMODULATORY AGENT		
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (mirikizumab-mrkz)	4	PA; SL (0.072 ml per day.); SMCS; SP
GASTROINTESTINAL DRUGS - Drugs for the Stomach		
5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (netupitant-palonosetron)	4	SL (1 capsule per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANZEMET ORAL TABLET 50 MG (dolasetron mesylate)	4	SL (6 tablets per prescription.)
granisetron hcl oral tablet 1 mg	2	
ondansetron hcl oral solution 4 mg/5ml	1	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	
ondansetron odt oral tablet dispersible 4 mg, 8 mg	1	
ANTIDIARRHEA AGENTS - Drugs for Diarrhea		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
LOMOTIL ORAL TABLET 2.5-0.025 MG (diphenoxylate-atropine)	4	
opium oral tincture 10 mg/ml (1%)	1	
XERMELO ORAL TABLET 250 MG (telotristat etiprate)	4	PA; SL (3 tablets per day.); SMCS; SP
ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
MARINOL ORAL CAPSULE 2.5 MG (dronabinol)	4	
promethazine hcl oral solution 6.25 mg/5ml	1	
promethazine hcl oral syrup 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethegan rectal suppository 12.5 mg, 25 mg, 50 mg	1	
scopolamine transdermal patch 72 hour 1 mg/3days	3	
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	4	PA; SL (4 ml per day.)
ANTIFLATULENTS - Drugs for Gas		
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
compro rectal suppository 25 mg	1	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	
trimethobenzamide hcl oral capsule 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation		
alosetron hcl oral tablet 0.5 mg, 1 mg	2	PA; SL (2 tablets per day)
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (mesalamine)	1	
balsalazide disodium oral capsule 750 mg	1	
mesalamine oral capsule delayed release 400 mg	2	
mesalamine oral tablet delayed release 1.2 gm	2	
mesalamine rectal enema 4 gm	1	
mesalamine rectal suppository 1000 mg	2	SL (1 suppository per day.)
mesalamine-cleanser rectal kit 4 gm	1	SL (4 grams per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
ANTIULCER AGENTS AND ACID SUPPRESSANTS - Drugs for Ulcers and Stomach Acid		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	1	
FIRST-METRONIDAZOLE ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
LIKMEZ ORAL SUSPENSION 500 MG/5ML (metronidazole)	4	
METRONIDAZOLE BENZO+SYRSPEND ORAL SUSPENSION RECONSTITUTED 50 MG/ML (metronidazole benzoate)	3	PA
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CATHARTICS AND LAXATIVES - Drugs for Constipation		
bisacodyl ec oral tablet delayed release 5 mg	E	H
bisacodyl oral tablet delayed release 5 mg	E	H
citroma oral solution 1.745 gm/30ml	E	H
clearlax oral powder 17 gm/scoop	E	H
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (sod picosulfate-mag ox-cit acid)	3	
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
ft clearlax oral powder 17 gm/scoop	E	H
ft laxative oral tablet delayed release 5 mg	E	H
ft magnesium citrate oral solution 1.745 gm/30ml	E	H
gavilax oral powder 17 gm/scoop	E	H
gavilyte-c oral solution reconstituted 240 gm	1	H
gavilyte-g oral solution reconstituted 236 gm	1	SL (4000 mL per prescription.); H
gentle laxative oral tablet delayed release 5 mg	E	H
gentlelax oral powder 17 gm/scoop	E	H
glycolax oral powder 17 gm/scoop	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (peg 3350-kcl-nabcb-nacl-nasulf)	4	SL (4000 mL per prescription.)
magnesium citrate oral solution 1.745 gm/30ml	E	H
mineral oil heavy oral oil	1	
mm clearlax oral powder 17 gm/scoop	E	H
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (peg-kcl-nacl-nasulf-na asc-c)	3	SL (1 kit per prescription.)
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	3	SL (354 ml per prescription.)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	SL (4000 ml per prescription.); H
peg-3350/electrolytes oral solution reconstituted 236 gm	1	SL (4000 mL per prescription.); H
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	3	SL (1 kit per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	3	SL (1 kit per prescription.)
PEG-PREP ORAL KIT 5-210 MG-GM (bisacodyl-peg-kcl-nabicar-nacl)	4	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (peg-kcl-nacl-nasulf-na asc-c)	3	SL (3 cartons per prescription.)
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
qc magnesium citrate oral solution 1.745 gm/30ml	E	H
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (peg 3350-kcl-nacl-nasulf-mgsul)	3	SL (2 doses (1 box) per prescription.)
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (na sulfate-k sulfate-mg sulf)	3	SL (354 ml per prescription.)
SUTAB ORAL TABLET 1479-225-188 MG (sodium sulfate-mag sulfate-kcl)	3	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
URSODIOL+SYRSPEND SF ORAL SUSPENSION 30 MG/ML (ursodiol)	3	PA
DIGESTANTS - Drugs for the Stomach		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (pancrelipase (lip-prot-amyl))	2	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (pancrelipase (lip-prot-amyl))	4	ST
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (pancrelipase (lip-prot-amyl))	4	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 (pancrelipase (lip-prot-amyl))	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
GI DRUGS, MISCELLANEOUS - Drugs for the Stomach		
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADBM SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
alvimopan oral capsule 12 mg	3	
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (adalimumab-atto)	3	PA; M; SL (0.4 ml per day.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
CHOLBAM ORAL CAPSULE 250 MG (cholic acid)	3	PA; SL (4 capsules per day.); SMCS; SP
CHOLBAM ORAL CAPSULE 50 MG (cholic acid)	3	PA; SMCS; SP
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (6 mL per 365 days.); SMCS; SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (1 kit per 21 days.); SMCS; SP
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
ENTEREG ORAL CAPSULE 12 MG (alvimopan)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
GATTEX SUBCUTANEOUS KIT 5 MG (teduglutide (rdna))	3	PA; M; SL (1 vial per day.); SMCS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (6 pens (1 kit) per year.); SMCS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (adalimumab)	3	PA; M; SL (2 kits per year.); SMCS; SP
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (3 syringes per year.); SMCS; SP
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (adalimumab)	3	PA; M; SL (3 pens per year.); SMCS; SP
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (linaclotide)	2	PA; SL (1 capsule per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	2	PA; SL (2 capsules per day.)
MOTEGRITY ORAL TABLET 1 MG, 2 MG (prucalopride succinate)	3	PA; SL (1 tablet per day.)
OCALIVA ORAL TABLET 10 MG, 5 MG (obeticholic acid)	4	PA; ST; SL (1 tablet per day.); SMCS; SP
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (mirikizumab-mrkz)	4	PA; SL (0.072 ml per day.); SMCS; SP
ORLISTAT ORAL CAPSULE 120 MG	3	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (methylnaltrexone bromide)	4	PA; M; SL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML (methylnaltrexone bromide)	4	PA; M; SL (0.4 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (risankizumab-rzaa)	3	PA; M; SL (1.2 ml per 42 days.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (risankizumab-rzaa)	3	PA; M; SL (2.4 mL per 42 days.); SMCS; SP
SYMPROIC ORAL TABLET 0.2 MG (naldemedine tosylate)	2	PA; SL (1 tablet per day.)
VIBERZI ORAL TABLET 100 MG, 75 MG (eluxadoline)	4	PA; SL (2 tablets per day.)
XENICAL ORAL CAPSULE 120 MG (orlistat)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (netupitant-palonosetron)	4	SL (1 capsule per prescription.)
aprepitant oral 80 & 125 mg	2	SL (3 capsules per prescription)
aprepitant oral capsule 125 mg, 40 mg	2	SL (1 capsule per prescription)
aprepitant oral capsule 80 & 125 mg	2	SL (3 capsules per prescription)
aprepitant oral capsule 80 mg	2	SL (2 capsules per prescription)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (aprepitant)	2	SL (3 pouches per prescription.)
PROKINETIC AGENTS - Drugs for the Stomach		
metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
REGLAN ORAL TABLET 10 MG, 5 MG (metoclopramide hcl)	4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (misoprostol)	4	
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	3	
misoprostol oral tablet 100 mcg, 200 mcg	1	
PROTECTANTS - Drugs for Ulcers and Stomach Acid		
sucralfate oral suspension 1 gm/10ml	3	
sucralfate oral tablet 1 gm	1	
PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid		
esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg	4	PA; ST; SL (1 packet per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
FIRST PANTOPRAZOLE ORAL SUSPENSION 4 MG/ML (pantoprazole sodium)	3	
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (lansoprazole)	3	PA
FIRST-OMEPRAZOLE ORAL SUSPENSION 2 MG/ML (omeprazole)	3	PA
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	3	PA; ST; SL (1 tablet per day.)
NEXIUM ORAL PACKET 10 MG, 20 MG, 40 MG (esomeprazole magnesium)	4	PA; ST; SL (1 packet per day)
NEXIUM ORAL PACKET 2.5 MG, 5 MG (esomeprazole magnesium)	4	PA; ST; SL (1 packet per day.)
OMECLAMOX-PAK ORAL 500-500-20 MG (amoxicillin-clarithro-omeprazole)	4	SL (1 carton (10 administrative cards, 80 tablets) per 6 months.)
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
OMEPRAZOLE+SYRSPEND SF ALKA ORAL SUSPENSION 2 MG/ML (omeprazole)	3	PA
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
rabeprazole sodium oral tablet delayed release 20 mg	2	SL (1 tablet per day)
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron		
CHEMET ORAL CAPSULE 100 MG (succimer)	2	
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	3	PA; SMCS; SP
deferasirox oral packet 180 mg, 360 mg, 90 mg	3	PA; SMCS; SP
deferasirox oral tablet 180 mg, 360 mg, 90 mg	3	PA; SMCS; SP
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	3	PA; SMCS; SP
deferiprone oral tablet 1000 mg	4	PA; SMCS
DEPEN TITRATABS ORAL TABLET 250 MG (penicillamine)	3	SMCS; SP
penicillamine oral tablet 250 mg	3	SMCS; SP
trientine hcl oral capsule 250 mg	4	PA; SMCS; SP
trientine hcl oral capsule 500 mg	4	PA; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR ANTAGONISTS		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (setmelanotide acetate)	3	PA; M; SMCS; SP
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (bremelanotide acetate)	4	PA; M; SL (4 autoinjector pens (1.2mls) per month.)
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones		
ADRENALS - Hormones		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (fluticasone-salmeterol)	3	SL (0.4 grams per day.)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	SL (10.7 grams per prescription.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (fluticasone furoate)	2	SL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (fluticasone furoate)	2	SL (1 packet per day.)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (fluticasone furoate-vilanterol)	3	SL (2 blisters per day.)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (budeson-glycopyrrol-formoterol)	3	SL (0.36 grams per day.)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	SL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	2	SL (60 ml (1 box) per 30 days.)
budesonide oral capsule delayed release particles 3 mg	2	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (hydrocortisone)	4	
dexamethasone intensol oral concentrate 1 mg/ml	1	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
fludrocortisone acetate oral tablet 0.1 mg	1	
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluticasone propionate nasal suspension 50 mcg/act	2	SL (16 grams (1 bottle) per prescription)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	SL (2 blisters per day)
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	3	SL (0.04 mcg per day.)
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (methylprednisolone)	4	
MEDROL ORAL TABLET 2 MG (methylprednisolone)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (methylprednisolone)	4	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (prednisolone sodium phosphate)	4	
PEDIAPRED ORAL SOLUTION 6.7 (5 BASE) MG/5ML (prednisolone sodium phosphate)	2	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	3	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	1	
prednisone intensol oral concentrate 5 mg/ml	1	
prednisone oral solution 5 mg/5ml	1	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	2	SL (10.6 grams per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (beclomethasone diprop hfa)	2	SL (42.4 grams per month.)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (budesonide-formoterol fumarate)	3	SL (0.35 grams per day.)
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (dexamethasone)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21) (dexamethasone)	4	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (dexamethasone)	3	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	3	SL (2 blisters per day.)
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	SL (2 blisters per day)
ALPHA-GLUCOSIDASE INHIBITORS - Drugs for Diabetes		
acarbose oral tablet 100 mg, 25 mg, 50 mg	1	
miglitol oral tablet 100 mg, 25 mg, 50 mg	2	
ANDROGENS - Hormones		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR (testosterone)	2	PA; SL (1 patch per day)
COVARYX HS ORAL TABLET 0.625-1.25 MG (est estrogens-methyltest)	3	
COVARYX ORAL TABLET 1.25-2.5 MG (est estrogens-methyltest)	2	
danazol oral capsule 100 mg, 200 mg, 50 mg	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (testosterone cypionate)	3	M
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (testosterone cypionate)	4	M
EC-RX TESTOSTERONE TRANSDERMAL CREAM 0.2 %, 0.4 %, 10 %, 20 %	3	PA
EEMT HS ORAL TABLET 0.625-1.25 MG (est estrogens-methyltest)	3	
EEMT ORAL TABLET 1.25-2.5 MG (est estrogens-methyltest)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
est estrogens-methyltest ds oral tablet 1.25-2.5 mg	1	
est estrogens-methyltest hs oral tablet 0.625-1.25 mg	1	
est estrogens-methyltest oral tablet 1.25-2.5 mg	1	
KYZATREX ORAL CAPSULE 100 MG (testosterone undecanoate)	4	PA; SL (2 capsules per day.)
KYZATREX ORAL CAPSULE 150 MG, 200 MG (testosterone undecanoate)	4	PA; SL (4 capsules per day.)
METHITEST ORAL TABLET 10 MG	2	
methyltestosterone oral capsule 10 mg	2	
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (testosterone)	2	PA; SL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day)
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	M
testosterone enanthate intramuscular solution 200 mg/ml	1	M
testosterone gel 20.25 mg/act (1.62%) transdermal	2	PA; SL (31 packets per month)
testosterone transdermal gel 1.62 %	2	PA; SL (31 packets per month)
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
colesevelam hcl oral packet 3.75 gm	2	
colesevelam hcl oral tablet 625 mg	2	
KORLYM ORAL TABLET 300 MG (mifepristone)	4	PA; SL (4 tablets per day.); SMCS; SP
mifepristone oral tablet 300 mg	4	PA; SL (4 tablets per day.); SMCS; SP
ANTIESTROGENS - Drugs for Women		
anastrozole oral tablet 1 mg	1	H
exemestane oral tablet 25 mg	2	H
KISQALI FEMARA ORAL TABLET THERAPY PACK 200 & 2.5 MG (ribociclib-letrozole)	4	PA; ST; SMCS; CM
letrozole oral tablet 2.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANTIGONADTROPINS - Hormones		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (degarelix acetate)	4	M; SMCS; SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (degarelix acetate)	4	M; SMCS; SP
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix-estradiol-norethind)	2	PA; SL (1 tablet day.)
ORGOVYX ORAL TABLET 120 MG (relugolix)	4	PA; SL (1 tablet per day); SMCS; SP; CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; SL (2 capsules per day.)
ORLISSA ORAL TABLET 150 MG (elagolix sodium)	2	PA; SL (1 tablet per day.)
ORLISSA ORAL TABLET 200 MG (elagolix sodium)	2	PA; SL (2 tablets per day.)
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	3	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (diazoxide)	4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
calcitonin (salmon) injection solution 200 unit/ml	3	M
calcitonin (salmon) nasal solution 200 unit/act	2	
cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg	3	PA
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (calcitonin (salmon))	3	M
ANTITHYROID AGENTS - Drugs for the Thyroid		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	1	
BIGUANIDES - Drugs for Diabetes		
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	2	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (linagliptin-metformin hcl)	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (linagliptin-metformin hcl)	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (linagliptin-metformin hcl)	2	SL (1 tablet per day.)
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	1	
metformin hcl oral solution 500 mg/5ml	3	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	SL (3 tablets per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	2	SL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	2	SL (31 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (empagliflozin-metformin hcl)	2	SL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (empagliflozin-metformin hcl)	2	SL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (empagliflozin-metformin hcl)	2	SL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (empagliflozin-linagliptin-metformin)	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 (empagliflozin-linagliptin-metformin)	2	SL (2 tablets per day.)
CONTRACEPTIVES - Drugs for Women		
afirmelle oral tablet 0.1-20 mg-mcg	1	H
aftera oral tablet 1.5 mg	1	H
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amethyst oral tablet 90-20 mcg	3	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (segesterone-ethinyl estradiol)	3	SL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 & 0.01 mg	3	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (levonorgest-eth estrad-fe bisg)	4	ST; H
balziva oral tablet 0.4-35 mg-mcg	1	H
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	3	H
camrese oral tablet 0.15-0.03 & 0.01 mg	3	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
cryselle-28 oral tablet 0.3-30 mg-mcg	1	H
curae oral tablet 1.5 mg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 & 0.01 mg	3	H
deblitane oral tablet 0.35 mg	1	H
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (medroxyprogesterone acetate)	4	SL (5 ml per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (medroxyprogesterone acetate)	4	SL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (medroxyprogesterone acetate)	2	SL (3.25 ml per year.); H
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
dolishale oral tablet 90-20 mcg	3	H
drosipren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	4	H
econtra one-step oral tablet 1.5 mg	1	H
elinest oral tablet 0.3-30 mg-mcg	1	H
ELLA ORAL TABLET 30 MG (ulipristal acetate)	1	SL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H
errin oral tablet 0.35 mg	1	H
estarylla oral tablet 0.25-35 mg-mcg	1	H
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
gemmily oral capsule 1-20 mg-mcg(24)	4	H
hailey 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey 24 fe oral tablet 1-20 mg-mcg(24)	1	H
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey fe 1/20 oral tablet 1-20 mg-mcg	1	H
haloette vaginal ring 0.12-0.015 mg/24hr	1	H
heather oral tablet 0.35 mg	1	H
her style oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
iclevia oral tablet 0.15-0.03 mg	2	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	2	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 & 0.01 mg	3	H
jencycla oral tablet 0.35 mg	1	H
jolessa oral tablet 0.15-0.03 mg	2	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	4	H
juleber oral tablet 0.15-30 mg-mcg	1	H
junel 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel fe 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 24 oral tablet 1-20 mg-mcg(24)	1	H
kaitlib fe oral tablet chewable 0.8-25 mg-mcg	4	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
kelnor 1/35 oral tablet 1-35 mg-mcg	1	H
kelnor 1/50 oral tablet 1-50 mg-mcg	1	H
kurvelo oral tablet 0.15-30 mg-mcg	1	H
larin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin 1/20 oral tablet 1-20 mg-mcg	1	H
larin 24 fe oral tablet 1-20 mg-mcg(24)	1	H
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin fe 1/20 oral tablet 1-20 mg-mcg	1	H
layolis fe oral tablet chewable 0.8-25 mg-mcg	4	H
leena oral tablet 0.5/1/0.5-35 mg-mcg	1	H
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth est & eth est oral tablet 42-21-21-7 days	4	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	2	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	4	H
levonorgestrel oral tablet 1.5 mg	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg	1	H
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	3	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	4	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	3	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lutra oral tablet 0.1-20 mg-mcg	1	H
lyleq oral tablet 0.35 mg	1	H
lyza oral tablet 0.35 mg	1	H
marlissa oral tablet 0.15-30 mg-mcg	1	H
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	1	SL (5 ml per year.); H
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	SL (5 mL per 365 days.); H
merzee oral capsule 1-20 mg-mcg(24)	4	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin 24 fe oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mono-lynyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (estradiol valerate-dienogest)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (drospirenone-estetrol)	4	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	3	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	4	H
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.8-25 mg-mcg	4	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
norlyroc oral tablet 0.35 mg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nymyo oral tablet 0.25-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
OPILL ORAL TABLET 0.075 MG (norgestrel)	1	H
option 2 oral tablet 1.5 mg	1	H
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
react oral tablet 1.5 mg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	4	H
setlakin oral tablet 0.15-0.03 mg	2	H
sharobel oral tablet 0.35 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
simpesse oral tablet 0.15-0.03 & 0.01 mg	3	H
SLYND ORAL TABLET 4 MG (drospirenone)	4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
take action oral tablet 1.5 mg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	4	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
trivora (28) oral tablet 50-30/75-40/ 125-30 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (levonorgestrel-eth estradiol)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (levonorgestrel-ethinyl estrad)	1	
tydemy oral tablet 3-0.03-0.451 mg	4	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	3	H
xulane transdermal patch weekly 150-35 mcg/24hr	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (drospirenone-ethinyl estradiol)	2	H
YAZ ORAL TABLET 3-0.02 MG (drospirenone-ethinyl estradiol)	2	H
zafemy transdermal patch weekly 150-35 mcg/24hr	3	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (empagliflozin-linagliptin)	2	ST; SL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (linagliptin-metformin hcl)	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (linagliptin-metformin hcl)	2	SL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (linagliptin-metformin hcl)	2	SL (1 tablet per day.)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	2	SL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	2	SL (31 tablets per month.)
TRADJENTA ORAL TABLET 5 MG (linagliptin)	2	SL (1 tablet per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (empagliflozin-linagliptin-metformin)	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 (empagliflozin-linagliptin-metformin)	2	SL (2 tablets per day.)
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
DUAVEE ORAL TABLET 0.45-20 MG (conj estrogens-bazedoxifene)	4	SL (1 tablet per day.)
OSPHEA ORAL TABLET 60 MG (ospemifene)	3	PA; SL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	2	H
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H
toremifene citrate oral tablet 60 mg	3	CM
ESTROGENS - Drugs for Women		
ACTIVELLA ORAL TABLET 1-0.5 MG (estradiol-norethindrone acet)	4	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (estradiol)	3	SL (8 patches (1 box) per 28 days.)
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amabelz oral tablet 0.5-0.1 mg	2	
amethyst oral tablet 90-20 mcg	3	H
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (drospirenone-estradiol)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (segesterone-ethinyl estradiol)	3	SL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 & 0.01 mg	3	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (levonorgest-eth estrad-fe bisg)	4	ST; H
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (estradiol-progesterone)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	3	H
camrese oral tablet 0.15-0.03 & 0.01 mg	3	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (estradiol-levonorgestrel)	3	SL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (estradiol-norethindrone acet)	3	SL (8 patches per 28 days.)
COVARYX HS ORAL TABLET 0.625-1.25 MG (est estrogens-methyltest)	3	
COVARYX ORAL TABLET 1.25-2.5 MG (est estrogens-methyltest)	2	
cryselle-28 oral tablet 0.3-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 &0.01 mg	3	H
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML (estradiol valerate)	4	M
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	3	M
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
DIVIGEL 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 (estradiol)	3	
dolishale oral tablet 90-20 mcg	3	H
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	2	SL (8 patches (1 box) per 28 days.)
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	4	H
DUAVEE ORAL TABLET 0.45-20 MG (conj estrogens-bazedoxifene)	4	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 (est estrogens-methyltest)	3	
EEMT ORAL TABLET 1.25-2.5 MG (est estrogens-methyltest)	2	
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (estradiol)	3	
elinest oral tablet 0.3-30 mg-mcg	1	H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H
est estrogens-methyltest ds oral tablet 1.25-2.5 mg	1	
est estrogens-methyltest hs oral tablet 0.625-1.25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
est estrogens-methyltest oral tablet 1.25-2.5 mg	1	
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol patch twice weekly 0.025 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.025 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.05 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.05 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.075 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.075 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.1 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.1 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
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	3	
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	1	SL (4 patches (1 carton) per 28 days.)
estradiol vaginal cream 0.1 mg/gm	4	
estradiol vaginal tablet 10 mcg	2	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	M
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	2	
ESTRING VAGINAL RING 7.5 MCG/24HR (estradiol)	2	SL (1 ring per 90 days.)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (estradiol)	3	SL (50 grams (1 box) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (estradiol)	2	
falmina oral tablet 0.1-20 mg-mcg	1	H
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (estradiol acetate)	4	SL (1 ring per 3 months.)
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	3	
gemmily oral capsule 1-20 mg-mcg(24)	4	H
hailey 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey 24 fe oral tablet 1-20 mg-mcg(24)	1	H
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey fe 1/20 oral tablet 1-20 mg-mcg	1	H
haloette vaginal ring 0.12-0.015 mg/24hr	1	H
iclevia oral tablet 0.15-0.03 mg	2	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG (estradiol)	2	SL (0.29 vaginal insert per day.)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (estradiol)	2	SL (0.29 insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (estradiol)	2	SL (18 inserts per year.)
introvale oral tablet 0.15-0.03 mg	2	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 & 0.01 mg	3	H
jinteli oral tablet 1-5 mg-mcg	3	
jolessa oral tablet 0.15-0.03 mg	2	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	4	H
juleber oral tablet 0.15-30 mg-mcg	1	H
junel 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
junel fe 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 24 oral tablet 1-20 mg-mcg(24)	1	H
kaitlib fe oral tablet chewable 0.8-25 mg-mcg	4	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
kelnor 1/35 oral tablet 1-35 mg-mcg	1	H
kelnor 1/50 oral tablet 1-50 mg-mcg	1	H
kurvelo oral tablet 0.15-30 mg-mcg	1	H
larin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin 1/20 oral tablet 1-20 mg-mcg	1	H
larin 24 fe oral tablet 1-20 mg-mcg(24)	1	H
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin fe 1/20 oral tablet 1-20 mg-mcg	1	H
layolis fe oral tablet chewable 0.8-25 mg-mcg	4	H
leena oral tablet 0.5/1/0.5-35 mg-mcg	1	H
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth est & eth est oral tablet 42-21-21-7 days	4	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg	3	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	2	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	4	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg	1	H
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	3	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	4	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	3	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lutera oral tablet 0.1-20 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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	2	SL (8 patches (1 box) per 28 days.)
marlissa oral tablet 0.15-30 mg-mcg	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.)
merzee oral capsule 1-20 mg-mcg(24)	4	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin 24 fe oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	2	
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix-estradiol-norethind)	2	PA; SL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (estradiol valerate-dienogest)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (drospirenone-estetrol)	4	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	3	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	4	H
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.8-25 mg-mcg	4	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nymyo oral tablet 0.25-35 mg-mcg	1	H
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; SL (2 capsules per day.)
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrea oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
portia-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 (estrogens conjugated)	4	
PREMARIN VAGINAL CREAM 0.625 MG/GM (estrogens, conjugated)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (conj estrog-medroxyprogest ace)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (conj estrog-medroxyprogest ace)	4	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	4	H
setlakin oral tablet 0.15-0.03 mg	2	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
simpesse oral tablet 0.15-0.03 & 0.01 mg	3	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	4	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
trivora (28) oral tablet 50-30/75-40/ 125-30 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (levonorgestrel-eth estradiol)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (levonorgestrel-ethinyl estrad)	1	
tydemy oral tablet 3-0.03-0.451 mg	4	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
wymzya fe oral tablet chewable 0.4-35 mg-mcg	3	H
xulane transdermal patch weekly 150-35 mcg/24hr	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (drospirenone-ethinyl estradiol)	2	H
YAZ ORAL TABLET 3-0.02 MG (drospirenone-ethinyl estradiol)	2	H
yuvaferm vaginal tablet 10 mcg	2	
zafemy transdermal patch weekly 150-35 mcg/24hr	3	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
GLYCOGENOLYTIC AGENTS - Hormones		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (glucagon)	2	SL (2 intranasal devices per prescription.)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (glucagon)	2	SL (2 intranasal devices per prescription.)
glucagon emergency kit injection kit 1 mg	2	SL (2 boxes per prescription.)
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	SL (2 boxes per prescription.)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (glucagon)	2	M; SL (0.2 ml per prescription.)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (glucagon)	2	M; SL (0.4 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (glucagon)	2	M; SL (0.2 ml per prescription.)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (glucagon)	2	M; SL (0.4 ml per prescription.)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (glucagon)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (glucagon)	2	SL (2 syringes per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (dasiglucagon hcl)	2	SL (1.2 ml per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (dasiglucagon hcl)	2	SL (1.2 ml per prescription.)
GONADOTROPINS - Hormones		
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; M; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SYNAREL NASAL SOLUTION 2 MG/ML (nafarelin acetate)	2	
INCRETIN MIMETICS - Drugs for Diabetes		
BYDUREON BCISE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (exenatide)	3	PA; ST; SL (3.4 ml per month.)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (exenatide)	3	PA; ST; SL (2.4 mL (one pen) per prescription)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (exenatide)	3	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 (tirzepatide)	3	PA; ST; SL (0.08 ml per day.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (semaglutide)	3	PA; ST; SL (6 ml per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (semaglutide)	3	PA; ST; SL (9 ml per 3 months.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (semaglutide)	3	PA; ST; SL (3 ml per 21 days.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (semaglutide)	3	PA; ST; SL (1 tablet per day.)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (liraglutide -weight management)	3	PA; M; SL (0.6 ml per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (insulin glargine-lixisenatide)	2	SL (18 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (dulaglutide)	3	PA; ST; SL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (dulaglutide)	3	PA; ST; SL (2 mL per 21 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (liraglutide)	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 (semaglutide-weight management)	3	PA; M; SL (0.08 ml per day and 4 ml per 365 days.)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (semaglutide-weight management)	3	PA; M; SL (0.11 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (insulin nph isophane & regular)	2	SL (75 ml per prescription.)
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (insulin nph isophane & regular)	2	SL (70 ml per prescription.)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (insulin nph human (isophane))	2	SL (75 ml per prescription.)
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (insulin nph human (isophane))	2	SL (70 ml per prescription.)
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (metreleptin)	4	PA; M; SL (0.9 vial per day.); SMCS; SP
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (insulin glargine)	2	SL (75 ml per prescription.)
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine)	2	SL (70 ml per prescription.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (insulin glargine-lixisenatide)	2	SL (18 ml per month.)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (insulin glargine)	3	SL (75 ml per prescription.)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (insulin glargine)	3	SL (37.5 ml per prescription.)
MEGLITINIDES - Drugs for Diabetes		
nateglinide oral tablet 120 mg, 60 mg	2	SL (3 tablets per day)
repaglinide oral tablet 0.5 mg, 1 mg	2	SL (4 tablets per day)
repaglinide oral tablet 2 mg	2	SL (8 tablets per day)
PITUITARY - Hormones		
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	M
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	M
desmopressin acetate spray nasal solution 0.01 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (somatrogon-ghla)	4	PA; M; SL (0.172 ml per day.); SMCS; SP
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG (desmopressin acetate)	3	PA; SL (1 tablet per day.)
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (somatropin)	3	PA; M; SL (13.5 mL per month.); SMCS
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML (somatropin)	3	PA; M; SL (9 mL per month.); SMCS; SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (somatropin)	3	PA; M; SL (27 mL per month.); SMCS
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (somatropin)	3	PA; M; SL (18 ml per month.); SMCS; SP
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (somatropin)	3	PA; M; SL (10 ml (5 cartridges) per month.); SMCS; SP
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (somatropin)	3	PA; M; SL (36 ml per month.); SMCS; SP
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (somatropin)	3	PA; M; SL (13.5 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (somatropin)	3	PA; M; SL (27 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (somatropin)	3	PA; M; SL (16 vials per month.); SMCS; 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 (lonapegsomatropin-tcgd)	4	PA; M; SL (0.143 cartridge per day.); SMCS; SP
PROGESTINS - Drugs for Women		
ACTIVELLA ORAL TABLET 1-0.5 MG (estradiol-norethindrone acet)	4	
afirmelle oral tablet 0.1-20 mg-mcg	1	H
aftera oral tablet 1.5 mg	1	H
altavera oral tablet 0.15-30 mg-mcg	1	H
alyacen 1/35 oral tablet 1-35 mg-mcg	1	H
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
amabelz oral tablet 0.5-0.1 mg	2	
amethyst oral tablet 90-20 mcg	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (drospirenone-estradiol)	3	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (segesterone-ethinyl estradiol)	3	SL (1 vaginal ring per 327 days); H
apri oral tablet 0.15-30 mg-mcg	1	H
aranelle oral tablet 0.5/1/0.5-35 mg-mcg	1	H
ashlyna oral tablet 0.15-0.03 & 0.01 mg	3	H
aubra eq oral tablet 0.1-20 mg-mcg	1	H
aurovela 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela 1/20 oral tablet 1-20 mg-mcg	1	H
aurovela 24 fe oral tablet 1-20 mg-mcg(24)	1	H
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
aurovela fe 1/20 oral tablet 1-20 mg-mcg	1	H
aviane oral tablet 0.1-20 mg-mcg	1	H
ayuna oral tablet 0.15-30 mg-mcg	1	H
azurette oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (levonorgest-eth estrad-fe bisg)	4	ST; H
balziva oral tablet 0.4-35 mg-mcg	1	H
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (estradiol-progesterone)	3	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	H
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
blisovi fe 1/20 oral tablet 1-20 mg-mcg	1	H
briellyn oral tablet 0.4-35 mg-mcg	1	H
camila oral tablet 0.35 mg	1	H
camrese lo oral tablet 0.1-0.02 & 0.01 mg	3	H
camrese oral tablet 0.15-0.03 & 0.01 mg	3	H
charlotte 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
chateal eq oral tablet 0.15-30 mg-mcg	1	H
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (estradiol-levonorgestrel)	3	SL (4 patches per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (estradiol-norethindrone acet)	3	SL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (progesterone)	4	ST
cryselle-28 oral tablet 0.3-30 mg-mcg	1	H
curae oral tablet 1.5 mg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 oral tablet 1-35 mg-mcg	1	H
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
daysee oral tablet 0.15-0.03 &0.01 mg	3	H
deblitane oral tablet 0.35 mg	1	H
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (medroxyprogesterone acetate)	4	SL (5 ml per year.)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (medroxyprogesterone acetate)	4	SL (5 mL per 365 days.)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (medroxyprogesterone acetate)	2	SL (3.25 ml per year.); H
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
dolishale oral tablet 90-20 mcg	3	H
drosipren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	4	H
econtra one-step oral tablet 1.5 mg	1	H
EC-RX PROGESTERONE TRANSDERMAL CREAM 10 %, 20 %	3	PA
elinest oral tablet 0.3-30 mg-mcg	1	H
ELLA ORAL TABLET 30 MG (ulipristal acetate)	1	SL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (progesterone)	2	
enilloring vaginal ring 0.12-0.015 mg/24hr	1	H
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	1	H
enskyce oral tablet 0.15-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
errin oral tablet 0.35 mg	1	H
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	2	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	H
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
FIRST-PROGESTERONE VGS VAGINAL SUPPOSITORY 100 MG, 200 MG (progesterone)	3	PA
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	3	
gemmily oral capsule 1-20 mg-mcg(24)	4	H
hailey 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey 24 fe oral tablet 1-20 mg-mcg(24)	1	H
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
hailey fe 1/20 oral tablet 1-20 mg-mcg	1	H
haloette vaginal ring 0.12-0.015 mg/24hr	1	H
heather oral tablet 0.35 mg	1	H
her style oral tablet 1.5 mg	1	H
iclevia oral tablet 0.15-0.03 mg	2	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	2	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 & 0.01 mg	3	H
jencycla oral tablet 0.35 mg	1	H
jinteli oral tablet 1-5 mg-mcg	3	
jolessa oral tablet 0.15-0.03 mg	2	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	4	H
juleber oral tablet 0.15-30 mg-mcg	1	H
junel 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
junel 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
junel fe 1/20 oral tablet 1-20 mg-mcg	1	H
junel fe 24 oral tablet 1-20 mg-mcg(24)	1	H
kaitlib fe oral tablet chewable 0.8-25 mg-mcg	4	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
kelnor 1/35 oral tablet 1-35 mg-mcg	1	H
kelnor 1/50 oral tablet 1-50 mg-mcg	1	H
kurvelo oral tablet 0.15-30 mg-mcg	1	H
larin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin 1/20 oral tablet 1-20 mg-mcg	1	H
larin 24 fe oral tablet 1-20 mg-mcg(24)	1	H
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
larin fe 1/20 oral tablet 1-20 mg-mcg	1	H
layolis fe oral tablet chewable 0.8-25 mg-mcg	4	H
leena oral tablet 0.5/1/0.5-35 mg-mcg	1	H
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth est & eth est oral tablet 42-21-21-7 days	4	H
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg	3	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	2	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	4	H
levonorgestrel oral tablet 1.5 mg	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg	1	H
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	3	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (norethin-eth estrad-fe biphas)	4	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	3	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
lutera oral tablet 0.1-20 mg-mcg	1	H
lyleq oral tablet 0.35 mg	1	H
lyza oral tablet 0.35 mg	1	H
marlissa oral tablet 0.15-30 mg-mcg	1	H
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	1	SL (5 ml per year.); H
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	SL (5 mL per 365 days.); H
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml	1	
megestrol acetate oral suspension 625 mg/5ml	3	
megestrol acetate oral tablet 20 mg, 40 mg	1	
merzee oral capsule 1-20 mg-mcg(24)	4	H
mibelas 24 fe oral tablet chewable 1-20 mg-mcg(24)	1	H
microgestin 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin 1/20 oral tablet 1-20 mg-mcg	1	H
microgestin 24 fe oral tablet 1-20 mg-mcg	1	H
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
microgestin fe 1/20 oral tablet 1-20 mg-mcg	1	H
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	2	
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
my choice oral tablet 1.5 mg	1	H
my way oral tablet 1.5 mg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix-estradiol-norethind)	2	PA; SL (1 tablet day.)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (estradiol valerate-dienogest)	1	H
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
new day oral tablet 1.5 mg	1	H
NEXTSTELLIS ORAL TABLET 3-14.2 MG (drospirenone-estetrol)	4	H
nora-be oral tablet 0.35 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	3	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	4	H
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H
norethindrone acetate oral tablet 5 mg	1	
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	H
norethindrone oral tablet 0.35 mg	1	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	3	
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg	3	H
norethin-eth estradiol-fe oral tablet chewable 0.8-25 mg-mcg	4	H
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
norgestimate-ethinyl estradiol triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
norlyroc oral tablet 0.35 mg	1	H
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	1	H
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	1	H
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	1	H
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nylia 1/35 oral tablet 1-35 mg-mcg	1	H
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	H
nymyo oral tablet 0.25-35 mg-mcg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
OPILL ORAL TABLET 0.075 MG (norgestrel)	1	H
option 2 oral tablet 1.5 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (elagolix-estradiol-norethind)	2	PA; SL (2 capsules per day.)
philith oral tablet 0.4-35 mg-mcg	1	H
pimtrex oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
PREMPHASE ORAL TABLET 0.625-5 MG (conj estrogen-medroxyprogesterone)	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (conj estrogen-medroxyprogesterone)	4	
progesterone intramuscular oil 50 mg/ml	1	M
PROGESTERONE MICRONIZED TRANSDERMAL CREAM 10 %	3	PA
progesterone oral capsule 100 mg, 200 mg	2	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (medroxyprogesterone acetate)	4	
react oral tablet 1.5 mg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	4	H
setlakin oral tablet 0.15-0.03 mg	2	H
sharobel oral tablet 0.35 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
simpesse oral tablet 0.15-0.03 & 0.01 mg	3	H
SLYND ORAL TABLET 4 MG (drospirenone)	4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
sronyx oral tablet 0.1-20 mg-mcg	1	H
take action oral tablet 1.5 mg	1	H
tarina 24 fe oral tablet 1-20 mg-mcg(24)	1	H
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	1	H
taysofy oral capsule 1-20 mg-mcg(24)	4	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
trivora (28) oral tablet 50-30/75-40/ 125-30 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	2	H
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
turqoz oral tablet 0.3-30 mg-mcg	1	H
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (levonorgestrel-eth estradiol)	4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (levonorgestrel-ethinyl estrad)	1	
tydemy oral tablet 3-0.03-0.451 mg	4	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vienva oral tablet 0.1-20 mg-mcg	1	H
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	2	H
vyfemla oral tablet 0.4-35 mg-mcg	1	H
vylibra oral tablet 0.25-35 mg-mcg	1	H
wera oral tablet 0.5-35 mg-mcg	1	H
wymzya fe oral tablet chewable 0.4-35 mg-mcg	3	H
xulane transdermal patch weekly 150-35 mcg/24hr	3	H
YASMIN 28 ORAL TABLET 3-0.03 MG (drospirenone-ethinyl estradiol)	2	H
YAZ ORAL TABLET 3-0.02 MG (drospirenone-ethinyl estradiol)	2	H
zafemy transdermal patch weekly 150-35 mcg/24hr	3	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
RAPID-ACTING INSULINS - Drugs for Diabetes		
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (insulin lispro)	2	SL (75 ml per prescription.)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (insulin lispro)	2	SL (75 ml (25 pens) per prescription.)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (insulin lispro prot & lispro)	2	SL (75 ml per prescription.)
HUMALOG MIX 50/50 VIAL SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (insulin lispro prot & lispro)	2	SL (70 ml per prescription.)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (insulin lispro prot & lispro)	2	SL (75 ml per prescription.)
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (insulin lispro prot & lispro)	2	SL (70 ml per prescription.)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (insulin lispro)	2	SL (75 ml per prescription.)
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (insulin lispro)	2	SL (75 ml per prescription.)
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SL (75 ml per prescription.)
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	2	SL (70 ml per prescription.)
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SL (75 ml per prescription.)
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	SL (75 ml per prescription.)
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (insulin lispro-aabc)	2	SL (75 ml per prescription.)
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (insulin lispro-aabc)	2	SL (70 ml per prescription.)
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (insulin nph isophane & regular)	2	SL (75 ml per prescription.)
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (insulin nph isophane & regular)	2	SL (70 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HUMULIN R SOLUTION 100 UNIT/ML INJECTION (insulin regular human)	1	SL (70 ml per prescription.)
HUMULIN R SOLUTION 100 UNIT/ML INJECTION (insulin regular human)	2	SL (70 ml per prescription.)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (insulin regular human)	2	SL (75 mL per prescription.)
HUMULIN R U-500 VIAL SUBCUTANEOUS SOLUTION 500 UNIT/ML (insulin regular human)	2	SL (80 ml per prescription.)
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (insulin regular(human) in nacl)	3	
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (bexagliflozin)	3	ST; SL (1 tablet per day.)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (empagliflozin-linagliptin)	2	ST; SL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG (empagliflozin)	2	SL (30 tablets per month.)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (empagliflozin-metformin hcl)	2	SL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (empagliflozin-metformin hcl)	2	SL (1 tablet per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (empagliflozin-metformin hcl)	2	SL (2 tablets per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (empagliflozin-linagliptin-metformin)	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 (empagliflozin-linagliptin-metformin)	2	SL (2 tablets per day.)
SOMATOSTATIN AGONISTS - Hormones		
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA; M; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SOMATOTROPIN AGONISTS - Hormones		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (mecasermin)	3	PA; M; SL (52 vials per month.); SMCS; SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (somatropin)	3	PA; M; SL (13.5 mL per month.); SMCS
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 30 MG/3ML (somatropin)	3	PA; M; SL (9 mL per month.); SMCS; SP
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (somatropin)	3	PA; M; SL (27 mL per month.); SMCS
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (somatropin)	3	PA; M; SL (18 ml per month.); SMCS; SP
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (somatropin)	3	PA; M; SL (10 ml (5 cartridges) per month.); SMCS; SP
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (somatropin)	3	PA; M; SL (36 ml per month.); SMCS; SP
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (somatropin)	3	PA; M; SL (13.5 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (somatropin)	3	PA; M; SL (27 mL per month.); SMCS
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (somatropin)	3	PA; M; SL (16 vials per month.); SMCS; SP
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (pioglitazone hcl-glimepiride)	3	SL (1 tablet per day)
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	2	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 2.5 MG, 5 MG (glipizide)	4	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	SL (1 tablet per day)
THIAZOLIDINEDIONES - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (pioglitazone hcl-glimepiride)	3	SL (1 tablet per day)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	SL (1 tablet per day)
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	SL (1 tablet per day)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	SL (3 tablets per day)
THYROID AGENTS - Drugs for the Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (thyroid)	3	
ERMEZA ORAL SOLUTION 150 MCG/5ML (levothyroxine sodium)	3	PA
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	1	
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	1	
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	1	
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	2	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	2	
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	3	
np thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
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	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing		
LOCAL ANESTHETICS (PARENTERAL) - Drugs for Numbing		
LETS KIT	3	PA
ZTLIDO EXTERNAL PATCH 1.8 % (lidocaine)	3	PA; SL (3 patches per day.)
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
dutasteride oral capsule 0.5 mg	2	
finasteride oral tablet 5 mg	1	
ALCOHOL DETERRENTS - Drugs for Alcohol Dependence		
disulfiram oral tablet 250 mg, 500 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTES - Drugs for Overdose or Poisoning		
acetylcysteine inhalation solution 10 %, 20 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (glucagon)	2	SL (2 intranasal devices per prescription.)
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (glucagon)	2	SL (2 intranasal devices per prescription.)
CHEMET ORAL CAPSULE 100 MG (succimer)	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (lanthanum carbonate)	3	ST
glucagon emergency kit injection kit 1 mg	2	SL (2 boxes per prescription.)
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	SL (2 boxes per prescription.)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (glucagon)	2	M; SL (0.2 ml per prescription.)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (glucagon)	2	M; SL (0.4 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (glucagon)	2	M; SL (0.2 ml per prescription.)
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (glucagon)	2	M; SL (0.4 ml per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (glucagon)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (glucagon)	2	SL (2 syringes per prescription.)
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	3	ST
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	
naloxone hcl injection solution cartridge 0.4 mg/ml	1	
naloxone hcl injection solution prefilled syringe 2 mg/2ml	1	
naltrexone hcl oral tablet 50 mg	1	
phytonadione oral tablet 5 mg	3	SL (5 tablets per prescription.)
RADIOGARDASE ORAL CAPSULE 0.5 GM (prussian blue insoluble)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	2	PA
sevelamer carbonate oral tablet 800 mg	2	
sevelamer hcl oral tablet 400 mg, 800 mg	3	
sodium polystyrene sulfonate oral powder	1	
SPS ORAL SUSPENSION 15 GM/60ML (sodium polystyrene sulfonate)	3	
VISTOGARD ORAL PACKET 10 GM (uridine triacetate)	3	SL (20 packets per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (dasiglucagon hcl)	2	SL (1.2 ml per prescription.)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (dasiglucagon hcl)	2	SL (1.2 ml per prescription.)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (naloxone hcl)	2	SL (1 ml per prescription.)
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	2	
colchicine oral tablet 0.6 mg	2	
colchicine-probenecid oral tablet 0.5-500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 375 MG (naproxen)	3	
EC-NAPROSYN ORAL TABLET DELAYED RELEASE 500 MG (naproxen)	4	
ec-naproxen oral tablet delayed release 375 mg, 500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	3	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (colchicine)	4	PA
INDOCIN RECTAL SUPPOSITORY 50 MG (indomethacin)	4	PA
indomethacin er oral capsule extended release 75 mg	2	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin rectal suppository 50 mg	3	PA
MITIGARE ORAL CAPSULE 0.6 MG (colchicine)	2	
naproxen dr oral tablet delayed release 500 mg	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen oral tablet delayed release 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	2	
probenecid oral tablet 500 mg	1	
ANTISENSE OLIGONUCLEOTIDES		
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML (inotersen sodium)	3	PA; M; SL (0.22 ml per day.); SMCS; SP
BONE RESORPTION INHIBITORS - Drugs for Bone Loss		
alendronate sodium oral solution 70 mg/75ml	1	
alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg	1	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (estradiol)	3	SL (8 patches (1 box) per 28 days.)
calcitonin (salmon) injection solution 200 unit/ml	3	M
calcitonin (salmon) nasal solution 200 unit/act	2	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML (estradiol valerate)	4	M
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	3	M
DIVIGEL 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 (estradiol)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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	2	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%) (estradiol)	3	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol patch twice weekly 0.025 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.025 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.05 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.05 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.075 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.075 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.1 mg/24hr transdermal	2	SL (8 patches (1 box) per 28 days.)
estradiol patch twice weekly 0.1 mg/24hr transdermal	4	SL (8 patches (1 box) per 28 days.)
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	3	
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	1	SL (4 patches (1 carton) per 28 days.)
estradiol vaginal cream 0.1 mg/gm	4	
estradiol vaginal tablet 10 mcg	2	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	M
ESTRING VAGINAL RING 7.5 MCG/24HR (estradiol)	2	SL (1 ring per 90 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) (estradiol)	3	SL (50 grams (1 box) per month.)
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (estradiol)	2	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (estradiol acetate)	4	SL (1 ring per 3 months.)
FOSAMAX ORAL TABLET 70 MG (alendronate sodium)	4	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (alendronate-cholecalciferol)	3	
ibandronate sodium oral tablet 150 mg	2	
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	2	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	M
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens conjugated)	4	
PREMARIN VAGINAL CREAM 0.625 MG/GM (estrogens, conjugated)	3	
raloxifene hcl oral tablet 60 mg	2	H
risedronate sodium oral tablet 150 mg	4	SL (1 tablet per month)
risedronate sodium oral tablet 30 mg, 5 mg	4	
risedronate sodium oral tablet 35 mg	4	SL (4 tablets per 28 days.)
yuvaferm vaginal tablet 10 mcg	2	
BRADYKININ RECEPTOR ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	3	PA; M; SL (0.6 ml per day.); SMCS; SP
CARBONIC ANHYDRASE INHIBITORS (MISC.)		
dichlorphenamide oral tablet 50 mg	3	PA; SL (4 tablets per day.); SMCS; SP
KEVEYIS ORAL TABLET 50 MG (dichlorphenamide)	4	PA; SL (4 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CARIOSTATIC AGENTS - Vitamins and Fluoride		
adc/f (0.5mg/ml) oral solution 0.5 mg/ml	1	
CLINPRO 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (sodium fluoride)	4	
DENTAGEL DENTAL GEL 1.1 % (sodium fluoride)	4	
easygel dental gel 0.4 %	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	
fluoridex daily renewal mouth/throat concentrate 0.63 %	1	
FLUORIDEX DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % (sod fluoride-potassium nitrate)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
FLUORIMAX 5000 SENSITIVE DENTAL PASTE 1.1-5 % (sod fluoride-potassium nitrate)	3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (sodium fluoride)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride tablet chewable 0.25 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	
multivitamin/fluoride tablet chewable 0.5 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
multivitamin/fluoride tablet chewable 1 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (pediatric multivitamins-fl)	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (ped multivitamins-fl-iron)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (ped multivitamins-fl-iron)	3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (sodium fluoride)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (sodium fluoride)	4	
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)	4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (sod fluoride-potassium nitrate)	3	
PREVIDENT DENTAL GEL 1.1 % (sodium fluoride)	4	
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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	
vitamins acid-fluoride oral solution 0.25 mg/ml	1	
COMPLEMENT INHIBITORS		
BERINERT INTRAVENOUS KIT 500 UNIT (c1 esterase inhibitor (human))	4	PA; ST; M; SL (0.4 boxes per day.); SMCS; SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (pegcetacoplan)	3	PA; M; SL (5.8 ml per day. 2,100 ml per 360 days.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (c1 esterase inhibitor (human))	3	PA; M; SL (24 vials per month.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (c1 esterase inhibitor (human))	3	PA; M; SL (16 vials per month.); SMCS; SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (c1 esterase inhibitor (recomb))	4	PA; M; SL (0.27 vials per day.); SMCS; SP
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (tocilizumab)	4	PA; ST; M; SL (3.6 ml per 21 days.); SMCS; SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (tocilizumab)	4	PA; ST; M; SL (4 syringes (3.6 ml) per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADBM SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML	3	PA; M; SMCS; SP
ADALIMUMAB-ADBM SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML	3	PA; M; SL (0.08 syringe per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (adalimumab-atto)	3	PA; M; SL (0.4 ml per day.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AZASAN ORAL TABLET 100 MG, 75 MG (azathioprine)	4	
azathioprine oral tablet 100 mg, 75 mg	3	
azathioprine oral tablet 50 mg	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (abrocitinib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (6 mL per 365 days.); SMCS; SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (1 kit per 21 days.); SMCS; SP
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.072 mL per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.036 mL per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (secukinumab)	4	PA; ST; M; SL (0.018 ml per day.); SMCS
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.072 mL per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.036 mL per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (secukinumab)	4	PA; ST; SL (0.072 ml per day.); SMCS; SP
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (6 auto-injector per 365 days.); SMCS; SP
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (4 auto-injector per 365 days.); SMCS; SP
DEPEN TITRATABS ORAL TABLET 250 MG (penicillamine)	3	SMCS; SP
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (6 pens (1 kit) per year.); SMCS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (adalimumab)	3	PA; M; SL (2 kits per year.); SMCS; SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (3 syringes per year.); SMCS; SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (adalimumab)	3	PA; M; SL (3 pens per year.); SMCS; SP
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (sarilumab)	4	PA; ST; M; SL (2.28 ml per month.); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (anakinra)	4	PA; ST; M; SL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	1	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
OLUMIANT ORAL TABLET 1 MG, 4 MG (baricitinib)	4	PA; SL (1 tablet per day.); SMCS
OLUMIANT ORAL TABLET 2 MG (baricitinib)	4	PA; SL (1 tablet per day.); SMCS; SP
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	4	PA; ST; M; SL (4 auto-injectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	4	PA; ST; M; SL (4 syringes per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (abatacept)	4	PA; ST; M; SL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (abatacept)	4	PA; ST; M; SL (0.1 ml per day.); SMCS; SP
OTEZLA ORAL TABLET 30 MG (apremilast)	3	PA; SL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	3	PA; SL (55 tablets (one starter pack) per year.); SMCS; SP
penicillamine oral tablet 250 mg	3	SMCS; SP
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (methotrexate (anti-rheumatic))	2	M; SL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (methotrexate (anti-rheumatic))	2	M; SL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (methotrexate (anti-rheumatic))	2	M; SL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (methotrexate (anti-rheumatic))	2	M; SL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (methotrexate (anti-rheumatic))	2	M; SL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (methotrexate (anti-rheumatic))	2	M; SL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (methotrexate (anti-rheumatic))	2	M; SL (2 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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 30 MG/0.6ML (methotrexate (anti-rheumatic))	2	M; SL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (methotrexate (anti-rheumatic))	2	M; SL (0.6 ml (4 auto-injectors) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (upadacitinib)	3	PA; SL (1 tablet per day.); SMCS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (upadacitinib)	3	PA; SL (84 tablets per 365 days.); SMCS; SP
SANDIMMUNE ORAL SOLUTION 100 MG/ML (cyclosporine)	4	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	4	PA; SL (4 ml per day.); CM
XELJANZ ORAL SOLUTION 1 MG/ML (tofacitinib citrate)	3	PA; SL (8 mL per day.); SMCS; SP
XELJANZ ORAL TABLET 10 MG, 5 MG (tofacitinib citrate)	3	PA; SL (2 tablets per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (tofacitinib citrate)	3	PA; SL (1 tablet per day.); SMCS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (tofacitinib citrate)	3	PA; SL (1 tablet per day.); SMCS
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (tocilizumab)	4	PA; ST; M; SL (3.6 ml per 21 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (tocilizumab)	4	PA; ST; M; SL (4 syringes (3.6 ml) per month.); SMCS; SP
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML (interferon gamma-1b)	3	PA; M; SL (8.5 mls per month.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	3	PA; M; SL (0.03 ml per day.); SMCS; SP
ADALIMUMAB-ADBM SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML (interferon alfa-n3)	3	M
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (adalimumab-atto)	3	PA; M; SL (0.4 ml per day.); SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (adalimumab-atto)	3	PA; M; SMCS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML (adalimumab-atto)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (interferon beta-1a)	3	PA; M; SL (4 pens (1 box) per month.); SMCS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (interferon beta-1a)	3	PA; M; SL (4 syringes (1 box) per month.); SMCS; SP
AZASAN ORAL TABLET 100 MG, 75 MG (azathioprine)	4	
azathioprine oral tablet 100 mg, 75 mg	3	
azathioprine oral tablet 50 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (monomethyl fumarate)	3	PA; SL (4 capsules per day.); SMCS; SP
BETASERON SUBCUTANEOUS KIT 0.3 MG (interferon beta-1b)	3	PA; M; SL (15 vials per month); SMCS
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (6 mL per 365 days.); SMCS; SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML (certolizumab pegol)	3	PA; M; SL (1 kit per 21 days.); SMCS; SP
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML (adalimumab-adbm)	3	PA; M; SL (0.08 syringe per day.); SMCS; SP
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; SL (56 capsules per year.); SMCS
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; SL (2 capsules per day.); SMCS
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; SL (60 capsules (1 starter pack) per 365 days.); SMCS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (etanercept)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
fingolimod hcl oral capsule 0.5 mg	1	PA; SL (1 capsule per day); SMCS
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	3	PA; M; SL (30 ml per month.); SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	3	PA; M; SL (12 ml per 21 days.); SMCS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	3	PA; M; SL (30 ml per month.); SMCS
glatopa subcutaneous solution prefilled syringe 40 mg/ml	3	PA; M; SL (12 ml per 21 days.); SMCS
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (adalimumab-bwwd)	3	PA; M; SL (0.03 ml per day.); SMCS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (adalimumab-bwwd)	3	PA; M; SL (0.06 ml per day.); SMCS; SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 pens per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS; SP
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (2 syringes per month.); SMCS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML (adalimumab)	3	PA; M; SL (6 pens (1 kit) per year.); SMCS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (adalimumab)	3	PA; M; SL (2 kits per year.); SMCS; SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (3 syringes per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (adalimumab)	3	PA; M; SL (4 pens per 365 days.); SMCS; SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (adalimumab)	3	PA; M; SL (3 pens per year.); SMCS; SP
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JOENJA ORAL TABLET 70 MG (leniolisib phosphate)	3	PA; SL (2 tablets per day.); SMCS; SP
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (ofatumumab)	3	PA; M; SL (0.02 ml per day.); SMCS; SP
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (anakinra)	4	PA; ST; M; SL (0.67 ml (1 syringe) per day.); SMCS; SP
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 2.5 mg, 5 mg	3	PA; SL (28 capsules per 21 days.); SMCS; SP; CM
lenalidomide oral capsule 15 mg, 20 mg, 25 mg	3	PA; SL (21 capsules per 21 days.); SMCS; SP; CM
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (cladribine)	4	PA; ST; SL (40 tablets per 720 days.); SMCS
MAYZENT ORAL TABLET 0.25 MG (siponimod fumarate)	4	PA; SL (4 tablets per day.); SMCS
MAYZENT ORAL TABLET 1 MG (siponimod fumarate)	4	PA; SL (1 tablet per day.); SMCS
MAYZENT ORAL TABLET 2 MG (siponimod fumarate)	4	PA; SL (1 tablet per day.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (siponimod fumarate)	4	PA; SL (12 tablets per 365 days.); SMCS
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (siponimod fumarate)	4	PA; SL (7 tablets per 365 days.); SMCS
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (abatacept)	4	PA; ST; M; SL (4 auto-injectors per month.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (abatacept)	4	PA; ST; M; SL (4 syringes per month); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (abatacept)	4	PA; ST; M; SL (0.06 ml per day.); SMCS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (abatacept)	4	PA; ST; M; SL (0.1 ml per day.); SMCS; SP
OTEZLA ORAL TABLET 30 MG (apremilast)	3	PA; SL (2 tablets per day.); SMCS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	3	PA; SL (55 tablets (one starter pack) per year.); SMCS; SP
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (peginterferon beta-1a)	4	PA; SL (1 ml per month.); SMCS
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML (peginterferon beta-1a)	4	PA; M; SL (1 ml per year.); SMCS; SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (peginterferon beta-1a)	4	PA; M; SL (1 ml per year.); SMCS; SP
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML (peginterferon beta-1a)	4	PA; M; SL (1 ml per month.); SMCS; SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (peginterferon beta-1a)	4	PA; M; SL (1 ml per month.); SMCS; SP
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	4	PA; SL (21 capsules per prescription.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (lenalidomide)	3	PA; SL (28 capsules per 21 days.); SMCS; SP; CM
REVLIMID ORAL CAPSULE 15 MG, 20 MG, 25 MG (lenalidomide)	3	PA; SL (21 capsules per 21 days.); SMCS; SP; CM
SANDIMMUNE ORAL SOLUTION 100 MG/ML (cyclosporine)	4	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (golimumab)	3	PA; M; SL (1 syringe per 21 days.); SMCS; SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (golimumab)	3	PA; M; SL (0.5 ml (1 syringe) per month); SMCS; SP
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
teriflunomide oral tablet 14 mg	3	PA; SL (1 tablet per day.); SMCS
teriflunomide oral tablet 7 mg	3	PA; SL (2 tablets per day.); SMCS
THALOMID ORAL CAPSULE 100 MG, 50 MG (thalidomide)	3	PA; SL (28 capsules per prescription.); SMCS; SP; CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	4	PA; SL (4 ml per day.); CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (ozanimod hcl)	4	PA; ST; SL (7 capsules per year.); SMCS
ZEPOSIA ORAL CAPSULE 0.92 MG (ozanimod hcl)	4	PA; ST; SL (1 capsule per day.); SMCS
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) (ozanimod hcl)	4	PA; ST; SMCS
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (azathioprine)	4	
azathioprine oral tablet 100 mg, 75 mg	3	
azathioprine oral tablet 50 mg	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (belimumab)	3	PA; M; SL (4 ml per month.); SMCS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (belimumab)	3	PA; M; SL (4 ml per month.); SMCS; SP
cyclophosphamide oral capsule 25 mg, 50 mg	3	CM
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 50 MG	3	CM
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
gengraf oral capsule 100 mg, 25 mg	1	
gengraf oral solution 100 mg/ml	1	
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	4	PA; SL (10 g per 23 days.)
leflunomide oral tablet 10 mg, 20 mg	1	
MAVENCLAD ORAL TABLET THERAPY PACK 10 MG (cladribine)	4	PA; ST; SL (40 tablets per 720 days.); SMCS
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	M
methotrexate sodium injection solution reconstituted 1 gm	1	M
methotrexate sodium oral tablet 2.5 mg	1	CM
mycophenolate mofetil oral capsule 250 mg	1	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	1	
mycophenolate mofetil oral tablet 500 mg	1	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	3	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	3	
pimecrolimus external cream 1 %	3	SL (30 grams per prescription.)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (tacrolimus)	4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (tacrolimus)	4	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (mercaptopurine)	4	SMCS; SP; CM
RAPAMUNE ORAL SOLUTION 1 MG/ML (sirolimus)	4	
SANDIMMUNE ORAL SOLUTION 100 MG/ML (cyclosporine)	4	
sirolimus oral solution 1 mg/ml	3	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
tacrolimus external ointment 0.03 %, 0.1 %	2	SL (30 grams per prescription.)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	4	PA; SL (4 ml per day.); CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (lanadelumab-flyo)	3	PA; M; SL (0.075 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (lanadelumab-flyo)	3	PA; SL (0.0375 ml per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (lanadelumab-flyo)	3	PA; SL (0.075 ml per day.); SMCS; SP
KALLIKREIN-KININ SYSTEM INHIBITORS		
BERINERT INTRAVENOUS KIT 500 UNIT (c1 esterase inhibitor (human))	4	PA; ST; M; SL (0.4 boxes per day.); SMCS; SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (pegcetacoplan)	3	PA; M; SL (5.8 ml per day. 2,100 ml per 360 days.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (c1 esterase inhibitor (human))	3	PA; M; SL (24 vials per month.); SMCS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (c1 esterase inhibitor (human))	3	PA; M; SL (16 vials per month.); SMCS; SP
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	3	PA; M; SL (0.6 ml per day.); SMCS; SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (c1 esterase inhibitor (recomb))	4	PA; M; SL (0.27 vials per day.); SMCS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (lanadelumab-flyo)	3	PA; M; SL (0.075 ml per day.); SMCS; SP
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (rilonacept)	3	PA; M; SMCS; SP
betaine oral powder	3	SMCS; SP
CERDELGA ORAL CAPSULE 84 MG (eliglustat tartrate)	3	PA; SMCS; SP
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (prenat-fecb-fefum-fa-dha w/o a)	3	
CYSTADANE ORAL POWDER (betaine)	4	SMCS; SP
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (cysteamine bitartrate)	3	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
dalfampridine er oral tablet extended release 12 hour 10 mg	3	PA; SL (2 tablets per day); SMCS
DEMSEER ORAL CAPSULE 250 MG (metyrosine)	4	
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (prasterone (dhea))	3	
ENBRACE HR ORAL CAPSULE (prenat vit-fe gly cys-fa-omega)	3	
ENDARI ORAL PACKET 5 GM (glutamine (sickle cell))	4	PA; SL (6 packets per day.)
EVOTAZ ORAL TABLET 300-150 MG (atazanavir-cobicistat)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (risdiplam)	3	PA; SL (6.7 ml per day, 1280 ml per 180 days.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (sparsentan)	4	PA; SL (1 tablet per day.); SMCS; SP
FIRDAPSE ORAL TABLET 10 MG (amifampridine phosphate)	3	PA; SL (8 tablets per day.); SMCS; SP
GALAFOLD ORAL CAPSULE 123 MG (migalastat hcl)	4	PA; SL (14 capsules per 21 days.); SMCS; SP
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine sf oral solution 1 gm/10ml	1	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
metyrosine oral capsule 250 mg	3	
miglustat oral capsule 100 mg	4	SMCS
NEONATAL + DHA ORAL 29-1 & 200 MG	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (prenat-fe-methylfol-dha w/o a)	3	
OPFOLDA ORAL CAPSULE 65 MG (miglustat (gaa deficiency))	3	PA; SL (8 capsules per 21 days.); SMCS; SP
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (nitisinone)	3	PA; SMCS; SP
ORFADIN ORAL SUSPENSION 4 MG/ML (nitisinone)	3	PA; SMCS; SP
PREMESISRX ORAL TABLET 1 MG (prenatal ca-b6-b12-fa-ginger)	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fecfn-feasp-meth-fa-dha)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PREZCOBIX ORAL TABLET 800-150 MG (darunavir-cobicistat)	2	
PRIMACARE ORAL CAPSULE 30-1-470 MG (pren-fe-meth-fa-omeg w/o a)	3	
PROCYSBI ORAL PACKET 300 MG, 75 MG (cysteamine bitartrate)	4	SMCS; SP
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
sapropterin dihydrochloride oral packet 100 mg	3	PA; SL (16 packets per day.); SMCS; SP
sapropterin dihydrochloride oral packet 500 mg	3	PA; SL (4 packets per day.); SMCS; SP
sapropterin dihydrochloride oral tablet 100 mg	3	PA; SL (16 tablets per day); SMCS; SP
SKYCLARYS ORAL CAPSULE 50 MG (omaveloxolone)	3	PA; SL (3 capsules per day.); SMCS; SP
SODIUM SULFACETAMIDE-BAKUCHIOL EXTERNAL LIQUID 10 %	3	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (palovarotene)	4	PA; SL (1 capsule per day.); SMCS; SP
STRIBILD ORAL TABLET 150-150-200-300 MG (elviteg-cobic-emtricit-tenofdf)	2	SL (1 tablet per day.)
SYMTUZA ORAL TABLET 800-150-200-10 MG (darun-cobic-emtricit-tenofaf)	3	SL (1 tablet per day.)
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG (tiopronin)	4	SMCS; SP
THIOLA ORAL TABLET 100 MG (tiopronin)	4	SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
tiopronin oral tablet 100 mg	4	SMCS; SP
tiopronin oral tablet delayed release 100 mg, 300 mg	1	SMCS; SP
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
TYBOST ORAL TABLET 150 MG (cobicistat)	2	
URELLE ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
uretron d/s oral tablet 81.6 mg	4	
URIMAR-T ORAL CAPSULE 120 MG (meth-hyo-m bl-na phos-ph sal)	4	
urin ds oral tablet 81.6 mg	4	
UROGESIC-BLUE ORAL TABLET 81.6 MG (methen-hyosc-meth blue-na phos)	2	
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (alpelisib)	4	PA; SL (84 tablets per 72 days.); SMCS; SP
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (alpelisib)	4	PA; SL (168 tablets per 72 days.); SMCS; SP
VILEVEV MB ORAL TABLET 81 MG (meth-hyo-m bl-na phos-ph sal)	4	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (prenat-fe poly-methfol-fa-dha)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (prenatal mv-min-fe fum-fa-dha)	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG (prenat w/o a-fe-methfol-fa-dha)	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG (prenat-fefum-fered-fa-dha w/oa)	3	
VOWST ORAL CAPSULE (fecal microb spores, live-brpk)	4	PA; SL (12 capsules per 365 days.); SMCS; SP
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (vosoritide)	4	PA; M; SL (1 vial per day.); SMCS; SP
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	3	PA; SL (1 capsule per day.); SMCS; SP
VYNDAQEL ORAL CAPSULE 20 MG (tafamidis meglumine (cardiac))	3	PA; SL (4 capsules per day.); SMCS; SP
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	4	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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 (uridine triacetate)	3	PA; SL (30 packets per prescription.); SMCS; SP
ZOKINVY ORAL CAPSULE 50 MG (lonafarnib)	3	PA; SL (5 capsules per day.); SMCS; SP
ZOKINVY ORAL CAPSULE 75 MG (lonafarnib)	3	PA; SL (1 tablet per day.); SMCS; SP
PROTECTIVE AGENTS		
MESNEX ORAL TABLET 400 MG (mesna)	4	SMCS; SP; CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (diaphragm arc-spring)	3	H
CONDOMS	3	SL (1 box of 12 condoms per 30 days.); H
DUREX EXTRA SENSITIVE THIN DEVICE (condoms latex lubricated)	3	SL (1 box of 12 condoms per 30 days.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (nonoxynol-9)	E	H
FC2 FEMALE CONDOM (condoms - female)	E	H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical caps)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (nonoxynol-9)	E	H
PHEXXI VAGINAL GEL 1.8-1-0.4 % (lactic ac-citric ac-pot bitart)	4	H
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (nonoxynol-9)	E	H
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (nonoxynol-9)	E	H
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (diaphragm wide seal)	2	H
OXYTOCICS - Drugs for Women		
OXYTOCICS - Drugs for Women		
CERVIDIL VAGINAL INSERT 10 MG (dinoprostone)	3	
methergine oral tablet 0.2 mg	1	SL (28 tablets per year.)
methylergonovine maleate oral tablet 0.2 mg	1	SL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG (mifepristone)	3	
mifepristone oral tablet 200 mg	1	
PREPIDIL VAGINAL GEL 0.5 MG/3GM (dinoprostone)	3	
PHARMACEUTICAL AIDS		
PHARMACEUTICAL AIDS		
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (transdermal base)	3	
RESPIRATORY TRACT AGENTS - Drugs for the Lungs		
ALPHA AND BETA ADRENERGIC AGONIST(RESPR) - Drugs for Asthma/COPD		
ADRENALIN NASAL SOLUTION 0.1 % (epinephrine hcl (nasal))	2	
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML (epinephrine)	2	SL (2 pens per prescription.)
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML, 0.3 MG/0.3ML (epinephrine)	2	SL (2 injections per prescription.)
epinephrine hcl (nasal) nasal solution 0.1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml	1	SL (2 injections per prescription.)
epinephrine injection solution auto-injector 0.15 mg/0.3ml	1	SL (4 injections per prescription.)
ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (ipratropium bromide hfa)	3	SL (0.87 grams per day.)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (ipratropium-albuterol)	4	SL (0.28 grams per day.)
ipratropium bromide inhalation solution 0.02 %	1	
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (tiotropium bromide monohydrate)	2	SL (1 capsule per day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (tiotropium bromide monohydrate)	2	SL (0.15 grams per day.)
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
pirfenidone oral capsule 267 mg	2	PA; SL (9 capsules per day.); SMCS; SP
pirfenidone oral tablet 267 mg	3	PA; SL (9 tablets per day.); SMCS; SP
pirfenidone oral tablet 534 mg	3	PA; SL (3 tablets per day.); SMCS
pirfenidone oral tablet 801 mg	3	PA; SL (3 tablets per day.); SMCS; SP
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (mepolizumab)	4	PA; M; SL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (mepolizumab)	4	PA; M; SL (0.04 mL per day.); SMCS; SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (mepolizumab)	4	PA; M; SL (0.015 ml per day.); SMCS
ANTITUSSIVES - Drugs for Cough and Cold		
benzonatate oral capsule 100 mg, 200 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
BROMFED DM ORAL SYRUP 2-30-10 MG/5ML (pseudoeph-bromphen-dm)	3	
codeine sulfate oral tablet 30 mg, 60 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (diphenhydramine hcl)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml	1	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	3	PA; SL (360 ml per month.)
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA; SL (120 mL per prescription and 360 ml per month.)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
hydromet oral solution 5-1.5 mg/5ml	1	PA; SL (120 mL per prescription and 360 ml per month.)
maxi-tuss ac oral solution 100-10 mg/5ml	1	
promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml	1	PA; SL (360 ml per month.)
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA; SL (360 ml per month.)
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (chlorpheniramine-codeine)	3	PA; SL (10 tablets per prescription and 30 tablets per month.)
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (lumacaftor-ivacaftor)	2	PA; SL (728 packets per 356 days.); SMCS; SP
ORKAMBI ORAL PACKET 75-94 MG (lumacaftor-ivacaftor)	2	PA; SL (2 packets per day and 56 packets per 21 days.); SMCS
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (lumacaftor-ivacaftor)	3	PA; SL (1456 tablets per 356 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (tezacaftor-ivacaftor)	3	PA; SL (728 tablets per 356 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (tezacaftor-ivacaftor)	3	PA; SL (728 tablets per 356 days.); SMCS
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (1092 tablets per 356 days.); SMCS; SP
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (3 tablets per day. 1092 tablets per 364 days.); SMCS; SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (2 packets per day. 728 packets per 356 days.); SMCS; SP
CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs		
KALYDECO ORAL PACKET 13.4 MG (ivacaftor)	3	PA; SL (2 packets per day. 728 packets per 356 days.); SMCS
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (ivacaftor)	3	PA; SL (728 packets per 356 days.); SMCS; SP
KALYDECO ORAL PACKET 5.8 MG (ivacaftor)	3	PA; SL (2 packets per day and 728 packets per 365 days.); SMCS
KALYDECO ORAL TABLET 150 MG (ivacaftor)	3	PA; SL (780 tablets per 356 days.); SMCS; SP
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (lumacaftor-ivacaftor)	2	PA; SL (728 packets per 356 days.); SMCS; SP
ORKAMBI ORAL PACKET 75-94 MG (lumacaftor-ivacaftor)	2	PA; SL (2 packets per day and 56 packets per 21 days.); SMCS
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (lumacaftor-ivacaftor)	3	PA; SL (1456 tablets per 356 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG (tezacaftor-ivacaftor)	3	PA; SL (728 tablets per 356 days.); SMCS; SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG (tezacaftor-ivacaftor)	3	PA; SL (728 tablets per 356 days.); SMCS
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (1092 tablets per 356 days.); SMCS; SP
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (3 tablets per day. 1092 tablets per 364 days.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (elexacaftor-tezacaftor-ivacaft)	3	PA; SL (2 packets per day. 728 packets per 356 days.); SMCS; SP
ENDOTHELIN RECEPTOR ANTAGONISTS - Drugs for the Lungs		
ambrisentan oral tablet 10 mg, 5 mg	3	PA; SL (1 tablet per day.); SMCS; SP
bosentan oral tablet 125 mg, 62.5 mg	3	PA; SL (2 tablets per day.); SMCS; SP
FILSPARI ORAL TABLET 200 MG, 400 MG (sparsentan)	4	PA; SL (1 tablet per day.); SMCS; SP
OPSUMIT ORAL TABLET 10 MG (macitentan)	3	PA; SL (1 tablet per day.); SMCS; SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG (bosentan)	3	PA; SL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (bosentan)	2	PA; SL (4 tablets per day.); SMCS; SP
EXPECTORANTS - Drugs for the Lungs		
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml	1	
iodine strong oral solution 5 %	1	
maxi-tuss ac oral solution 100-10 mg/5ml	1	
potassium iodide oral solution 1 gm/ml	1	
SSKI ORAL SOLUTION 1 GM/ML (potassium iodide (expectorant))	3	
FIRST GENERATION ANTIHIST.(RESPIR TRACT) - Drugs for Allergy		
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
clemastine fumarate oral tablet 2.68 mg	1	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
DICOPANOL FUSEPAQ ORAL SUSPENSION RECONSTITUTED 5 MG/ML (diphenhydramine hcl)	3	PA
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
promethazine hcl oral solution 6.25 mg/5ml	1	
promethazine hcl oral syrup 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
promethegan rectal suppository 12.5 mg, 25 mg, 50 mg	1	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (dupilumab)	3	PA; M; SL (0.09 ml per day.); SMCS; SP
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (benralizumab)	4	PA; M; SL (1 pen per 56 days.); SMCS
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
ACCOLATE ORAL TABLET 10 MG, 20 MG (zafirlukast)	4	
montelukast sodium oral packet 4 mg	2	
montelukast sodium oral tablet 10 mg	1	
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	
SINGULAIR ORAL PACKET 4 MG (montelukast sodium)	3	
zafirlukast oral tablet 10 mg, 20 mg	1	
MAST-CELL STABILIZERS - Drugs for Inflammation		
ALOCRILOPHthalmic SOLUTION 2 % (nedocromil sodium)	3	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
MUCOLYTIC AGENTS - Drugs for the Lungs		
acetylcysteine inhalation solution 10 %, 20 %	1	
HYPERSAL INHALATION NEBULIZATION SOLUTION 3.5 %, 7 % (sodium chloride)	2	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (sodium chloride)	3	
PULMOSAL INHALATION NEBULIZATION SOLUTION 7 % (sodium chloride)	2	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (dornase alfa)	3	PA; SL (5 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %	1	
NASAL PREPARATIONS (STEROIDS) - Drugs for Inflammation		
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluticasone propionate nasal suspension 50 mcg/act	2	SL (16 grams (1 bottle) per prescription)
ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	SL (10.7 grams per prescription.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (fluticasone furoate)	2	SL (1 blister per day.)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (fluticasone furoate)	2	SL (1 packet per day.)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	SL (120 ml (2 boxes) per 30 days.)
budesonide inhalation suspension 1 mg/2ml	2	SL (60 ml (1 box) per 30 days.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	2	SL (10.6 grams per month.)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (beclomethasone diprop hfa)	2	SL (42.4 grams per month.)
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
DALIRESP ORAL TABLET 250 MCG (roflumilast)	4	PA; SL (31 tablets per year.)
DALIRESP ORAL TABLET 500 MCG (roflumilast)	4	PA; SL (1 tablet per day)
roflumilast oral tablet 250 mcg	3	PA; SL (31 tablets per year.)
roflumilast oral tablet 500 mcg	3	PA; SL (1 tablet per day)
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; SL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	2	SL (0.5 tablet per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
sildenafil citrate oral tablet 20 mg	1	SL (0.5 tablet per day.); SMCS
tadalafil oral tablet 10 mg, 20 mg	2	SL (0.5 tablet per day.)
tadalafil oral tablet 2.5 mg, 5 mg	2	SL (1 tablet per day.)
TADLIQ ORAL SUSPENSION 20 MG/5ML (tadalafil (pah))	4	PA; SL (10 ml per day.); SMCS; SP
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (336 tablets per year.); SMCS; SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (treprostinil diolamine)	4	PA; SL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	4	PA; SL (6 tablets per day.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (treprostinil)	3	PA; SL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG (treprostinil)	3	PA; SL (196 cartridges per 365 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (treprostinil)	3	PA; SL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (iloprost)	3	PA; SMCS; SP
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
pirfenidone oral capsule 267 mg	2	PA; SL (9 capsules per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
pirfenidone oral tablet 267 mg	3	PA; SL (9 tablets per day.); SMCS; SP
pirfenidone oral tablet 534 mg	3	PA; SL (3 tablets per day.); SMCS
pirfenidone oral tablet 801 mg	3	PA; SL (3 tablets per day.); SMCS; SP
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (tezepelumab-ekko)	4	PA; M; SL (0.07 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (omalizumab)	3	SL (0.08 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (omalizumab)	3	SL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (omalizumab)	3	SL (0.04 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (omalizumab)	3	PA; M; SL (0.08 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (omalizumab)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (omalizumab)	3	PA; M; SL (0.04 ml per day.); SMCS; SP
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	3	
azelastine hcl ophthalmic solution 0.05 %	1	
SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (albuterol-budesonide)	3	SL (10.7 grams per prescription.)
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (1 inhaler per prescription.)
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (6.7 grams per prescription.)
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	2	SL (8.5 grams per prescription.)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	3	PA
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml	3	SL (90 ml per prescription.)
levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml	3	SL (30 vials per prescription)
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SL (15 grams per prescription.)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (salmeterol xinafoate)	2	SL (2 blisters per day.)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (olodaterol hcl)	2	SL (0.14 grams per day.)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (levalbuterol tartrate)	3	SL (15 grams per prescription.)
VASODILATING AGENTS (RESPIRATORY TRACT) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (riociguat)	3	PA; SL (3 tablets per day.); SMCS; SP
ambrisentan oral tablet 10 mg, 5 mg	3	PA; SL (1 tablet per day.); SMCS; SP
bosentan oral tablet 125 mg, 62.5 mg	3	PA; SL (2 tablets per day.); SMCS; SP
OPSUMIT ORAL TABLET 10 MG (macitentan)	3	PA; SL (1 tablet per day.); SMCS; SP
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (168 tablets per year.); SMCS; SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (treprostinil diolamine)	4	PA; SL (336 tablets per year.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (treprostinil diolamine)	4	PA; SL (252 tablets per year.); SMCS; SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	4	PA; SL (6 tablets per day.); SMCS; SP
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; SL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	2	SL (0.5 tablet per day.)
sildenafil citrate oral tablet 20 mg	1	SL (0.5 tablet per day.); SMCS
TADLIQ ORAL SUSPENSION 20 MG/5ML (tadalafil (pah))	4	PA; SL (10 ml per day.); SMCS; SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG (bosentan)	3	PA; SL (2 tablets per day.); SMCS; SP
TRACLEER ORAL TABLET SOLUBLE 32 MG (bosentan)	2	PA; SL (4 tablets per day.); SMCS; SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (treprostinil)	3	PA; SL (112 cartridges per 23 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG (treprostinil)	3	PA; SL (196 cartridges per 365 days.); SMCS; SP
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (treprostinil)	3	PA; SL (252 cartridges per 365 days.); SMCS; SP
TYVASO INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML (treprostinil)	3	PA; SMCS
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (selexipag)	4	PA; SL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (selexipag)	4	PA; SL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (selexipag)	4	PA; SL (2 tablets per day.); SMCS; SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (selexipag)	4	PA; SL (200 tablets per year.); SMCS; SP
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (iloprost)	3	PA; SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
VASODILATING AGENTS, MISC - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (riociguat)	3	PA; SL (3 tablets per day.); SMCS; SP
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (selexipag)	4	PA; SL (2 tablets per day.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (selexipag)	4	PA; SL (140 tablets per 365 days.); SMCS; SP
UPTRAVI TABLET 200 MCG ORAL (selexipag)	4	PA; SL (2 tablets per day.); SMCS; SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (selexipag)	4	PA; SL (200 tablets per year.); SMCS; SP
XANTHINE DERIVATIVES - Drugs for Asthma/COPD		
elixophyllin oral elixir 80 mg/15ml	3	
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (theophylline)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ANTIBACTERIALS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (sulfacetamide sodium-sulfur)	4	
benzoyl peroxide-erythromycin external gel 5-3 %	1	SL (23.3 grams per prescription.)
CLEOCIN VAGINAL CREAM 2 % (clindamycin phosphate)	4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	3	
clindacin-p external swab 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	3	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
clindamycin phosphate external foam 1 %	3	
clindamycin phosphate external gel 1 %	2	SL (75 grams per prescription.)
clindamycin phosphate external lotion 1 %	3	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	2	
CLINDESSE VAGINAL CREAM 2 % (clindamycin phosphate (1 dose))	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (clindamycin-tretinoin-cholesty)	3	PA
ery external pad 2 %	1	
ERYGEL EXTERNAL GEL 2 % (erythromycin)	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
gentamicin sulfate external cream 0.1 %	1	SL (30 grams per prescription.)
gentamicin sulfate external ointment 0.1 %	1	SL (30 grams per prescription.)
KLARON EXTERNAL LOTION 10 % (sulfacetamide sodium (acne))	4	
METROCREAM EXTERNAL CREAM 0.75 % (metronidazole)	4	
METROLOTION EXTERNAL LOTION 0.75 % (metronidazole)	4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole vaginal gel 0.75 %	2	
mupirocin calcium external cream 2 %	3	SL (15 grams per prescription)
mupirocin external ointment 2 %	1	SL (22 grams per prescription.)
neuac external gel 1.2-5 %	3	SL (1 bottle (45 grams) per month.)
OVACE PLUS EXTERNAL CREAM 10 % (sulfacetamide sodium)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
OVACE PLUS EXTERNAL SHAMPOO 10 % (sulfacetamide sodium)	3	
OVACE PLUS WASH EXTERNAL GEL 10 % (sulfacetamide sodium)	3	
OVACE PLUS WASH EXTERNAL LIQUID 10 % (sulfacetamide sodium)	4	
OVACE WASH EXTERNAL LIQUID 10 % (sulfacetamide sodium)	4	
sodium sulfacetamide external shampoo 10 %	1	
sodium sulfacetamide wash external liquid 10 %	1	
SODIUM SULFACETAMIDE-BAKUCHIOL EXTERNAL LIQUID 10 %	3	
sss 10-5 external cream 10-5 %	1	
SSS 10-5 EXTERNAL FOAM 10-5 %	4	
sulfacetamide sodium (acne) external lotion 10 %	1	
sulfacetamide sodium (cleans) external gel 10 %	1	
sulfacetamide sodium external liquid 10 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	4	
XACIATO VAGINAL GEL 2 % (clindamycin phosphate)	2	SL (5 grams per prescription.)
XEPI EXTERNAL CREAM 1 % (ozenoxacin)	3	SL (30 g per prescription.)
ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin		
EXODERM EXTERNAL LOTION 25-1 % (sod thiosulfate-salicylic acid)	3	
ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (crisaborole)	3	ST; SL (60 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
VTAMA EXTERNAL CREAM 1 % (tapinarof)	4	PA; SL (60 grams per prescription.)
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	4	
doxepin hcl external cream 5 %	4	PA; SL (45 grams per prescription.)
ENOVARX-LIDOCAINE HCL EXTERNAL CREAM 10 %, 5 %	3	PA
EPIFOAM EXTERNAL FOAM 1-1 % (pramoxine-hc)	2	
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FIRST-MOUTHWASH BLM MOUTH/THROAT SUSPENSION (dph-lido-alhydr-mghydr-simeth)	3	PA
glydo external prefilled syringe 2 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	3	PA
lidocaine external ointment 5 %	2	SL (1.19 grams per day.)
lidocaine external patch 5 %	3	PA; SL (3 patches per day)
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	1	
LIDTOPIC MAX EXTERNAL CREAM 10 % (lidocaine hcl)	3	PA
phenazo oral tablet 200 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL CREAM 1-2.5 % (pramoxine-hc)	4	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (pramoxine-hc)	4	
premium lidocaine external ointment 5 %	2	SL (1.19 grams per day.)
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (hydrocortisone ace-pramoxine)	2	
PYRIDIDIUM ORAL TABLET 100 MG, 200 MG (phenazopyridine hcl)	3	
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
acyclovir external ointment 5 %	3	SL (15 grams per prescription.)
ASTRINGENTS - Drugs for the Skin		
DRYSOL EXTERNAL SOLUTION 20 % (aluminum chloride)	4	
AZOLES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
clotrimazole mouth/throat troche 10 mg	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
econazole nitrate external cream 1 %	2	
EXELDERM EXTERNAL CREAM 1 % (sulconazole nitrate)	3	
EXELDERM EXTERNAL SOLUTION 1 % (sulconazole nitrate)	3	
GYNAZOLE-1 VAGINAL CREAM 2 % (butoconazole nitrate (1 dose))	3	
ketoconazole external cream 2 %	1	SL (30 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ketoconazole external foam 2 %	3	ST
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	3	ST
miconazole 3 vaginal suppository 200 mg	1	
ORAVIG BUCCAL TABLET 50 MG (miconazole)	4	
SULCONAZOLE NITRATE EXTERNAL CREAM 1 %	3	
SULCONAZOLE NITRATE EXTERNAL SOLUTION 1 %	3	
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
BASIC LOTIONS AND LINIMENTS - Drugs for the Skin		
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (salicylic acid-lactic acid)	2	
methyl salicylate external liquid	1	
PRONAL EXTERNAL GEL 40-10 % (urea-lactic acid)	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (salicylic acid-urea in lactac)	3	
turpentine external spirit	1	
VITAMIN C BRIGHTENING SERUM EXTERNAL LIQUID	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (benzoyl peroxide-hyaluronate)	3	
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
benzoin compound external tincture	1	
benzoin external tincture	1	
CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin		
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (clindamycin-tretinoin-cholesty)	3	PA
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	3	SL (20 grams per prescription.)
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ALA SCALP EXTERNAL LOTION 2 % (hydrocortisone)	4	
alclometasone dipropionate external cream 0.05 %	1	
alclometasone dipropionate external ointment 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
amcinonide external ointment 0.1 %	1	
ANALPRAM HC EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM HC SINGLES EXTERNAL CREAM 2.5-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM-HC EXTERNAL CREAM 1-1 % (hydrocortisone ace-pramoxine)	4	
ANALPRAM-HC EXTERNAL LOTION 2.5-1 % (hydrocortisone ace-pramoxine)	3	
anucort-hc rectal suppository 25 mg	2	
ANUSOL-HC EXTERNAL CREAM 2.5 % (hydrocortisone)	4	
APEXICON E EXTERNAL CREAM 0.05 % (diflorasone diacet emoll base)	2	SL (30 grams per prescription.)
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	3	
betamethasone dipropionate aug external ointment 0.05 %	3	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
budesonide rectal foam 2 mg	2	
CAPEX EXTERNAL SHAMPOO 0.01 % (fluocinolone acetone)	2	
clobetasol prop emollient base external cream 0.05 %	2	SL (30 grams per prescription.)
clobetasol propionate e external cream 0.05 %	2	SL (30 grams per prescription.)
clobetasol propionate external cream 0.05 %	2	SL (30 grams per prescription.)
clobetasol propionate external gel 0.05 %	2	SL (30 grams per prescription.)
clobetasol propionate external liquid 0.05 %	1	SL (59 ml per prescription)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
clobetasol propionate external ointment 0.05 %	2	SL (30 grams per prescription.)
clobetasol propionate external solution 0.05 %	1	SL (25 ml per prescription.)
clocortolone pivalate external cream 0.1 %	3	ST; SL (75 grams per prescription.)
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (flurandrenolide)	3	SL (1 packet per prescription.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylonol)	4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (hydrocortisone)	4	
CORTIFOAM EXTERNAL FOAM 10 % (hydrocortisone acetate)	2	
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (fluocinolone acetonide)	4	SL (118.28 ml per prescription.)
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (fluocinolone acetonide)	4	
desonide external cream 0.05 %	2	SL (15 grams per prescription.)
desonide external lotion 0.05 %	3	SL (60 ml per prescription.)
desonide external ointment 0.05 %	2	SL (15 grams per prescription.)
DESOWEN EXTERNAL CREAM 0.05 % (desonide)	3	SL (15 grams per prescription.)
desoximetasone external cream 0.05 %	1	SL (60 gm per prescription.)
desoximetasone external cream 0.25 %	1	SL (15 grams per prescription.)
desoximetasone external gel 0.05 %	3	SL (15 grams per prescription.)
desoximetasone external ointment 0.05 %	3	SL (60 grams per prescription.)
desoximetasone external ointment 0.25 %	3	SL (15 grams per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
diflorasone diacetate external cream 0.05 %	3	SL (30 grams per prescription.)
DIPROLENE EXTERNAL OINTMENT 0.05 % (betamethasone dipropionate aug)	4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (calcipotriene-betameth diprop)	4	SL (60 grams per prescription.)
EPIFOAM EXTERNAL FOAM 1-1 % (pramoxine-hc)	2	
fluocinolone acetonide body external oil 0.01 %	3	SL (118.28 ml per prescription.)
fluocinolone acetonide external cream 0.01 %, 0.025 %	3	SL (15 grams per prescription.)
fluocinolone acetonide external ointment 0.025 %	2	SL (15 grams per prescription.)
fluocinolone acetonide external solution 0.01 %	3	SL (60 ml per prescription.)
fluocinolone acetonide scalp external oil 0.01 %	3	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
flurandrenolide external cream 0.05 %	3	ST; SL (120 ml per prescription.)
flurandrenolide external lotion 0.05 %	3	ST; SL (120 ml per prescription.)
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
halobetasol propionate external cream 0.05 %	2	SL (15 grams per prescription.)
halobetasol propionate external ointment 0.05 %	2	SL (15 grams per prescription.)
HALOG EXTERNAL OINTMENT 0.1 % (halcinonide)	3	ST; SL (30 grams per prescription.)
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
hydrocortisone acetate rectal suppository 25 mg, 30 mg	2	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	2	SL (15 grams per prescription.)
hydrocortisone valerate external ointment 0.2 %	3	SL (15 grams per prescription.)
hydrocortisone-iodoquinol external cream 1-1 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
kourzeq mouth/throat paste 0.1 %	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NUCORT EXTERNAL LOTION 2 % (hydrocortisone acetate)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
oralone mouth/throat paste 0.1 %	1	
PANDEL EXTERNAL CREAM 0.1 % (hydrocortisone probutate)	3	
PRAMOSONE EXTERNAL CREAM 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL CREAM 1-2.5 % (pramoxine-hc)	4	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-1 % (pramoxine-hc)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (pramoxine-hc)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 % (hydrocortisone ace-pramoxine)	2	
procto-med hc external cream 2.5 %	1	
proctosol hc external cream 2.5 %	1	
proctozone-hc external cream 2.5 %	1	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (hc & sal acid-sulfur & shampoo)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (hydrocortisone)	2	
TOPICORT EXTERNAL CREAM 0.05 % (desoximetasone)	4	SL (60 gm per prescription.)
TOPICORT EXTERNAL CREAM 0.25 % (desoximetasone)	4	SL (15 grams per prescription.)
TOPICORT EXTERNAL GEL 0.05 % (desoximetasone)	4	SL (15 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.05 % (desoximetasone)	4	SL (60 grams per prescription.)
TOPICORT EXTERNAL OINTMENT 0.25 % (desoximetasone)	4	SL (15 grams per prescription.)
triamcinolone acetonide external aerosol solution 0.147 mg/gm	2	SL (63 grams per prescription.)
triamcinolone acetonide external cream 0.025 %, 0.1 %	1	
triamcinolone acetonide external cream 0.5 %	1	SL (15 grams per prescription.)
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide mouth/throat paste 0.1 %	1	
triderm external cream 0.5 %	1	SL (15 grams per prescription.)
EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin		
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	
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % (benzoyl peroxide-vitamin e)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ciclodan external solution 8 %	1	
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	2	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
IMMUNOMODULATORY AGENT(S) - Drugs for the Skin		
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (tralokinumab-ldrm)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	4	PA; SL (10 g per 23 days.)
pimecrolimus external cream 1 %	3	SL (30 grams per prescription.)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (risankizumab-rzaa)	3	PA; M; SL (1 ml per 63 days.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (risankizumab-rzaa)	3	PA; M; SL (1 ml per 63 days.); SMCS; SP
tacrolimus external ointment 0.03 %, 0.1 %	2	SL (30 grams per prescription.)
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (guselkumab)	3	PA; M; SL (1 ml per 42 days.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (guselkumab)	3	PA; M; SL (2 ml per 2 months.); SMCS; SP
KERATOLYTIC AGENTS - Drugs for the Skin		
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (sulfacetamide sodium-sulfur)	4	
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline-sunscreen-sal acid)	3	
cerovel external lotion 40 %	1	
EXODERM EXTERNAL LOTION 25-1 % (sod thiosulfate-salicylic acid)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (salicylic acid-lactic acid)	2	
HYDRO 40 EXTERNAL FOAM 40 % (urea)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 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	
PROMISEB EXTERNAL CREAM (antiseborrheic products, misc.)	4	PA
PRONAL EXTERNAL GEL 40-10 % (urea-lactic acid)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RAYASAL EXTERNAL CREAM 5.9 %	3	
SALICATE EXTERNAL LIQUID 10 % (salicylic acid)	3	
salicylic acid external solution 26 %	1	
SALIMEZ EXTERNAL CREAM 6 %	3	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (salicylic acid-urea in lactac)	3	
SALYCIM EXTERNAL CREAM 6 % (salicylic acid)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (hc & sal acid-sulfur & shampoo)	3	
sss 10-5 external cream 10-5 %	1	
SSS 10-5 EXTERNAL FOAM 10-5 %	4	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	1	
sulfacetamide sodium-sulfur external liquid 10-5 %, 9-4 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
urea external cream 20 %, 40 %, 45 %	1	
urea external lotion 40 %	1	
urea nail external gel 45 %	1	
UREMEZ-40 EXTERNAL CREAM 40 %	3	
KERATOPLASTIC AGENTS - Drugs for the Skin		
coal tar external solution 20 %	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
benzalkonium chloride external solution	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
benzalkonium chloride external solution 50 %	1	
benzoyl peroxide-erythromycin external gel 5-3 %	1	SL (23.3 grams per prescription.)
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	3	SL (1 bottle (45 grams) per month.)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (hc-pramoxine-chloroxylenol)	4	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (sulfuric acid-sulf phenolics)	2	
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid-oxyquinoline)	4	
hydrocortisone-iodoquinol external cream 1-1 %	1	
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	
INOVA EXTERNAL KIT 4 & 5 %, 8 & 5 % (benzoyl peroxide-vitamin e)	4	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
mafenide acetate external packet 5 %	3	
neuac external gel 1.2-5 %	3	SL (1 bottle (45 grams) per month.)
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (chlorhexidine gluconate)	4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (silver sulfadiazine)	4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (mafenide acetate)	3	
SULFAMYLON EXTERNAL PACKET 5 % (mafenide acetate)	4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (benzoyl peroxide-hyaluronate)	3	
ZACLIR CLEANSING EXTERNAL LOTION 8 %	3	
NONSTEROIDAL ANTI-INFLAMMAT.AGENTS(SKIN) - Drugs for the Skin		
diclofenac sodium external gel 3 %	2	PA; SL (100 grams per prescription.)
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
ENOVARX-DICLOFENAC SODIUM EXTERNAL CREAM 2.5 %	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 % (ketoprofen)	3	PA
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	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
PIGMENTING AGENTS - Drugs for the Skin		
methoxsalen rapid oral capsule 10 mg	1	
POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
klayesta external powder 100000 unit/gm	1	SL (120 grams per prescription.)
nyamyc external powder 100000 unit/gm	1	SL (120 grams per prescription.)
nystatin external cream 100000 unit/gm	1	SL (90 grams per prescription.)
nystatin external ointment 100000 unit/gm	1	SL (90 grams per prescription.)
nystatin external powder 100000 unit/gm	1	SL (120 grams per prescription.)
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
nystop external powder 100000 unit/gm	1	SL (120 grams per prescription.)
SCABICIDES AND PEDICULICIDES - Drugs for the Skin		
CROTAN EXTERNAL LOTION 10 % (crotamiton)	3	
malathion external lotion 0.5 %	1	
OVIDE EXTERNAL LOTION 0.5 % (malathion)	4	
permethrin external cream 5 %	1	
SOOLANTRA EXTERNAL CREAM 1 % (ivermectin)	4	SL (45 grams per prescription.)
spinosad external suspension 0.9 %	3	
sulfurated lime external solution	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
A.A.G.C. KIT IN TERODERM EXTERNAL CREAM 8-4-10-4 % (amantad-amitrip-gabap-cycloben)	3	PA
acutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (tralokinumab-ldrm)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
AKLIEF EXTERNAL CREAM 0.005 % (trifarotene)	4	PA; SL (45 grams per prescription.)
ALEVAMAX EXTERNAL CREAM	3	
AMELUZ EXTERNAL GEL 10 % (aminolevulinic acid hcl)	3	
amnesteem oral capsule 10 mg, 20 mg, 40 mg	2	
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (fibrin sealant component)	3	
ARTISS EXTERNAL SOLUTION (fibrin sealant component)	3	
azelaic acid external gel 15 %	3	
B & C EXTERNAL OINTMENT	3	
balsam peru-castor oil external ointment	1	
bexarotene external gel 1 %	4	SL (60 grams per prescription.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
brimonidine tartrate external gel 0.33 %	3	PA; SL (30 grams per prescription.)
calcipotriene external cream 0.005 %	2	SL (60 grams per prescription)
calcipotriene external ointment 0.005 %	2	
calcipotriene external solution 0.005 %	1	SL (60 mL per prescription)
CALCITRENE EXTERNAL OINTMENT 0.005 % (calcipotriene)	3	
calcitriol external ointment 3 mcg/gm	1	SL (100 grams per prescription)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (abrocitinib)	3	PA; SL (1 tablet per day.); SMCS; SP; CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
CLINOIN EXTERNAL CREAM 1.25-0.025-1 % (clindamycin-tretinoin-cholesty)	3	PA
CONDYLOX EXTERNAL GEL 0.5 % (podofilox)	4	
COPASIL EXTERNAL GEL (scar treatment products)	3	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.072 mL per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.036 mL per day.); SMCS; SP
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (secukinumab)	4	PA; ST; M; SL (0.018 ml per day.); SMCS
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.072 mL per day.); SMCS; SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (secukinumab)	4	PA; ST; M; SL (0.036 mL per day.); SMCS; SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (secukinumab)	4	PA; ST; SL (0.072 ml per day.); SMCS; SP
DERMASO PLUS EXTERNAL CREAM (dermatological products, misc.)	3	
DUAL COMPLEX FORMULA 1 KIT EXTERNAL CREAM	3	PA
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML (dupilumab)	3	PA; M; SL (0.09 ml per day.); SMCS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML (dupilumab)	3	PA; M; SL (0.15 ml per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (dupilumab)	3	PA; M; SL (0.15 ml per day.); SMCS; SP
EFUDEX EXTERNAL CREAM 5 % (fluorouracil)	4	
ENOVARX-DICLOFENAC SODIUM EXTERNAL CREAM 2.5 %	3	PA
ENOVARX-TRAMADOL EXTERNAL CREAM 5 %	3	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (calcipotriene-betameth diprop)	4	SL (60 grams per prescription.)
FBL KIT EXTERNAL CREAM 15-4-5 %	3	PA
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid-oxyquinoline)	4	
FINACEA EXTERNAL FOAM 15 % (azelaic acid)	4	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (dermatological products, misc.)	3	PA
HYFTOR EXTERNAL GEL 0.2 % (sirolimus)	4	PA; SL (10 g per 23 days.)
imiquimod external cream 5 %	1	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
K.B.G.L IN TERODERM EXTERNAL CREAM 15-4-10-2 % (ketoprofen-baclofen-gabap-lido)	3	PA
KLISYRI EXTERNAL OINTMENT 1 % (tirbanibulin)	4	ST; SL (5 units per prescription)
LITFULO ORAL CAPSULE 50 MG (ritlecitinib tosylate)	4	PA; SL (1 capsule per day.); SMCS; SP
LUXAMEND EXTERNAL CREAM (wound dressings)	3	
MEDERMA SPF 30 EXTERNAL CREAM (scar treatment products)	3	PA
MIRVASO EXTERNAL GEL 0.33 % (brimonidine tartrate)	4	PA; SL (30 grams per prescription.)
NEOSALUS EXTERNAL CREAM (dermatological products, misc.)	3	
OTEZLA ORAL TABLET 30 MG (apremilast)	3	PA; SL (2 tablets per day.); SMCS; SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 THERAPY PACK 10 & 20 & 30 MG (apremilast)	3	PA; SL (55 tablets (one starter pack) per year.); SMCS; SP
PANRETIN EXTERNAL GEL 0.1 % (alitretinoin)	3	
pimecrolimus external cream 1 %	3	SL (30 grams per prescription.)
PODOCON-25 EXTERNAL SOLUTION 25 % (podophyllum resin)	3	
podofilox external gel 0.5 %	3	
podofilox external solution 0.5 %	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
REGRANEX EXTERNAL GEL 0.01 % (becaplermin)	2	PA; SL (30 grams per prescription.)
REMIGEN EXTERNAL CREAM	3	
RHOFADE EXTERNAL CREAM 1 % (oxymetazoline hcl)	4	PA; SL (30 grams per prescription.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (collagenase)	4	SL (90 grams per prescription.)
SCARCIN EXTERNAL CREAM	3	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (risankizumab-rzaa)	3	PA; M; SL (1 ml per 63 days.); SMCS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (risankizumab-rzaa)	3	PA; M; SL (1 ml per 63 days.); SMCS; SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (ustekinumab)	3	PA; M; SL (0.006 ml per day.); SMCS; SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (ustekinumab)	3	PA; M; SL (0.012 ml per day.); SMCS; SP
tacrolimus external ointment 0.03 %, 0.1 %	2	SL (30 grams per prescription.)
tazarotene external cream 0.1 %	3	PA; SL (30 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	3	PA; SL (30 grams per prescription.)
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (fibrin sealant component)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (guselkumab)	3	PA; M; SL (1 ml per 42 days.); SMCS; SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (guselkumab)	3	PA; M; SL (2 ml per 2 months.); SMCS; SP
TRIPLE COMPLEX FORMULA 3 KIT EXTERNAL CREAM 20-2-10 %	3	
VALCHLOR EXTERNAL GEL 0.016 % (mechlorethamine hcl (topical))	3	PA; SL (120 grams per prescription.); SMCS; SP
VENELEX EXTERNAL OINTMENT (balsam peru-castor oil)	3	
VP FC KIT EXTERNAL CREAM	3	PA
VP GKL KIT EXTERNAL CREAM 20-2-10 %	3	PA
VTAMA EXTERNAL CREAM 1 % (tapinarof)	4	PA; SL (60 grams per prescription.)
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	2	
ZORYVE EXTERNAL CREAM 0.3 % (roflumilast)	4	PA; SL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (roflumilast (antiseborrheic))	3	SL (60 grams per prescription.)
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (doxycycline-sunscreen-sal acid)	3	
THIOCARBAMATES(SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
MYCOZYL AL EXTERNAL SOLUTION 1 % (tolnaftate)	3	
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles		
ANTIMUSCARINICS - Drugs for the Urinary System		
flavoxate hcl oral tablet 100 mg	1	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	2	
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 2.5 mg	4	
oxybutynin chloride oral tablet 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	2	
tolterodine tartrate oral tablet 1 mg, 2 mg	3	ST
tropium chloride oral tablet 20 mg	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
elixophyllin oral elixir 80 mg/15ml	3	
sildenafil citrate oral suspension reconstituted 10 mg/ml	4	PA; SL (186 ml per month.); SMCS; SP
sildenafil citrate oral tablet 20 mg	1	SL (0.5 tablet per day.); SMCS
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (theophylline)	3	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral elixir 80 mg/15ml	1	
theophylline oral solution 80 mg/15ml	1	
VITAMINS		
MULTIVITAMIN PREPARATIONS		
adc/f (0.5mg/ml) oral solution 0.5 mg/ml	1	
ATABEX OB ORAL TABLET 29-1 MG (prenatal vit w/ fe bisg-fa)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (prenat-fecb-fefum-fa-dha w/o a)	3	
ELITE-OB ORAL TABLET 50-1.25 MG (prenatal vit-iron carbonyl-fa)	3	
ENBRACE HR ORAL CAPSULE (prenat vit-fe gly cys-fa-omega)	3	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (pediatric multivitamins-fl)	3	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride tablet chewable 0.25 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
multivitamin/fluoride tablet chewable 0.5 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
multivitamin/fluoride tablet chewable 1 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	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 (prenatal vit-fe fumarate-fa)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (prenat-fe-methylfol-dha w/o a)	3	
NESTABS ORAL TABLET 32-1 MG (prenat-fe bisgly-fa-w/o vit a)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (pediatric multivitamins-fl)	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)	3	
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (ped multivitamins-fl-iron)	3	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (ped multivitamins-fl-iron)	3	
PREMESISRX ORAL TABLET 1 MG (prenatal ca-b6-b12-fa-ginger)	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral oral tablet 27-1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (prenatal-feaspgly-methylfol-fa)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fecbn-feasp-meth-fa-dha)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (prenat mv-min-methylfolate-fa)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	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 (pren-fe-meth-fa-omeg w/o a)	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	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (prenatal vit-fe psac cmplx-fa)	4	
TRINATE ORAL TABLET (prenatal vit-fe fumarate-fa)	3	
TRISTART DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
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	
VINATE ONE ORAL TABLET 60-1 MG (prenatal vit-fe fumarate-fa)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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 (prenat-fe poly-methfol-fa-dha)	3	
VITAFOL STRIPS ORAL FILM 1 MG (prenatal-b6-b12-d3-folic acid)	3	
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG (prenatal-fe fum-methf-fa w/o a)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (prenatal mv-min-fe fum-fa-dha)	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG (prenat w/o a-fe-methfol-fa-dha)	3	
vitamins acd-fluoride oral solution 0.25 mg/ml	1	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG (prenat-fefum-fered-fa-dha w/oa)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (prenatal vit-fe fumarate-fa)	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	4	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
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	
VITAMIN A		
adc/f (0.5mg/ml) oral solution 0.5 mg/ml	1	
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	
vitamins acd-fluoride oral solution 0.25 mg/ml	1	
VITAMIN B COMPLEX		
ATABEX OB ORAL TABLET 29-1 MG (prenatal vit w/ fe bisg-fa)	3	
CALCIFOL ORAL WAFER 1342-1.6 MG (ca carb-fa-d-b6-b12-boron-mg)	3	
CITRANATAL MEDLEY ORAL CAPSULE 27-1-200 MG (prenat-fecb-fefum-fa-dha w/o a)	3	
cyanocobalamin injection solution 1000 mcg/ml	1	M

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	M
cyanocobalamin nasal solution 500 mcg/0.1ml	3	M
DODEX INJECTION SOLUTION 1000 MCG/ML (cyanocobalamin)	4	M
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	4	H
ELITE-OB ORAL TABLET 50-1.25 MG (prenatal vit-iron carbonyl-fa)	3	
ENBRACE HR ORAL CAPSULE (prenat vit-fe gly cys-fa- omega)	3	
folic acid oral tablet 1 mg	1	
folic acid oral tablet 400 mcg, 800 mcg	E	H
hematinic/folic acid oral tablet 324-1 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
multivitamin/fluoride tablet chewable 0.25 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.25 MG ORAL (RX)	3	
multivitamin/fluoride tablet chewable 0.5 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 0.5 MG ORAL (RX)	3	
multivitamin/fluoride tablet chewable 1 mg oral (rx)	1	
MULTIVITAMIN/FLUORIDE TABLET CHEWABLE 1 MG ORAL (RX)	3	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (cyanocobalamin)	4	M
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 (prenatal vit-fe fumarate-fa)	3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (prenat-fe- methylfol-dha w/o a)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
NESTABS ORAL TABLET 32-1 MG (prenat-fe bisgly-fa-w/o vit a)	3	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
PREMESISRX ORAL TABLET 1 MG (prenatal ca-b6-b12-fa-ginger)	3	
PRENAISSANCE ORAL CAPSULE 29-1.25-325 MG	2	
prenatal oral tablet 27-1 mg	1	
prenatal plus vitamin/mineral oral tablet 27-1 mg	1	
PRENATE DHA ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (prenatal-feaspgly-methylfol-fa)	3	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	3	
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (prenat-fecbn-feasp-meth-fa-dha)	3	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (prenat mv-min-methylfolate-fa)	3	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (prenat-feasp-meth-fa-dha w/o a)	3	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (prenat w/o a-fe-methfol-fa-dha)	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 (pren-fe-meth-fa-omeg w/o a)	3	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (prenatal vit-fe psac cmplx-fa)	4	
TRINATE ORAL TABLET (prenatal vit-fe fumarate-fa)	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 mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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	
TRUE FOLIC ACID ORAL TABLET 400 MCG	E	H
tydemy oral tablet 3-0.03-0.451 mg	4	H
VINATE ONE ORAL TABLET 60-1 MG (prenatal vit-fe fumarate-fa)	3	
VITAFOL FE+ ORAL CAPSULE 90-0.6-0.4-200 MG (prenat-fe poly-methfol-fa-dha)	3	
VITAFOL-NANO ORAL TABLET 18-0.6-0.4 MG (prenatal-fe fum-methf-fa w/o a)	3	
VITAFOL-OB+DHA ORAL 65-1 & 250 MG (prenatal mv-min-fe fum-fa-dha)	3	
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE 30-0.6-0.4-200 MG (prenat w/o a-fe-methfol-fa-dha)	3	
VITAPEARL ORAL CAPSULE EXTENDED RELEASE 30-1.4-200 MG (prenat-fefum-fered-fa-dha w/oa)	3	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (prenatal vit-fe fumarate-fa)	3	
WESCAP-C DHA ORAL CAPSULE 53.5-38-1 MG	4	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	4	
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	
VITAMIN C		
adc/f (0.5mg/ml) oral solution 0.5 mg/ml	1	
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (peg-kcl-nacl-nasulf-na asc-c)	3	SL (1 kit per prescription.)
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	3	SL (1 kit per prescription.)
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	3	SL (1 kit per prescription.)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (peg-kcl-nacl-nasulf-na asc-c)	3	SL (3 cartons per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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
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	
vitamins acd-fluoride oral solution 0.25 mg/ml	1	
VITAMIN D		
adc/f (0.5mg/ml) oral solution 0.5 mg/ml	1	
CALCIFOL ORAL WAFER 1342-1.6 MG (ca carb-fa-d-b6-b12-boron-mg)	3	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	
calcitriol oral solution 1 mcg/ml	1	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	1	
DRISDOL ORAL CAPSULE 1.25 MG (50000 UT) (ergocalciferol)	4	
ergocalciferol oral capsule 1.25 mg (50000 ut)	1	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (sodium fluoride-vitamin d)	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (alendronate-cholecalciferol)	3	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	1	
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	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit	1	
vitamins acd-fluoride oral solution 0.25 mg/ml	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (paricalcitol)	4	
VITAMIN E		
wheat germ oil oral oil	1	
VITAMIN K ACTIVITY		
phytonadione oral tablet 5 mg	3	SL (5 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range cost medications; Drug Tier 4: 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. M: May be covered under the medical benefit with prior authorization for HMO plans; SMCS: Specialty medication cost share may apply (for HMO plans, does not apply to injectables covered under the medical benefit); 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

A.A.G.C. KIT IN TERODERM	253	ADVAIR HFA	58, 164	alprazolam xr	108
abacavir sulfate	27	ADVATE	65	ALPROLIX	65, 66
abacavir sulfate-lamivudine	28	ADVOCATE INSULIN PEN		ALREX	149
abiraterone acetate	35	NEEDLE	127	ALTACAINE	153
ABRYSVO	46	ADYNOVATE	65	altafrin	153, 154
acamprosate calcium	109	AEROCHAMBER HOLDING		altavera	169, 177, 189
acarbose	166	CHAMBER	127	ALTUVIIIIO	66
ACCOLATE	232	AEROCHAMBER PLS FLOVU		ALUNBRIG	35
ACCU-CHEK AVIVA	127	MTHPIECE	127	alvimopan	159
ACCU-CHEK FASTCLIX		AEROCHAMBER PLUS FLO-		alyacen 1/35	169, 177, 189
LANCET KIT	127	VU INTERM	127	alyacen 7/7/7	169, 177, 189
ACCU-CHEK GUIDE	127, 134	AEROCHAMBER PLUS FLO-		amabelz	177, 189
ACCU-CHEK GUIDE		VU LARGE	127	amantadine hcl	16, 17, 94
CONTROL	127	AEROCHAMBER PLUS FLO-		ambrisentan	91, 231, 236
ACCU-CHEK GUIDE ME	127	VU MEDIUM	127	amcinonide	244
ACCU-CHEK SMARTVIEW		AEROCHAMBER PLUS FLO-		AMELUZ	253
CONTROL	127	VU SMALL	127	amethyst	169, 177, 189
ACCU-CHEK SOFTCLIX		afirmelle	169, 177, 189	amiloride hcl	90, 140
LANCET DEVICE KIT	127	AFLURIA QUADRIVALENT	46, 47	amiloride-	
ACCURETIC	75, 143	AFSTYLA	65	hydrochlorothiazide	140, 143
accutane	253	aftera	169, 189	aminocaproic acid	66
ACD-A NOCLOT-50	62	AIMOVIG	109	amiodarone hcl	84
acebutolol hcl	60, 77, 78, 83	AIRSUPRA	58, 149, 164, 233, 235	amitriptyline hcl	125
acetaminophen-codeine	95, 113	AKLIEF	253	AMJEVITA	159, 210, 215
acetazolamide	81, 97, 139, 149	AKTEN	153	AMJEVITA-PED.10KG-15.9,2	159, 210, 215
acetazolamide er		AKYNZEO	154, 162	AMJEVITA-PED.15KG-19,2	159, 210, 215
	81, 97, 139, 149	ALA SCALP	243	AMLODIPINE	
acetic acid	152	albendazole	18	BES+SYRSPEND SF	86, 91
acetylcysteine	202, 232	albuterol sulfate	59, 235, 236	amlodipine besylate	86, 91
acitretin	253	ALBUTEROL SULFATE	59, 236	amlodipine besylate-	
ACTEMRA	209, 215	albuterol sulfate hfa	58, 59, 235	benazepril hcl	75, 86
ACTEMRA ACTPEN	209, 214	ALCAINE	153	amlodipine besylate-	
ACTHIB	46	alclometasone dipropionate	243	valsartan	74, 86
ACTIMMUNE	215	ALCOHOL PREP PADS	127	amnesteem	253
ACTIVELLA	177, 189	ALECENSA	35	amoxapine	125
ACULAR	152	alendronate sodium	204	amoxicillin	17, 156
ACULAR LS	152	ALEVAMAX	253	amoxicillin-potassium	
acyclovir	31, 242	ALFERON N	30, 35, 215	clavulanate	17, 18
ADACEL	46	alfuzosin hcl er	58	amphetamine sulfate	94
ADALIMUMAB-ADAZ		ALINIA	19	amphetamine-	
	159, 209, 215	allopurinol	203	dextroamphetamine	94
ADALIMUMAB-ADBM		almotriptan malate	123	amphetamine-	
	159, 209, 215	ALOCRIIL	146, 232	dextroamphetamine er	94
ADASUVE	104	ALOMIDE	15, 146	ampicillin	18
ADBRY	249, 253	ALORA	177, 204	anagrelide hcl	72
adc/f (0.5mg/ml)		alose tron hcl	156	ANALPRAM HC	241, 244
	207, 258, 261, 264, 265	ALPHAGAN P	145	ANALPRAM HC SINGLES	
ADDYI	109	ALPHANATE	65		241, 244
adefovir dipivoxil	31	ALPHANINE SD	65	ANALPRAM-HC	241, 244
ADEMPAS	236, 238	alprazolam	107, 108	ANASPAZ	52
ADIPEX-P	94	alprazolam er	107	anastrozole	35, 167
ADRENALIN	51, 154, 227	alprazolam intensol	107	ANCOBON	32, 33

ANDRODERM.....	166	ASSURE ID PRO PEN		bac.....	95, 106, 120
ANGELIQ.....	177, 190	NEEDLES.....	128	bacitracin	146
ANNOVERA.....	169, 177, 190	ASTRINGYN.....	66	bacitracin-polymyxin b	146
ANORO ELLIPTA.....	52, 59	ATABEX OB.....	69, 258, 261	bacitra-neomycin-	
ANTICOAGULANT SODIUM		atazanavir sulfate	29	polymyxin-hc	146, 149
CITRATE.....	62	atenolol	60, 77, 78, 83	BACLOFEN.....	56
anucort-hc	244	ATENOLOL+SYRSPEND SF		baclofen	56
ANUSOL-HC.....	244	.....	60, 77, 78, 83	BACTRIM.....	19, 33, 34
ANZEMET.....	155	atenolol-chlorthalidone ..	77, 144	BACTRIM DS.....	19, 33, 34
APEXICON E.....	244	atomoxetine hcl	110	BAFIERTAM.....	216
apraclonidine hcl	152	ATORVALIQ.....	88	BALCOLTRA.....	170, 178, 190
aprepitant	162	atorvastatin calcium	88	balsalazide disodium	156
apri	169, 177, 190	atovaquone	19	balsam peru-castor oil	253
APRISO.....	156	atovaquone-proguanil hcl	18	balziva	170, 178, 190
APTIVUS.....	29	atropine sulfate	153	BAQSIMI ONE PACK.....	186, 202
AQ INSULIN SYRINGE.....	127	ATROVENT HFA.....	52, 228	BAQSIMI TWO PACK.....	186, 202
AQINJECT PEN NEEDLE.....	127	aubra eq	170, 178, 190	BARACLUDGE.....	31
AQUORAL.....	152	AUM INSULIN SAFETY PEN		BAXDELA.....	33
ARAKODA.....	18	NEEDLE.....	128	BD AUTOSHIELD DUO PEN	
aranelle	170, 178, 190	AUM MINI INSULIN PEN		NEEDLES.....	128
ARANESP (ALBUMIN FREE)		NEEDLE.....	128	BD ECLIPSE LUER-LOK	
.....	61, 63, 64	AUM PEN NEEDLE.....	128	NEEDLE.....	128
ARCALYST.....	222	AUM READYGARD DUO PEN		BD ECLIPSE NEEDLE.....	128
AREXVY.....	47	NEEDLE.....	128	BD SHARPS COLLECTOR...	128
arformoterol tartrate	59	AUM SAFETY PEN NEEDLE..	128	BD ULTRA-FINE INSULIN	
ARIKAYCE.....	17	aurovela 1.5/30	170, 178, 190	SYRINGES.....	128
aripiprazole	100, 105	aurovela 1/20	170, 178, 190	BD ULTRA-FINE PEN	
armodafinil	126	aurovela 24 fe	170, 178, 190	NEEDLES.....	128
ARMOUR THYROID.....	201	aurovela fe 1.5/30 ..	170, 178, 190	BELBUCA.....	117
ARNUITY ELLIPTA.....	164, 233	aurovela fe 1/20	170, 178, 190	belladonna alkaloids-opium	
ARTISS.....	253	AUSTEDO.....	126	.....	52, 113
ARZOL SILVER NIT		AUSTEDO XR.....	126	benazepril hcl	75
APPLICATORS.....	151	AUSTEDO XR PATIENT		benazepril-	
ascomp-codeine		TITRATION.....	126	hydrochlorothiazide	75, 143
.....	106, 113, 120, 122	AUTOLET LANCING DEVICE	128	BENEFIX.....	66
ashlyna	170, 178, 190	AUVI-Q.....	51, 227	BENLYSTA.....	220
aspirin	71, 72, 102, 122	AVAR CLEANSER.....	238, 249	benzalkonium chloride ..	250, 251
aspirin 81	71, 72, 102, 122	aviane	170, 178, 190	BENZHYDROCODONE-	
aspirin adult low dose		avidoxy	18, 34	ACETAMINOPHEN.....	95, 113
.....	71, 72, 102, 122	AVIDOXY DK.....	34, 249, 257	BENZNIDAZOLE.....	20
aspirin adult low strength		AVONEX PEN.....	215	benzoin	243
.....	71, 72, 102, 122	AVONEX PREFILLED.....	215	benzoin compound	243
aspirin childrens	71, 72, 102, 122	ayuna	170, 178, 190	benzonatate	228
aspirin ec low dose		AYVAKIT.....	36	benzoyl peroxide-	
.....	71, 72, 102, 122	AZASAN.....	210, 215, 220	erythromycin	238, 251
aspirin ec low strength		AZASITE.....	146	benzphetamine hcl	94
.....	71, 72, 102, 122	azathioprine	210, 215, 220	benztropine mesylate	54, 96
aspirin low dose	71, 72, 102, 122	azelaic acid	253	BERINERT.....	209, 222
aspirin regimen	72, 102, 122	azelastine hcl	146, 235	BESIVANCE.....	146
aspirin-dipyridamole er ..	72, 122	azithromycin	31	BETADINE OPHTHALMIC	
ASPRUZYO SPRINKLE.....	82	AZSTARYS.....	120	PREP.....	151
ASSURE ID DUO PRO PEN		azurette	170, 178, 190	betaine	222
NEEDLES.....	128	B & C.....	253		

betamethasone dipropionate	244	BUMEX	88, 139	captopril-	
betamethasone dipropionate aug	244	buprenorphine	117	hydrochlorothiazide	75, 143
betamethasone valerate	244	buprenorphine hcl	117	carbamazepine	97, 100
BETAPACE AF.....	56, 77, 78, 83, 84	buprenorphine hcl-naloxone hcl	116, 117	carbamazepine er	97, 100
BETASERON.....	216	bupropion hcl	100	carbidopa	111
betaxolol hcl ..	60, 77, 78, 83, 148	bupropion hcl er (smoking det)	50, 99	carbidopa-levodopa	111
bethanechol chloride	57	bupropion hcl er (sr)	99	carbidopa-levodopa er	111
BETIMOL.....	148	bupropion hcl er (xl)	100	carbidopa-levodopa- entacapone	109, 111
BETOPTIC-S.....	148	bupirone hcl	104	carbinoxamine maleate ..	14, 231
BEVESPI AEROSPHERE...52, 59		butalbital-acetaminophen	95, 106	CARDURA.....	57, 73
bexarotene	36, 253	butalbital-apap-caff-cod	95, 106, 113, 120	CARDURA XL.....	57, 73
BEXSERO.....	47	butalbital-apap-caffeine	95, 106, 120	CAREPOINT POLY HUB NEEDLE.....	128, 129
BEYFORTUS.....	30	butalbital-apap-caffeine	95, 106, 120	CAREPOINT SAFETY 1ST NEEDLE.....	129
bicalutamide	36	butalbital-asa-caff-codeine	106, 113, 120, 122	CARESENS CONTROL SOLUTION A/B.....	129
BIJUVA.....	178, 190	butalbital-asa-caff-codeine	106, 113, 120, 122	CARESENS LANCETS 30G... 129	
BIKTARVY.....	26, 27, 28	butalbital-aspirin-caffeine	106, 120, 122	CARESTART COVID-19 HOME TEST.....	135
BILTRICIDE.....	18	butorphanol tartrate	102, 117	CARETOUCH CONTROL SOL LEVEL 2.....	129
bimatoprost	153	BYDUREON BCISE AUTOINJECTOR.....	187	CARETOUCH HYPODERMIC NEEDLE.....	129
BINAXNOW COVID-19 AG HOME TEST.....	135	BYETTA 10 MCG PEN.....	187	CARETOUCH LANCING/EJECTOR.....	129
bisacodyl	157	BYETTA 5 MCG PEN.....	187	carglumic acid	137
bisacodyl ec	157	cabergoline	111	carisoprodol	55
bisoprolol fumarate	60, 77, 78, 83	CABLIVI.....	62	CAROSPIR.....	88, 89, 90, 140
bisoprolol-		CABOMETRYX.....	36	carteolol hcl	148
hydrochlorothiazide	77, 143	caffeine citrate	102, 120	cartia xt	79, 80, 85, 91
blisovi 24 fe	170, 178, 190	CALCIFOL.....	140, 261, 265	carvedilol ... 56, 58, 73, 77, 78, 84	
blisovi fe 1.5/30	170, 178, 190	calcipotriene	254	CASODEX.....	36
blisovi fe 1/20	170, 178, 190	calcitonin (salmon)	168, 204	CAVERJECT.....	91
BOOSTRIX.....	46, 47	CALCITRENE.....	254	CAVERJECT IMPULSE.....	91
bosentan	91, 231, 236	calcitriol	254, 265	CAYA.....	226
BOSULIF.....	36	calcium acetate	139, 140	cefaclor	16
BREATHE COMFORT CHAMBER/ADULT.....	128	calcium acetate (phos binder)	139, 140	cefaclor er	16
BREATHE COMFORT CHAMBER/CHILD.....	128	CALQUENCE.....	36	cefadroxil	16
BRENZAVVY.....	199	camila	170, 190	cefdinir	16
BREO ELLIPTA.....	59, 164	CAMINO PRO COMPLETE/GLYTACTIN.....	137	cefixime	16
BREZTRI AEROSPHERE	52, 59, 164	camrese	170, 178, 190	cefpodoxime proxetil	16
briellyn	170, 178, 190	camrese lo	170, 178, 190	cefprozil	16
BRILINTA.....	72	CAMZYOS.....	82	cefuroxime axetil	16
brimonidine tartrate	145, 254	candesartan cilexetil	74	celecoxib	110
brinzolamide	149	candesartan cilexetil-hctz	74, 143	CELONTIN.....	125
BROMFED DM.....	15, 51, 229	capecitabine	36	CEQUR SIMPLICITY 2U.....	129
bromfenac sodium (once- daily)	152	CAPEX.....	244	CERDELGA.....	222
bromocriptine mesylate	111	CAPLYTA.....	105	cerovel	249
BRUKINSA.....	36	CAPRELSA.....	36	CERVIDIL.....	227
budesonide	164, 233, 244	captopril	75	CETRAXAL.....	146
bumetanide	88, 139				

cevimeline hcl	57	clindacin-p	238	CONDYLOX	254
charlotte 24 fe	170, 178, 190	clindamycin hcl	30	constulose	137
chateal eq	170, 178, 190	clindamycin palmitate hcl	30	CONTOUR CONTROL	129
CHEMET	163, 202	clindamycin phos-benzoyl perox	238, 251	CONTOUR NEXT CONTROL	129
CHEMSTRIP BG LOG BOOK	129	clindamycin phosphate	239	CONTOUR NEXT MONITOR	129
CHEMSTRIP K	136	CLINDESSE	239	CONTOUR NEXT ONE	129
CHEMSTRIP UGK	136	CLINITEST RAPID COVID-19 TEST	135	CONTOUR NEXT TEST	135
chlordiazepoxide hcl	108	CLINOIN	79, 239, 243, 254	CONTRAVE	96
chlordiazepoxide-amitriptyline	108, 125	CLINPRO 5000	207	COPASIL	254
chlorhexidine gluconate	151, 251	clobazam	107, 108	COPIKTRA	36
chloroquine phosphate	18	clobetasol prop emollient base	244	CORDRAN	245
chlorpromazine hcl	119	clobetasol propionate	244, 245	CORGARD	56, 77, 78
chlorthalidone	91, 144	clobetasol propionate e	244	CORIFACT	66
chlorzoxazone	55	clocortolone pivalate	245	CORLANOR	82, 91
CHOLBAM	159	clomipramine hcl	125	CORTANE-B	241, 245, 251
cholestyramine	79	clonazepam	107, 108	CORTEF	164
cholestyramine light	79	clonidine	52, 82	CORTENEMA	245
CIBINQO	210, 254	clonidine hcl	52, 82	CORTIFOAM	245
ciclodan	249	clonidine hcl er	52, 82	CORTISPORIN-TC	146, 149
ciclopirox	249	clopidogrel bisulfate	72	CORTROSYN	134
ciclopirox olamine	249	clorazepate dipotassium	107, 108	COSENTYX (300 MG DOSE)	210, 254
cilostazol	72, 90	clotrimazole	242	COSENTYX 150 MG/ML	210, 254
CILOXAN	146	clotrimazole-betamethasone	242, 245	COSENTYX SENSOREADY (300 MG)	210, 254
CIMDUO	28	clozapine	105	COSENTYX SENSOREADY PEN	210, 254
cimetidine	15, 162	CLOZARIL	105	COSENTYX UNOREADY	211, 254
CIMZIA	159, 210, 216	COAGADEX	66	COSOPT	148, 149
CIMZIA STARTER KIT	159, 210, 216	coal tar	250	cosyntropin	134
cinacalcet hcl	168	COARTEM	18	COTELIC	36
CIPRO	20, 33	codeine sulfate	113, 229	COVARYX	166, 178
ciprofloxacin hcl	21, 33, 146	colchicine	203	COVARYX HS	166, 178
ciprofloxacin-dexamethasone	146, 149	colchicine-probenecid	144, 203	COVID-19 AT HOME ANTIGEN TEST	135
citalopram hydrobromide	124	colesevelam hcl	79, 167	COVID-19 AT-HOME TEST	135
CITRANATAL MEDLEY	69, 222, 258, 261	COLESTID	79	CREON	145, 158
citroma	157	COLESTID FLAVORED	79	CRESEMBA	22
claravis	254	colestipol hcl	79	CRINONE	191
clarithromycin	21, 32, 156	colistimethate sodium (cba)	32	cromolyn sodium	146, 152, 232
clarithromycin er	21, 32, 156	COLY-MYCIN M	32	CROTAN	253
CLEARDETECT COVID-19 AG HOME	135	COMBIGAN	146, 148	cryselle-28	170, 178, 191
clearlax	157	COMBIPATCH	178, 191	curae	170, 191
clemastine fumarate	14, 231	COMBIVENT RESPIMAT	52, 59, 228	CUVPOSA	52
CLENPIQ	157	COMETRIQ	36	CVS KETONE CARE	136
CLEOCIN	30, 238	COMFORT EZ PRO PEN NEEDLES	129	cyanocobalamin	71, 261, 262
CLEVER CHOICE COMFORT EZ	129	COMIRNATY	47	CYANOCOBALAMIN	71, 262
CLIMARA PRO	178, 190	COMPLERA	27, 28	cyclobenzaprine hcl	55
clindacin	238	compro	119, 155	CYCLOGYL	153
clindacin etz	238	CONDOMS	226	CYCLOMYDRIL	153, 154
				cyclopentolate hcl	153
				cyclophosphamide	36, 220

CYCLOPHOSPHAMIDE... 37, 220	DEPAKOTE SPRINKLES	dicloxacillin sodium.....32
cycloserine 21	..... 97, 100, 102	DICOPANOL FUSEPAQ
cyclosporine 211, 216, 220	DEPEN TITRATABS 163, 211	..... 14, 54, 96, 104, 229, 231
cyclosporine modified	DEPO-ESTRADIOL..... 179, 204	dicyclomine hcl 52
..... 211, 216, 220	DEPO-PROVERA... 170, 171, 191	diethylpropion hcl 94
CYLTEZO (2 PEN)..... 211	DEPO-SUBQ PROVERA 104	diethylpropion hcl er 94
CYLTEZO (2 SYRINGE)	..... 171, 191	DIFICID..... 32
..... 159, 211, 216	DEPO-TESTOSTERONE 166	diflorasone diacetate 246
CYLTEZO-CD/UC/HS	DERMA-SMOOTH/FS BODY	diflunisal 118
STARTER..... 211	..... 245	difluprednate 149
CYLTEZO-PSORIASIS/UV	DERMA-SMOOTH/FS	digoxin 76, 82
STARTER..... 211	SCALP..... 245	dihydroergotamine mesylate
cyproheptadine hcl 14, 231	DERMASO PLUS..... 254	..... 57, 102
cyred eq 170, 179, 191	DERMOTIC..... 149	DILANTIN..... 83, 112
CYSTADANE..... 222	DESCOVY..... 28	DILANTIN INFATABS 83, 112
CYSTADROPS..... 152	desipramine hcl 125	diltiazem hcl 80, 81, 85, 92
CYSTAGON..... 222	desmopressin ace spray	diltiazem hcl er 80, 81, 85, 92
CYSTARAN..... 152	refrig 66, 188	diltiazem hcl er beads
CYTOTEC..... 162	desmopressin acetate 66, 188	..... 79, 80, 85, 91
cytra k crystals 136	desmopressin acetate pf 66, 188	diltiazem hcl er coated
dabigatran etexilate	desmopressin acetate spray	beads 79, 80, 85, 91
mesylate 63	..... 66, 188	dilt-xr 80, 81, 85, 92
dalfampridine er 223	desogestrel-ethinyl estradiol	dimethyl fumarate 216
DALIRESP..... 233	..... 171, 179, 191	dimethyl fumarate starter
danazol 166	desonide 245	pack 216
DANTRIUM..... 56	DESOWEN..... 245	diphenhydramine hcl
dantrolene sodium 56	desoximetasone 245	..... 14, 54, 97, 104, 229, 231
dapsone 19, 20	desvenlafaxine succinate er 122	diphenoxylate-atropine .. 52, 155
DAPTACEL..... 46, 47	dexamethasone 164	DIPROLENE..... 246
DARAPRIM..... 18	dexamethasone intensol 164	dipyridamole 72, 92, 134
darunavir 29	dexamethasone sodium	disopyramide phosphate 82
dasetta 1/35 170, 179, 191	phosphate 149	disulfiram 202
dasetta 7/7/7 170, 179, 191	DEXCOM G6 RECEIVER..... 129	DIURIL..... 91, 143
DAURISMO..... 37	DEXCOM G6 SENSOR..... 130	divalproex sodium .. 97, 100, 103
DAYBUE..... 110	DEXCOM G6 TRANSMITTER 130	divalproex sodium er
DAYPRO..... 118	DEXCOM G7 RECEIVER..... 130	..... 97, 100, 102
daysee 170, 179, 191	DEXCOM G7 SENSOR..... 130	DIVIGEL..... 179, 204
DEBACTEROL..... 152, 251	dexmethylphenidate hcl 120	DODEX..... 71, 262
deblitane 170, 191	dexmethylphenidate hcl er .. 120	dofetilide 84
deferasirox 163	dextroamphetamine sulfate .. 95	DOJOLVI..... 137
deferasirox granules 163	dextroamphetamine sulfate	dolishale 171, 179, 191
deferiprone 163	er 94	donepezil hcl 57, 58
DELESTROGEN..... 179, 204	DIATRUST COVID-19 HOME	DOPTLET..... 64
DELSTRIGO..... 27, 28	TEST..... 135	DORZOLAMIDE HCL..... 149
delyla 170, 179, 191	diazepam 107, 108	dorzolamide hcl 149
demeclocycline hcl 34	diazepam intensol 107, 108	dorzolamide hcl-timolol mal
DEMSEER..... 136, 223	diazoxide 168	..... 148, 149
DENGVAXIA..... 47	dichlorphenamide 206	dotti 179, 205
DENTA 5000 PLUS..... 207	diclofenac potassium 118	DOUBLE PM..... 146, 149
DENTAGEL..... 207	diclofenac sodium	DOVATO..... 26, 28
DEPAKOTE..... 97, 100, 102	..... 118, 126, 152, 252	doxazosin mesylate 57, 73
DEPAKOTE ER..... 97, 100, 102	diclofenac sodium er 118	doxepin hcl 125, 241
	diclofenac-misoprostol 118, 162	doxercalciferol 265

doxycycline hyclate	18, 34	ELESTRIN	179, 205	ENTEREG	159
doxycycline monohydrate	19, 34	eletriptan hydrobromide	123	ENTRESTO	74, 90
DRISDOL	265	elinest	171, 179, 191	enulose	137
dronabinol	155	ELIQUIS	63	EPANED	75
DROPSAFE SAFETY		ELIQUIS DVT/PE STARTER		EPCLUSA	24, 25
SYRINGE/NEEDLE	130	PACK	63	EPIDIOLEX	97
DROPSAFE SICURA	130	ELITE-OB	69, 258, 262	EPIFOAM	241, 246
drosipren-eth estrad-		elixophyllin		epinastine hcl	146
levomefol	171, 179, 191, 262	.....	87, 120, 139, 238, 258	epinephrine	51, 228
DROXIA	37	ELLA	171, 191	epinephrine hcl (nasal)	
DRYSOL	242	ELLUME COVID-19 HOME		.....	51, 154, 227
DUAL COMPLEX FORMULA 1		TEST	135	epitol	97, 101
KIT	55, 252, 254	eluryng	171, 179, 191	eplerenone	89, 90, 140
DUAVEE	177, 179	EMBRACE PEN NEEDLES ...	130	EQUETRO	97, 101
DUETACT	200, 201	EMCYT	37	ergocalciferol	265
duloxetine hcl	111, 122	EMEND	162	ergoloid mesylates	57
DUOPA	111	EMGALITY	109	ergotamine-caffeine	57, 103, 120
DUPIXENT	232, 254, 255	EMPAVELI	209, 222	ERIVEDGE	37
DUREX EXTRA SENSITIVE		emtricitabine	28	ERLEADA	37
THIN	226	emtricitabine-tenofovir df	28	erlotinib hcl	37
DUREZOL	149	EMTRIVA	28	ERMEZA	201
dutasteride	202	EMVERM	18	errin	171, 192
E.E.S. GRANULES	23	enalapril maleate	75	ery	239
EASIVENT	130	enalapril-		ERYGEL	239
EASY COMFORT SHARPS		hydrochlorothiazide	75, 143	ERYPED 200	23
CONTAINER	130	ENBRACE HR ..	69, 223, 258, 262	ERYPED 400	23
easygel	207	ENBREL	211, 216	ERY-TAB	23
EASYMAX 15 LEVEL 2-3		ENBREL MINI	211, 216	ERYTHROCIN STEARATE	23
CONTROL	130	ENBREL SURECLICK	211, 216	erythromycin	23, 146, 239
EASYMAX CONTROL	130	ENCARE	226	erythromycin base	23
EASYMAX CONTROL		ENDARI	223	erythromycin ethylsuccinate ..	23
NORMAL/HIGH	130	endocet	95, 113	escitalopram oxalate	124
EC-NAPROSYN	103, 118, 204	ENDOMETRIN	191	ESGIC	95, 106, 120
ec-naproxen	103, 118, 204	ENGERIX-B	47	esomeprazole magnesium ...	162
econazole nitrate	242	enilloring	171, 179, 191	est estrogens-methyltest	
econtra one-step	171, 191	ENLITE GLUCOSE SENSOR ..	130	.....	167, 180
EC-RX DHEA	223	ENOVARX-AMITRIPTYLINE ..	125	est estrogens-methyltest ds	
EC-RX ESTRADIOL	179, 205	ENOVARX-BACLOFEN	56	.....	167, 179
EC-RX PROGESTERONE	191	ENOVARX-		est estrogens-methyltest hs	
EC-RX TESTOSTERONE	166	CYCLOBENZAPRINE HCL	55	.....	167, 179
EDEX	92	ENOVARX-DICLOFENAC		estarylla	171, 180, 192
EDURANT	27	SODIUM	252, 255	estazolam	108
EEMT	166, 179	ENOVARX-IBUPROFEN	252	estradiol	180, 205
EEMT HS	166, 179	ENOVARX-LIDOCAINE HCL ..	241	estradiol valerate	180, 205
efavirenz	27	ENOVARX-NAPROXEN	252	estradiol-norethindrone acet	
efavirenz-emtricitab-tenofo		ENOVARX-TRAMADOL	255	.....	180, 192
df	27, 28	enoxaparin sodium	68	ESTRING	180, 205
efavirenz-lamivudine-		enpresse-28	171, 179, 191	ESTROGEL	180, 206
tenofovir	27, 28	enskyce	171, 179, 191	eszopiclone	104
EFFER-K	141	ENSTILAR	246, 255	ethacrynic acid	88, 139
effe-k	141	ENSURE PLUS	137	ethambutol hcl	21
EFUDEX	255	entacapone	109	ethosuximide	125
EGATEN	18	entecavir	31		

ethynodiol diac-eth estradiol	FIRMAGON (240 MG DOSE)	FLUORIMAX 5000
..... 171, 181, 192	..... 37, 168	..... 207
etodolac 118	FIRST PANTOPRAZOLE..... 163	FLUORIMAX 5000 SENSITIVE
etodolac er 118	FIRST-LANSOPRAZOLE..... 163	..... 126, 207
etonogestrel-ethinyl	FIRST-METRONIDAZOLE	fluorometholone 150
estradiol 171, 181, 192	..... 17, 20, 156	fluorouracil 255
etoposide 37	FIRST-MOUTHWASH BLM	fluoxetine hcl 124
etravirine 27	..... 14, 153, 154, 155, 157, 241	fluphenazine hcl 119
EUCRISA..... 240	FIRST-OMEPRAZOLE..... 163	flurandrenolide 246
euthyrox 201	FIRST-PROGESTERONE	flurazepam hcl 108
EVAMIST..... 181, 206	VGS..... 192	flurbiprofen 118
everolimus 37	FIRVANQ..... 23	flurbiprofen sodium 152
EVOTAZ..... 29, 223	flac 150	fluticasone propionate
EVRYSDI..... 223	FLAREX..... 150	..... 150, 165, 233, 246
EXELDERM..... 242	flavoxate hcl 257	fluticasone-salmeterol ... 59, 165
exemestane 37, 167	flecainide acetate 83	FLUTICASONE-
EXKIVITY..... 37	FLEQSUVY..... 56	SALMETEROL..... 59, 165
EXODERM..... 240, 249	FLEXICHAMBER..... 130	fluvastatin sodium 88
EYSUVIS..... 150	FLEXICHAMBER ADULT	fluvoxamine maleate 124
EZALLOR SPRINKLE..... 88	MASK/SMALL..... 130	fluvoxamine maleate er 124
ezetimibe 82	FLEXICHAMBER CHILD	FLUZONE HIGH-DOSE
falmina 171, 181, 192	MASK/LARGE..... 130	QUADRIVALENT..... 48
famciclovir 31	FLEXICHAMBER CHILD	FLUZONE QUADRIVALENT... 48
famotidine 15, 162	MASK/SMALL..... 130	FML FORTE..... 150
FANATREX FUSEPAQ..... 95, 97	FLOLIPID..... 88	FML LIQUIFILM..... 150
FASENRA PEN..... 232	FLORIVA..... 207, 265	folic acid 262
FASTEP COVID-19 ANTIGEN	FLORIVA PLUS..... 207, 258	fondaparinux sodium 62
TEST..... 135	FLOWFLEX COVID-19 AG	FORA TEST N' GO ADVANCE
FBL KIT..... 56, 241, 252, 255	HOME TEST..... 135	..... 130
FC2 FEMALE CONDOM..... 226	FLUAD QUADRIVALENT..... 47	FORA TEST N'GO ADV-
febuxostat 204	FLUARIX QUADRIVALENT..... 47	VOICE-6 CON..... 135
FEIBA..... 66	FLUBLOK QUADRIVALENT..... 47	FORANE..... 112
felbamate 98	FLUCELVAX	formaldehyde 136
FELBATOL..... 98	QUADRIVALENT..... 47	FORTISCARE CONTROL..... 130
FELDENE..... 118	fluconazole 22	FOSAMAX..... 206
felodipine er 86	flucytosine 33	FOSAMAX PLUS D..... 206, 265
FEM PH..... 251, 255	fludrocortisone acetate 165	fosamprenavir calcium 29
FEMCAP..... 226	FLULAVAL QUADRIVALENT... 48	fosfomycin tromethamine 34
FEMRING..... 181, 206	FLUMIST QUADRIVALENT..... 48	fosinopril sodium 75, 76
fenofibrate 87	flunisolide 150, 165, 233	fosinopril sodium-hctz ... 76, 143
fenofibrate micronized 87	fluocinolone acetonide 150, 246	FOSRENOL..... 139, 202
fenofibric acid 87	fluocinolone acetonide body 246	FREESTYLE LIBRE 14 DAY
fentanyl 113	fluocinolone acetonide scalp	READER..... 131
fentanyl citrate 113	..... 246	FREESTYLE LIBRE 14 DAY
FILSPARI..... 223, 231	fluocinonide 246	SENSOR..... 131
FINACEA..... 255	fluocinonide emulsified base	FREESTYLE LIBRE 2
finasteride 202	..... 246	READER..... 131
fingolimod hcl 216	FLUORIDEX..... 207	FREESTYLE LIBRE 2
finzala 171, 181, 192	fluoridex daily renewal 207	SENSOR..... 131
FIORICET..... 95, 106, 120	FLUORIDEX ENHANCED	FREESTYLE LIBRE 3
FIRDAPSE..... 58, 223	WHITENING..... 207	READER..... 131
FIRMAGON..... 37, 168	FLUORIDEX SENSITIVITY	FREESTYLE LIBRE 3
	RELIEF..... 126, 207	SENSOR..... 131
		FREESTYLE LIBRE READER 131

FROTEK.....	252	glyburide micronized	200	GVOKE PFS.....	186, 203
frovatriptan succinate	123	glyburide-metformin	168, 201	GYNAZOLE-1	242
FRUZAQLA	37	glycolax	157	habitrol	50, 54
ft aspirin low dose ..	72, 103, 122	glycopyrrolate	52	HADLIMA.....	160, 211, 217
ft clearlax	157	glydo	241	HADLIMA PUSH TOUCH	
ft laxative	157	GLYTACTIN BETTERMILK 15	137	.....	160, 211, 217
ft magnesium citrate	157	GLYTACTIN BETTERMILK		HAEGARDA.....	209, 222
ft nicotine	50, 54	DE-LITE	138	hailey 1.5/30	171, 181, 192
ft nicotine mini	50, 54	GLYTACTIN BUILD 10PE	138	hailey 24 fe	171, 181, 192
furosemide	88, 139	GLYTACTIN BUILD 20/20	138	hailey fe 1.5/30	171, 181, 192
FUZEON	26	GLYTACTIN BUILD 20/20		hailey fe 1/20	171, 181, 192
fyavolv	181, 192	PKU	138	HALCION.....	108
FYCOMPA	98	GLYTACTIN BURST	138	halobetasol propionate	246
gabapentin	96, 98	GLYTACTIN COMPLETE		haloette	171, 181, 192
GALAFOLD	223	10PE	138	HALOG	246
galantamine hydrobromide	58	GLYTACTIN RESTORE 10	138	haloperidol	109
galantamine hydrobromide		GLYTACTIN RESTORE 5	138	haloperidol lactate	109
er	58	GLYTACTIN RESTORE LITE		HALUCORT	255
GALZIN	141	10	138	HARVONI	24, 25
GARDASIL 9	48	GLYTACTIN RESTORE LITE		HAVRIX	48
gatifloxacin	146	10PE	138	heather	171, 192
GATTEX	160	GLYTACTIN RTD 10	138	hematinic/folic acid	69, 262
gavilax	157	GLYTACTIN RTD 15	138	HEMLIBRA	66
gavilyte-c	157	GLYTACTIN RTD LITE 15	138	HEMOPIL M	66
gavilyte-g	157	GLYTACTIN SWIRL 15	138	heparin na (pork) lock flsh pf .	69
GAVRETO	38	GLYTACTIN SWIRL 15PE	138	heparin sod (pork) lock flush .	69
gefitinib	38	GLYXAMBI	176, 199	heparin sodium (porcine)	69
GELFILM	66	GOLYTELY	157	heparin sodium (porcine) pf ..	69
gemfibrozil	88	goodsense aspirin low dose		HEPLISAV-B.....	48
gemmily	171, 181, 192	.....	72, 73, 103, 122	her style	171, 192
generlac	137	goodsense nicotine	50, 54	HETLIOZ	104
engraf	211, 216, 221	GORDOFILM	243, 249	HETLIOZ LQ	104
gentamicin sulfate	147, 239	granisetron hcl	155	HIBERIX	48
gentle laxative	157	GRASTEK	45	HIPREX	34
gentlelax	157	griseofulvin microsize	18	HUMALOG	198
GENVOYA	26, 28	griseofulvin ultramicrosize	18	HUMALOG KWIKPEN.....	198
GILOTRIF	38	guaifenesin-codeine	229, 231	HUMALOG MIX 50/50	
glatiramer acetate	216, 217	guanfacine hcl	82, 110	KWIKPEN.....	198
glatopa	217	guanfacine hcl er	110	HUMALOG MIX 50/50 VIAL....	198
GLEOSTINE	38	GUARDIAN 4 GLUCOSE		HUMALOG MIX 75/25	
glimepiride	200	SENSOR.....	131	KWIKPEN.....	198
glipizide	200	GUARDIAN 4 TRANSMITTER	131	HUMALOG MIX 75/25 VIAL....	198
glipizide er	200	GUARDIAN CONNECT		HUMALOG U-100 JUNIOR	
glipizide xl	200	TRANSMITTER	131	KWIKPEN.....	198
glipizide-metformin hcl .	168, 200	GUARDIAN LINK 3		HUMATE-P	66
GLOPERBA	204	TRANSMITTER	131	HUMATIN	17
glucagon emergency kit		GUARDIAN SENSOR (3)	131	HUMIRA.....	160, 212, 217
.....	186, 202	GUARDIAN SENSOR 3.....	131	HUMIRA (2 PEN)	
GLUCAGON EMERGENCY		GVOKE HYPOPEN 1-PACK		.....	160, 211, 212, 217
KIT	186, 202	.....	186, 202	HUMIRA (2 SYRINGE)	
GLUCOTROL XL	200	GVOKE HYPOPEN 2-PACK		.....	160, 212, 217
glutaraldehyde	136	.....	186, 202	HUMIRA PEN.....	160, 212, 217
glyburide	201	GVOKE KIT.....	186, 203		

HUMIRA-CD/UC/HS		INQOVI.....	39
STARTER.....	160, 212, 217	INSPIREASE RESERVOIR	
HUMIRA-PED		BAGS.....	132
.....	160, 212, 217	INSULIN LISPRO.....	198
HUMIRA-PED>/=40KG		INSULIN LISPRO (1 UNIT	
CROHNS START	160, 212, 217	DIAL).....	198
HUMIRA-PED>/=40KG UC		INSULIN LISPRO JUNIOR	
STARTER.....	160, 212, 218	KWIKPEN.....	198
HUMIRA-PSORIASIS/UVEIT		INSULIN LISPRO PROT &	
STARTER.....	161, 212, 218	LISPRO.....	198
HUMULIN 70/30 KWIKPEN		INSULIN PEN NEEDLES.....	132
.....	188, 198	INSULIN SYRINGES.....	132
HUMULIN 70/30 VIAL.....	188, 198	INTELENCE.....	27
HUMULIN N KWIKPEN.....	188	INTELISWAB COVID-19	
HUMULIN N VIAL.....	188	RAPID TEST.....	135
HUMULIN R U-500 KWIKPEN	199	introvale	172, 181, 192
HUMULIN R U-500 VIAL.....	199	INVELTYS.....	150
HUMULIN R VIAL.....	199	iodine strong	231
HYCAMTIN.....	38	iodine tincture	251
hydralazine hcl	87	IOPIDINE.....	152
HYDREA.....	38	IPOL.....	48
HYDRO 40.....	249	ipratropium bromide	53, 228
hydrochlorothiazide	91, 143	ipratropium-albuterol	53, 59, 228
hydrocod poli-chlorphe poli		irbesartan	74
er	15, 229	irbesartan-	
hydrocodone bitartrate er	113	hydrochlorothiazide	74, 143
hydrocodone bit-homatrop		IRESSA.....	39
mbr	53, 229	ISENTRESS.....	26
hydrocodone-		ISENTRESS HD.....	26
acetaminophen	96, 113	isibloom	172, 181, 192
hydrocodone-ibuprofen	114, 118	isoflurane	112
hydrocortisone	165, 247	isoniazid	21
hydrocortisone (perianal)	246	isosorb dinitrate-hydralazine	
hydrocortisone ace-		.....	87, 89
pramoxine	241, 246	isosorbide dinitrate	89
hydrocortisone acetate	247	isosorbide mononitrate	89
hydrocortisone butyrate	247	isosorbide mononitrate er	89
hydrocortisone valerate	247	isotretinoin	255
hydrocortisone-acetic acid		isradipine	86
.....	150, 152	ISTALOL.....	148
hydrocortisone-iodoquinol		itraconazole	22
.....	247, 251	ivermectin	18
hydrocort-pramoxine		jaimiess	172, 181, 192
(perianal)	241, 247	JAKAFI.....	39
hydromet	53, 229	jantoven	63
hydromorphone hcl	114	JARDIANCE.....	199
hydromorphone hcl er	114	JAYPIRCA.....	39
hydroxychloroquine sulfate		jencycla	172, 192
.....	19, 212, 218	JENTADUETO.....	168, 176
hydroxyurea	38	JENTADUETO XR..	168, 169, 176
hydroxyzine hcl	14, 15, 104	JESDUVROQ.....	61, 64
hydroxyzine pamoate	14, 15, 104	jinteli	181, 192
HYFTOR.....	221, 249, 255	JIVI.....	67
hyoscyamine sulfate	53		
hyoscyamine sulfate er	53		
hyoscyamine sulfate sl	53		
hyosyne	53		
HYPERSAL.....	232		
ibandronate sodium	206		
IBRANCE.....	38		
ibuprofen	103, 118		
icatibant acetate	206, 222		
iclevia	172, 181, 192		
ICLUSIG.....	38		
IDELVION.....	66		
IDHIFA.....	38		
IHEALTH COVID-19 RAPID			
TEST.....	135		
imatinib mesylate	38		
IMBRUVICA.....	38		
IMCIVREE.....	96, 164		
imipramine hcl	125		
imipramine pamoate	125		
imiquimod	255		
IMPAVIDO.....	20		
IMVEXXY MAINTENANCE			
PACK.....	181		
IMVEXXY STARTER PACK...	181		
INBRIJA.....	111		
incassia	172, 192		
INCRELEX.....	200		
indapamide	91, 144		
INDICAID COVID-19 RAPID			
TEST.....	135		
INDOCIN.....	119, 204		
indomethacin	119, 204		
indomethacin er	119, 204		
INFANRIX.....	46, 48		
INLYTA.....	39		
INOVA.....	248, 251		
INOVA 4/1 ACNE CONTROL			
THERAPY.....	248, 250, 251		
INOVA 8/2 ACNE CONTROL			
THERAPY.....	248, 250, 251		
INPEN 100-BLUE-LILLY-			
HUMALOG.....	131		
INPEN 100-BLUE-NOVOLOG-			
FIASP.....	131		
INPEN 100-GREY-LILLY-			
HUMALOG.....	131		
INPEN 100-GREY-			
NOVOLOG-FIASP.....	131		
INPEN 100-PINK-LILLY-			
HUMALOG.....	131		
INPEN 100-PINK-NOVOLOG-			
FIASP.....	132		

JOENJA.....	218	K-PHOS.....	141	LEUKERAN.....	40
jolessa	172, 181, 192	K-PHOS NO 2.....	136	LEUKINE.....	64
JORNAY PM.....	120	K-PHOS-NEUTRAL.....	141	leuprolide acetate	40, 186
joyeaux	172, 181, 192	k-prime	141	levabuterol hcl	59, 236
juleber	172, 181, 192	KRAZATI.....	39	LEVALBUTEROL HFA.....	60, 236
JULUCA.....	26, 27	KRINTAFEL.....	19	LEVBID.....	53
junel 1.5/30	172, 181, 192	KRISTALOSE.....	137	levetiracetam	98
junel 1/20	172, 181, 192	K-TAB.....	141	levetiracetam er	98
junel fe 1.5/30	172, 181, 192	kurvelo	172, 182, 193	levobunolol hcl	148
junel fe 1/20	172, 182, 193	KYZATREX.....	167	levocarnitine	223
junel fe 24	172, 182, 193	labetalol hcl 56, 58, 73, 77, 78, 84		levocarnitine sf	223
JUST RIGHT 5000.....	207	lacosamide	98	levocetirizine	
JYNARQUE.....	144	LACRISERT.....	152	dihydrochloride	15, 16
K.B.G.L IN TERODERM		lactulose	137	levofloxacin	21, 33, 147
.....	56, 119, 241, 252, 255	lactulose encephalopathy ...	137	levonest	172, 182, 193
kaitlib fe	172, 182, 193	LAGEVRIO.....	31	levonorgest-eth est & eth est	
KALETRA.....	29	LAMICTAL ODT.....	98, 101	.....	172, 182, 193
kalliga	172, 182, 193	lamivudine	28	levonorgest-eth estrad 91-	
KALYDECO.....	230	lamivudine-zidovudine	28	day	172, 173, 182, 193
KAPSPARGO SPRINKLE		lamotrigine	98, 101	levonorgest-eth estradiol-	
.....	60, 77, 78, 84	lamotrigine starter kit-blue		iron	173, 182, 193
kariva	172, 182, 193	.....	98, 101	levonorgestrel	173, 193
kelnor 1/35	172, 182, 193	lamotrigine starter kit-green		levonorgestrel-ethinyl estrad	
kelnor 1/50	172, 182, 193	.....	98, 101	.....	173, 182, 193
KESIMPTA.....	218	lamotrigine starter kit-		levonorg-eth estrad triphasic	
ketoconazole	22, 242, 243	orange	98, 101	.....	173, 182, 193
ketodan	243	LAMPIT.....	20	levora 0.15/30 (28) . 173, 182, 193	
KETO-DIASTIX.....	136	LANCETS.....	132	levo-t	201
KETONE TEST.....	136	LANOXIN.....	76, 82	levothyroxine sodium	201
ketorolac tromethamine 119, 153		lansoprazole	163	levoxyl	201
KETOSTIX.....	136	lanthanum carbonate ...	139, 203	LEVSIN.....	53
KEVEYIS.....	206	LANTUS SOLOSTAR.....	188	LEVSIN/SL.....	53
KEVZARA.....	212	LANTUS U-100 VIAL.....	188	lidocaine	241
KINERET.....	212, 218	lapatinib ditosylate	39	lidocaine hcl	153, 241
KIPROFEN.....	103, 119	larin 1.5/30	172, 182, 193	lidocaine hcl	
KISQALI FEMARA.....	39, 167	larin 1/20	172, 182, 193	urethral/mucosal	241
KLARON.....	239	larin 24 fe	172, 182, 193	lidocaine viscous hcl	153
klayesta	252	larin fe 1.5/30	172, 182, 193	lidocaine-prilocaine	241
KLISYRI.....	255	larin fe 1/20	172, 182, 193	LIDTOPIC MAX.....	241
klor-con	141	LASIX.....	88, 139	LIKMEZ.....	17, 20, 156
klor-con 10	141	LATANOPROST.....	154	linezolid	32
klor-con m10	141	latanoprost	154	LINZESS.....	161
klor-con m15	141	layolis fe	172, 182, 193	liothyronine sodium	201
klor-con m20	141	LEDIPASVIR-SOFOSBUVIR		lisdexamfetamine dimesylate 95	
klor-con/ef	141	.....	24, 25	lisinopril	75, 76
KLOXXADO.....	116	leena	172, 182, 193	lisinopril-	
KOATE.....	67	leflunomide	212, 218, 221	hydrochlorothiazide	76, 143
KOATE-DVI.....	67	lenalidomide	39, 218	L-ISOLEUCINE.....	138
KOGENATE FS.....	67	LENVIMA.....	39, 40	LITFULO.....	255
KORLYM.....	167	lessina	172, 182, 193	lithium	101
KOSELUGO.....	39	letrozole	40, 167	lithium carbonate	101
kourzeq	247	LETS.....	51, 202	lithium carbonate er	101
KOVALTRY.....	67	leucovorin calcium	203, 262	LITHOBID.....	101

LITHOSTAT	137	MATULANE	40	methotrexate sodium	40, 41, 213, 218, 221
LIVTENCITY	21	matzim la	80, 81, 85, 92	methotrexate sodium (pf)	40, 212, 218, 221
LO LOESTRIN FE ...	173, 182, 193	MAVENCLAD	218, 221	methoxsalen rapid	252
lojaimiess	173, 182, 193	MAVYRET	24, 25	methscopolamine bromide ...	53
LOKELMA	140	MAXIDEX	150	methsuximide	125
LOMAIRA	94	MAXITROL	147, 150	methyl salicylate	243
LOMOTIL	53, 155	maxi-tuss ac	229, 231	METHYLDOPA	52, 82
LOPID	88	MAXZIDE	140, 144	methylergonovine maleate ...	227
lopinavir-ritonavir	29	MAYZENT	218	methylphenidate hcl	121
LOPRESSOR	60, 77, 78, 84	MAYZENT STARTER PACK ..	218	methylphenidate hcl er	121
lorazepam	107, 108	me/naphos/mb/hyo1 .	34, 53, 223	METHYLPHENIDATE HCL ER	121
lorazepam intensol	107, 108	meclofenamate sodium	119	.....	121
LORBRENA	40	MEDERMA SPF 30	255	methylphenidate hcl er (cd)	120, 121
losartan potassium	74	MEDROL	165	.....	120, 121
losartan potassium-hctz .	74, 143	medroxyprogesterone		methylphenidate hcl er (la) ..	121
LOTEMAX	150	acetate	173, 194	methylphenidate hcl er	(osm)
LOTEMAX SM	150	mefenamic acid	119	.....	121
LOTENSIN	75, 76	mefloquine hcl	19	methylprednisolone	165
LOTENSIN HCT	76, 144	megestrol acetate	40, 194	methyltestosterone	167
loteprednol etabonate	150	MEKINIST	40	metoclopramide hcl	162
lovastatin	88	MELOXICAM	119	metolazone	91, 144
low-ogestrel	173, 182, 193	meloxicam	119	metoprolol succinate er	60, 77, 78, 84
loxapine succinate	104	melphalan	40	.....	60, 77, 78, 84
lubiprostone	161	memantine hcl	110	metoprolol-	
LUGOLS STRONG IODINE ...	251	memantine hcl er	110	hydrochlorothiazide	77, 144
LUMAKRAS	40	MENEST	183, 206	METROCREAM	239
LUMIGAN	154	MENOSTAR	183, 206	METROLOTION	239
lurasidone hcl	105	MENQUADFI	48	metronidazole ...	17, 20, 156, 239
lutera	173, 182, 194	MENVEO	48	METRONIDAZOLE	
LUXAMEND	255	meperidine hcl	114	BENZO+SYRSPEND ..	17, 20, 156
lyleq	173, 194	meprobamate	104	metyrosine	136, 223
lyllana	183, 206	mercaptapurine	40, 221	mexiletine hcl	83
LYNPARZA	40	merzee	173, 183, 194	MIACALCIN	168, 206
LYRICA	98, 111	mesalamine	156	mibelas 24 fe	173, 183, 194
LYSODREN	40	mesalamine-cleanser	156	miconazole 3	243
LYTGOBI (12 MG DAILY		MESNEX	226	microgestin 1.5/30 .	173, 183, 194
DOSE)	40	MESTINON	58	microgestin 1/20 ...	173, 183, 194
LYTGOBI (16 MG DAILY		metaxalone	55	microgestin 24 fe ..	173, 183, 194
DOSE)	40	metformin hcl	169	microgestin fe 1.5/30	173, 183, 194
LYTGOBI (20 MG DAILY		metformin hcl er	169	.....	173, 183, 194
DOSE)	40	methadone hcl	114	microgestin fe 1/20 173, 183, 194	
LYUMJEV KWIKPEN	198	methadone hcl intensol	114	MICROLET NEXT LANCING	
LYUMJEV VIAL	198	METHADOSE	114	DEVICE	132
lyza	173, 194	methadose	114	midazolam hcl	108
MACROBID	34	METHADOSE SUGAR-FREE .	114	MIDAZOLAM+SYRSPEND SF	108
MACRODANTIN	34	methamphetamine hcl	95	.....	108
mafenide acetate	251	methazolamide	82, 149	midodrine hcl	52
magnesium citrate	157	methenamine hippurate	34	MIFEPREX	227
MALARONE	19	methenamine mandelate	34	mifepristone	167, 227
malathion	253	methergine	227	MIGERGOT	57, 103, 121
maraviroc	26	methimazole	168		
MARINOL	155	METHITEST	167		
marlissa	173, 183, 194	methocarbamol	27, 55		

miglitol	166	MUSE	92	NESTABS	69, 259, 263
miglustat	223	my choice	173, 194	NESTABS ONE	69, 223, 259, 262
mili	173, 183, 194	my way	173, 194	neuac	239, 251
mimvey	183, 194	MYALEPT	188	NEULASTA	64
mineral oil heavy	157	MYAMBUTOL	21	NEURAPTINE	96
MINIPRESS	57, 73	MYCOBUTIN	21, 33	NEVANAC	153
minocycline hcl	19, 34	mycophenolate mofetil	221	nevirapine	27
minoxidil	87	mycophenolate sodium	221	nevirapine er	27
mirtazapine	100	mycophenolic acid	221	new day	174, 194
MIRVASO	255	MYCOZYL AL	257	NEXIUM	163
misoprostol	162	MYFEMBREE	168, 183, 194	NEXLETOL	76
MITIGARE	204	MYLERAN	41	NEXLIZET	76, 82
MITOSOL	147	MYXREDLIN	141, 199	NEXTSTELLIS	174, 183, 194
mm aspirin	72, 73, 103, 122	na sulfate-k sulfate-mg sulf	157	NGENLA	189
mm clearlax	157	nabumetone	119	niacin er	
M-M-R II	48	nadolol	56, 77, 78	(antihyperlipidemic)	76
M-NATAL PLUS	69, 258, 262	naloxone hcl	116, 203	nicardipine hcl	86, 92
modafinil	126	naltrexone hcl	116, 202, 203	NICORETTE	50, 51, 55
MODERNA COVID-19 VAC		naproxen	103, 119, 204	NICORETTE MINI	50, 55
6M-11Y	49	naproxen dr	103, 119, 204	nicotine	51, 55
moexipril hcl	75, 76	naproxen sodium ..	103, 119, 204	nicotine mini	51, 55
molindone hcl	104	naratriptan hcl	123	nicotine polacrilex	51, 55
mometasone furoate	247	NARCAN	116	nicotine polacrilex mini	51, 55
mondoxyne nl	19, 34	NARDIL	112	nicotine step 1	51, 55
mono-linyah	173, 183, 194	NASCOBAL	71, 262	nicotine step 2	51, 55
MONSELS FERRIC		NATACYN	148	nicotine step 3	51, 55
SUBSULFATE	67	NATAL PNV	69, 259, 262	NICOTROL	51, 55
montelukast sodium	232	NATAZIA	173, 183, 194	NICOTROL NS	51, 55
morphine sulfate	115	nateglinide	188	nifedipine	86, 87, 92
morphine sulfate		NAYZILAM	107	nifedipine er	86, 87, 92
(concentrate)	114	NEBUSAL	232	nifedipine er osmotic release	
morphine sulfate er	114, 115	necon 0.5/35 (28) ...	174, 183, 194	.....	86, 87, 92
morphine sulfate er beads ...	114	nefazodone hcl	124	nimodipine	86, 87, 92
MOTEGRITY	161	neomycin sulfate	17	NINLARO	41
MOTPOLY XR	98	neomycin-bacitracin zn-		nisoldipine er	86, 87
MOUNJARO	187	polymyx	147	nitazoxanide	20
MOVIPREP	157, 264	neomycin-polymyxin-		NITRO-BID	89
moxifloxacin hcl	21, 33, 147	dexameth	147, 150	NITRO-DUR	89
moxifloxacin hcl (2x day)	147	neomycin-polymyxin-		nitrofurantoin	35
MOZOBIL	64	gramicidin	147	nitrofurantoin macrocrystal ...	35
MUCOSITISRX	152	neomycin-polymyxin-hc		nitrofurantoin monohydrate	
MULPLETA	64	.....	147, 150, 151	macrocrystals	35
multivitamin w/fluoride	207, 258	NEONATAL + DHA		nitroglycerin	89
multivitamin/fluoride		.....	69, 141, 223, 259, 262	NITROSTAT	89
.....	207, 258, 259, 262	NEONATAL 19	259	NITRO-TIME	89
MULTIVITAMIN/FLUORIDE		NEONATAL COMPLETE		NIVA THYROID	201
.....	207, 258, 259, 262	.....	69, 259, 262	NOCDURNA	67, 189
multi-vitamin/fluoride ...	207, 258	NEONATAL FE	69, 259, 262	nora-be	174, 194
multi-vitamin/fluoride/iron		NEONATAL PLUS	69, 259, 262	NORDIPEN 5 INJECTION	
.....	69, 207, 259	neo-polycin	147	DEVICE	132
MULTI-VIT-FLOR	207, 259	neo-polycin hc	147, 151	NORDITROPIN FLEXPRO	
mupirocin	239	NEOSALUS	255	.....	189, 200
mupirocin calcium	239	NERLYNX	41		

norelgestromin-eth estradiol	NUTROPIN AQ NUSPIN 20	ONETOUCH DELICA SAFETY
..... 174, 183, 195	..... 189, 200	LANCING..... 133
norethin ace-eth estrad-fe	NUTROPIN AQ NUSPIN 5	ONETOUCH ULTRA..... 133, 135
..... 174, 183, 195	..... 189, 200	ONETOUCH ULTRA 2..... 133
norethindrone 174, 195	NUWIQ.....67	ONETOUCH VERIO..... 133, 135
norethindrone acetate 195	NUZYRA..... 17	ONETOUCH VERIO FLEX
norethindrone acet-ethinyl	nyamyc.....252	SYSTEM..... 133
est 174, 183, 195	nylia 1/35 174, 184, 195	ONETOUCH VERIO
norethindrone-eth estradiol	nylia 7/7/7 174, 184, 195	REFLECT.....133
..... 183, 195	NYMALIZE..... 86, 87, 92	ONFI..... 107, 108
norethindron-ethinyl estrad-	nymyo 174, 184, 195	ONUREG..... 41
fe 174, 184, 195	nystatin 32, 252	opcicon one-step 174, 195
norethin-eth estradiol-fe	nystatin-triamcinolone	OPFOLDA.....223
..... 174, 184, 195	..... 247, 252, 253	OPILL.....175, 195
norgestimate-eth estradiol	nystop 253	opium 155
..... 174, 184, 195	OCALIVA..... 161	OPSUMIT.....92, 231, 236
norgestimate-ethinyl	octreotide acetate 161, 199	option 2 175, 195
estradiol triphasic .. 174, 184, 195	OCUFLOX.....147	OPTIONS GYNOL II
NORLIQVA..... 86, 87, 92	ODACTRA..... 45	CONTRACEPTIVE..... 226
norlyroc 174, 195	ODEFSEY.....27, 28	OPVEE.....116
NORPACE..... 83	ODOMZO..... 41	ORACIT..... 136
NORPACE CR..... 83	ofloxacin 33, 147	ORAL CITRATE..... 137
NORPRAMIN..... 125	OJJAARA..... 41	ORALAIR..... 45
nortrel 0.5/35 (28) .. 174, 184, 195	olanzapine 101, 105	ORALAIR ADULT STARTER
nortrel 1/35 (21) 174, 184, 195	olanzapine-fluoxetine hcl	PACK..... 45
nortrel 1/35 (28) 174, 184, 195	..... 105, 124	ORALAIR CHILDRENS
nortrel 7/7/7 174, 184, 195	olmesartan medoxomil 74	STARTER PACK..... 45
nortriptyline hcl 125	olmesartan medoxomil-hctz	oralone 247
NORVIR.....29	..... 74, 144	ORAPRED ODT.....165
NOVAVAX COVID-19	olopatadine hcl 15, 146	ORAVIG..... 243
VACCINE..... 49	OLUMIANT..... 213	ORENCIA.....213, 219
NOVOEIGHT..... 67	OMECLAMOX-PAK.... 18, 32, 163	ORENCIA CLICKJECT... 213, 219
NOVOFINE AUTOCOVER	omega-3-acid ethyl esters 76	ORENITRAM..... 93, 234, 237
PEN NEEDLE..... 132	omeprazole 163	ORENITRAM MONTH 1
NOVOFINE PEN NEEDLE 132	OMEPRAZOLE+SYRSPEND	..... 92, 234, 236
NOVOFINE PLUS PEN	SF ALKA..... 163	ORENITRAM MONTH 2
NEEDLE.....132	OMNIPOD 5 G6 INTRO (GEN	..... 92, 234, 236
NOVOPEN ECHO.....133	5)..... 133	ORENITRAM MONTH 3
NOVOSEVEN RT..... 67	OMNIPOD 5 G6 PODS (GEN	..... 93, 234, 237
NOXAFIL.....22	5)..... 133	ORFADIN.....223
np thyroid 201	OMNITROPE..... 189, 200	ORGOVYX.....41, 168
NUBEQA.....41	OMVOH..... 154, 161	ORIAHNN..... 168, 184, 196
NUCALA..... 228	ON/GO COVID-19 ANTIGEN	ORLISSA..... 168
NUCORT.....247	TEST..... 135	ORKAMBI..... 229, 230
NUCYNTA.....115	ON/GO ONE COVID-19	ORLISTAT..... 161
NUCYNTA ER.....115	HOME TEST..... 136	orphenadrine citrate er
NUDEXTA..... 110	ondansetron hcl 155	..... 56, 61, 97
NULEV..... 53	ondansetron odt 155	ORSERDU..... 41
NUPLAZID..... 105	ONE VITE WOMENS PLUS	OSCIMIN.....53
NURTEC..... 109	..... 69, 259, 263	oseltamivir phosphate.....30, 31
NUTROPIN AQ NUSPIN 10	ONETOUCH DELICA PLUS	OSPHENA..... 177
..... 189, 200	LANCING..... 133	OTEZLA..... 213, 219, 255, 256
		OVACE PLUS..... 239, 240

OVACE PLUS WASH.....	240	permethrin	253	PLEGRIDY STARTER PACK.	219
OVACE WASH.....	240	perphenazine	119	PLENVU	158, 264
OVIDE.....	253	perphenazine-amitriptyline		plerixafor	64
oxaprozin	119	.....	119, 125	PNEUMOVAX 23.....	49
oxazepam	108	PERTZYE	145, 158	PODOCON-25.....	256
oxcarbazepine	98	PFIZER COVID-19 VAC-TRIS		podofilox	256
OXERVATE	152	5-11Y.....	49	polycin	147
oxybutynin chloride	257	PFIZER COVID-19 VAC-TRIS		polyethylene glycol 3350	158
oxybutynin chloride er	257	6M-4Y.....	49	polymyxin b-trimethoprim	147
oxycodone hcl	115	phenazo	241	POLY-VI-FLOR.....	208, 259
oxycodone-acetaminophen		phenazopyridine hcl	242	POLY-VI-FLOR/IRON	
.....	96, 115	phendimetrazine tartrate	94	.....	69, 70, 208, 259
oxymorphone hcl	115	phendimetrazine tartrate er	94	POMALYST.....	41, 219
oxymorphone hcl er	115	phenelzine sulfate	112	portia-28	175, 184, 196
OZEMPIC.....	187	phenobarbital	106	posaconazole	22
OZOBAX DS.....	56	phenoxybenzamine hcl	57, 88	potassium chloride	142
PACERONE.....	84	phentermine hcl	94	potassium chloride crys er ..	141
PALFORZIA.....	45	phenylephrine hcl	153, 154	potassium chloride er	141
PANDEL.....	247	phenytek	83, 112	potassium citrate er	137
PANRETIN.....	256	phenytoin	83, 112	potassium citrate-citric acid	137
pantoprazole sodium	163	phenytoin infatabs	83, 112	potassium iodide	231
PARI VORTEX ADULT MASK	133	phenytoin sodium extended		PRADAXA.....	63
paricalcitol	265	.....	83, 112	pramipexole dihydrochloride	
PARNATE	112	PHEXXI.....	226	.....	113
paroxetine hcl	124	philit	175, 184, 196	PRAMOSONE.....	242, 247
paroxetine hcl er	124	PHOSPHA 250 NEUTRAL.....	141	PRAMOTIC.....	151, 153
PAXIL.....	124	PHOSPHOLINE IODIDE.....	153	prasugrel hcl	72
PAXLOVID (150/100).....	21	phosphorous	141	pravastatin sodium	88
PAXLOVID (300/100).....	21	phospho-trin 250 neutral	141	praziquantel	18
PEDIAPRED.....	165	PHOXILLUM B22K4/0.....	141	prazosin hcl	57, 73
PEDIARIX.....	46, 49	PHOXILLUM BK4/2.5.....	141	PRED MILD	151
PEDVAX HIB.....	49	phytonadione	203, 265	prednisolone	165
peg 3350-kcl-na bicarb-nacl .	157	PIFELTRO	27	prednisolone acetate	151
peg-3350/electrolytes	157	pilocarpine hcl	58, 153	prednisolone sodium	
peg-		PILOT COVID-19 AT-HOME		phosphate	151, 165
3350/electrolytes/ascorbat		TEST	136	prednisone	165
.....	157, 264	pimecrolimus	221, 249, 256	prednisone intensol	165
PEGASYS.....	30	pimozide	104	pregabalin	98, 111
peg-kcl-nacl-nasulf-na asc-c		pimtrea	175, 184, 196	PREHEVBRIO.....	49
.....	158, 264	pindolol	56, 77, 78, 84	PREKUNIL.....	138
PEG-PREP.....	158	pioglitazone hcl	201	PREMARIN.....	184, 206
PEMAZYRE	41	pioglitazone hcl-glimepiride	201	PREMESISRX 142, 223, 259, 263	
PENBRAYA	49	pioglitazone hcl-metformin		premium lidocaine	242
penicillamine	163, 213	hcl	169, 201	PREMPHASE.....	184, 196
penicillin v potassium	30	PIP GLUCOSE CONTROL		PREMPRO.....	184, 196
PENTACEL.....	46, 49	SOLUTION.....	133	PRENAISSANCE	
pentamidine isethionate	20	PIQRAY.....	41	.....	70, 158, 223, 259, 263
pentazocine-naloxone hcl		pirfenidone	228, 234, 235	prenatal	70, 259, 263
.....	116, 117	piroxicam	119	prenatal plus vitamin/mineral	
pentoxifylline er	65	PKU EASY MICROTABS.....	138	.....	70, 259, 263
PERIDEX.....	151, 251	PKU EASY SHAKE & GO.....	138	PRENATE.....	142, 260, 263
perindopril erbumine	75, 76	PLAN B ONE-STEP	175, 196		
perio gard	151, 251	PLEGRIDY.....	219		

PRENATE DHA 70, 142, 223, 260, 263	prochlorperazine maleate 119, 155	qc magnesium citrate 158
PRENATE ELITE 70, 260, 263	PROCTOFOAM HC 242, 248	QSYMIA.....96
PRENATE ENHANCE 70, 142, 224, 260, 263	procto-med hc 248	QUADRACEL.....46, 49
PRENATE ESSENTIAL 70, 142, 224, 260, 263	proctosol hc 248	QUALAQUIN.....19
PRENATE MINI 70, 142, 224, 260, 263	proctozone-hc 248	QUESTRAN.....79
PRENATE PIXIE 70, 142, 224, 260, 263	PROCYSBI..... 224	QUESTRAN LIGHT 79
PRENATE RESTORE 70, 142, 224, 260, 263	PROFILNINE 67	quetiapine fumarate 101, 105
PRENATVITE COMPLETE 70, 142, 260, 263	progesterone 196	quetiapine fumarate er . 101, 105
PRENATVITE PLUS 70, 142, 260, 263	PROGESTERONE	QUFLORA PEDIATRIC.. 208, 260
PRENATVITE RX 70, 142, 260, 263	MICRONIZED 196	QUICKVUE AT-HOME COVID-19 TEST 136
PREPIDIL.....227	PROGLYCEM..... 168	quinapril hcl .....75, 76
PRETOMANID 21	PROGRAF..... 221	quinapril- hydrochlorothiazide .....76, 144
prevalite 79	PROMACTA .....64	quinidine gluconate er 19, 83
PREVIDENT 208	promethazine hcl 14, 15, 104, 155, 232	quinidine sulfate 19, 83
PREVIDENT 5000 BOOSTER PLUS .....208	promethazine vc 15, 52	quinine sulfate .....19
PREVIDENT 5000 DRY MOUTH .....208	promethazine vc/codeine 15, 52, 229	QVAR REDIHALER 165, 166, 233
PREVIDENT 5000 ENAMEL	promethazine-codeine 15, 229	rabeprazole sodium 163
PROTECT 126, 208	promethazine-dm 15, 229	RADICAVA ORS..... 110
PREVIDENT 5000 ORTHO DEFENSE .....208	promethegan 14, 15, 104, 155, 232	RADICAVA ORS STARTER KIT..... 110
PREVIDENT 5000 PLUS 208	PROMISEB..... 250	RADIOGARDASE..... 139, 203
PREVIDENT 5000 SENSITIVE 126, 208	PRONAL 243, 250	RAGWITEK.....45
PREVNAR 20 .....49	propafenone hcl 83	raloxifene hcl 177, 206
PREVYMIS 21	propafenone hcl er .....83	ramelteon 104
PREZCOBIX..... 29, 224	proparacaine hcl 153	ramipril 75, 76
PREZISTA..... 29, 30	propranolol hcl 57, 77, 78, 84, 103	ranolazine er .....82
PRIFTIN 21, 33	propranolol hcl er 57, 77, 78, 84, 103	RAPAMUNE .....221
PRIMACARE .....70, 224, 260, 263	propylthiouracil 168	RASUVO.....213, 214
primaquine phosphate 19	PROQUAD.....49	RAVICTI.....137
primidone .....106	PRO-STAT/FIBER..... 138	RAYA SURE PEN NEEDLE... 133
PRIORIX..... 49	protriptyline hcl 125	RAYASAL..... 250
PRISMASOL B22GK 4/0..... 142	PROVERA..... 196	react 175, 196
PRISMASOL BGK 0/2.5..... 142	pseudoephedrine- bromphen-dm 15, 52, 229	reclipsen 175, 184, 196
PRISMASOL BGK 2/0..... 142	PULMOSAL 232	RECOMBIMATE .....68
PRISMASOL BGK 2/3.5..... 142	PULMOZYME 145, 232	RECOMBIVAX HB.....49
PRISMASOL BGK 4/0/1.2..... 142	PURE COMFORT SAFETY	RECOTHROM..... 68
PRISMASOL BGK 4/2.5..... 142	PEN NEEDLE 133	RECOTHROM SPRAY KIT .....68
PRISMASOL BK 0/0/1.2..... 142	PURIXAN..... 41, 221	REGLAN 162
probenecid .....144, 204	pyrazinamide 21	REGRANEX.....256
prochlorperazine 119, 155	PYRIDIDIUM..... 242	RELENZA DISKHALER..... 31
	pyridostigmine bromide 58	RELISTOR..... 116, 161
	pyridostigmine bromide er ....58	RELNATE DHA . 70, 224, 260, 263
	pyrimethamine 19	RELYVRIO..... 110
	PYROGALLIC ACID227, 250, 256	REMIGEN..... 256
	PYRUKYND 62	repaglinide 188
	PYRUKYND TAPER PACK..... 62	REPATHA..... 89
	QBRELIS..... 76	REPATHA PUSHTRONEX SYSTEM 89
		REPATHA SURECLICK..... 90
		RESTASIS..... 152
		RESTORIL..... 108

RETACRIT.....	61, 62, 65	saxagliptin-metformin er	169, 177	SOFOSBUVIR-VELPATASVIR	24, 25
RETEVMO.....	41	SAXENDA.....	187	SOHONOS.....	224
RETROVIR.....	28	SCALACORT DK.....	248, 250	solifenacin succinate	257
REVLIMID.....	42, 219	SCARCIN.....	256	SOLIQUA.....	187, 188
REYATAZ.....	30	scopolamine	53, 155	SOOLANTRA.....	253
REZLIDHIA.....	42	SELECT-OB.....	70, 260, 263	sorafenib tosylate	42
RHOFADE.....	256	selegiline hcl	112	sotalol hcl	57, 78, 79, 84
RHOPRESSA.....	154	selenium sulfide	251	sotalol hcl (af)	57, 78, 84
ribavirin	31	SELZENTRY.....	26	SOTYLIZE.....	57, 78, 79, 84
rifabutin	21, 33	SEREVENT DISKUS.....	60, 236	SOVALDI.....	24
rifampin	21, 33	sertraline hcl	124	SPEEDY SWAB COVID-19	
RIFAMPIN+SYRSPEND SF21,	33	setlakin	175, 184, 196	ANTIGEN.....	136
riluzole	110	sevelamer carbonate	140, 203	SPIKEVAX.....	50
rimantadine hcl	17	sevelamer hcl	140, 203	spinosad	253
RINVOQ.....	214	sevoflurane	112	SPIRIVA HANDIHALER....	54, 228
risedronate sodium	206	sf	208	SPIRIVA RESPIMAT.....	54, 228
risperidone	101, 105	sf 5000 plus	208	spironolactone	89, 90, 91, 140
ritonavir	30	sharobel	175, 196	spironolactone-hctz ..	89, 91, 144
rivastigmine	58	SHARPS COLLECTOR.....	133	SPORANOX.....	22
rivastigmine tartrate	58	SHARPS CONTAINER.....	133	SPRAVATO (56 MG DOSE)...	100
rivelsa	175, 184, 196	SHINGRIX.....	50	SPRAVATO (84 MG DOSE)...	100
RIXUBIS.....	68	sildenafil citrate	90, 233, 234, 237, 258	sprintec 28	175, 185, 196
rizatriptan benzoate	123	silodosin	58	SPRYCEL.....	42
ROCKLATAN.....	154	SILVADENE.....	251	SPS.....	140, 203
roflumilast	233	silver nitrate	151	sronyx	175, 185, 196
ropinirole hcl	113	silver sulfadiazine	251	ssd	251
rosuvastatin calcium	88	simliya	175, 184, 196	SSKI.....	231
ROTARIX.....	49	simpesse	175, 185, 196	sss 10-5	240, 250
ROTATEQ.....	49	SIMPONI.....	161, 214, 219, 220	SSS 10-5.....	240, 250
roweepra	99	simvastatin	88	ST JOSEPH LOW DOSE	
ROZLYTREK.....	42	SINEMET.....	111	.....	72, 73, 103, 122
RUCONEST.....	209, 222	SINGULAIR.....	232	STALEVO 150.....	109, 111
rufinamide	99	sirolimus	221	STELARA.....	256
RUKOBIA.....	26	SIRTURO.....	21	STENDRA.....	90
RYBELSUS.....	187	SKYCLARYS.....	224	STIOLTO RESPIMAT.....	54, 60
RYDAPT.....	42	SKYRIZI.....	161, 249, 256	STIVARGA.....	42
SABRIL.....	99	SKYRIZI PEN.....	249, 256	STRENSIQ.....	145
SAFETY PEN NEEDLES.....	133	SKYTROFA.....	189	STRIBILD.....	26, 28, 224
SALAGEN.....	58	SLYND.....	175, 196	STRIVERDI RESPIMAT..	60, 236
SALICATE.....	250	sod citrate-citric acid	137	STROMECTOL.....	18
salicylic acid	250	sodium chloride	233	SUBOXONE.....	117, 118
SALIMEZ.....	250	sodium fluoride	208, 209	subvenite	99, 102
salsalate	122	sodium fluoride 5000 plus	208	subvenite starter kit-blue	99, 102
SALVAX DUO PLUS.....	243, 250	sodium fluoride 5000 ppm ...	208	subvenite starter kit-green	99, 102
SALYCIM.....	250	sodium fluoride 5000 ppm ...	208	subvenite starter kit-orange	99, 102
SANDIMMUNE.....	214, 219, 221	sodium phenylbutyrate	137	.....	99, 102
SANTYL.....	145, 256	sodium polystyrene		SUCRAID.....	145
sapropterin dihydrochloride	224	sulfonate	140, 203	sucrafate	162
SAVELLA.....	111, 123	sodium sulfacetamide	240	SUFLAVE.....	158
SAVELLA TITRATION PACK		sodium sulfacetamide wash	240	SULAR.....	86, 87
.....	111, 123	SODIUM SULFACETAMIDE-		SULCONAZOLE NITRATE.....	243
saxagliptin hcl	176	BAKUCHIOL.....	224, 240		

sulfacetamide sodium .. 147, 240	take action 175, 196	THROMBIN-JMI 68
sulfacetamide sodium (acne) 240	TAKHZYRO 222	THROMBIN-JMI EPISTAXIS 68
sulfacetamide sodium (cleans) 240	tamoxifen citrate 42, 177	THROMBOGEN 68
sulfacetamide sodium-sulfur 240, 250	tamsulosin hcl 58	thyroid 201
sulfacetamide sod-sulfur wash 240, 250	TAPERDEX 12-DAY 166	tiadylt er 80, 81, 85, 93
sulfacetamide-prednisolone 147, 151	TAPERDEX 6-DAY 166	tiagabine hcl 99
sulfacetamide-sulfur in urea 240, 250	TAPERDEX 7-DAY 166	TIAZAC 80, 81, 85, 93
sulfadiazine 33	tarina 24 fe 175, 185, 196	TIBSOVO 43
sulfamethoxazole-trimethoprim 20, 33, 35	tarina fe 1/20 eq 175, 185, 196	TIKOSYN 84
SULFAMYLON 251	TASIGNA 42	tilia fe 175, 185, 196
sulfasalazine 33, 156, 214, 220	tasimelteon 104	timolol maleate 57, 78, 79, 84, 103, 149
sulfatrim pediatric 20, 33, 35	TAVALISSE 62	timolol maleate (once-daily) .148
sulfurated lime 253	taysofy 175, 185, 196	timolol maleate pf 149
sulindac 119	tazarotene 256	TIMOPTIC OCUDOSE 149
sumatriptan 123	taztia xt 80, 81, 85, 93	tinidazole 20
sumatriptan succinate 123	TAZVERIK 43	tiopronin 225
sumatriptan succinate refill subcutaneous solution cartridge 123	TDVAX 46	TISSEEL 256
sunitinib malate 42	TECHLITE LANCETS 26G 133	TIVICAY 26
SUNLENCA 20, 26	TEGLUTIK 110	TIVICAY PD 26
SUNOSI 126	TEGSEDI 204	tizanidine hcl 55, 56
SUPREP BOWEL PREP KIT .. 158	telmisartan 74	TOBRADEX 147, 151
SUTAB 158	telmisartan-hctz 74, 144	tobramycin 17, 148
SYMBICORT 60, 166	temazepam 109	tobramycin-dexamethasone 148, 151
SYMBYAX 106, 124	TEMBEXA 31	TOBEX 148
SYMDEKO 229, 230	temozolomide 43	tolterodine tartrate 257
SYMFI 27, 29	TENCON 96, 107	tolvaptan 144
SYMFI LO 27, 28	TENIVAC 46	TOPICORT 248
SYMPAZAN 107, 108	tenofovir disoproxil fumarate 29	topiramate 99, 103
SYMPROIC 161	terazosin hcl 57, 73	toremifene citrate 43, 177
SYMTUZA 29, 30, 224	terbinafine hcl 17	torsemide 88, 139
SYNAPRYN FUSEPAQ 115	terbutaline sulfate 60, 236	TOUJEO MAX SOLOSTAR 188
SYNAREL 187	terconazole 243	TOUJEO SOLOSTAR 188
SYNDROS 155	teriflunomide 220	TRACLEER 93, 231, 237
SYNJARDY 169, 199	terrell 112	TRADJENTA 177
SYNJARDY XR 169, 199	TESTIM 167	tramadol hcl 116
TABLOID 42	testosterone 167	tramadol hcl (er biphasic) 116
TABRADOL FUSEPAQ 55	testosterone cypionate 167	tramadol hcl er 116
TABRECTA 42	testosterone enanthate 167	tramadol-acetaminophen 96, 116
tacrolimus 221, 249, 256	tetrabenazine 126	trandolapril 75, 76
tadalafil 90, 234	tetracaine hcl 153	trandolapril-verapamil hcl er 76, 81
TADLIQ 90, 234, 237	tetracycline hcl 19, 34, 156	tranexamic acid 68
TAFINLAR 42	TEXACORT 248	tranylcypramine sulfate 112
tafluprost (pf) 154	TEZSPIRE 235	trazodone hcl 124
TAGRISSE 42	THALOMID 220	TRECTOR 21
	THEO-24 ... 87, 121, 139, 238, 258	TRELEGY ELLIPTA 54, 60, 166
	theophylline 87, 121, 139, 238, 258	TREMFYA 249, 257
	theophylline er 87, 121, 139, 238, 258	tretinoin 43, 243
	THIOLA 224	TRETTEN 68
	THIOLA EC 224	TREXALL 43, 214, 220, 222
	thioridazine hcl 120	triamcinolone acetonide 248
	thiothixene 125	

triamterene	90, 140	turpentine	243	vardenafil hcl	90
triamterene-hctz	140, 144	turqoz	176, 185, 197	varenicline tartrate	51, 55
triazolam	109	TUXARIN ER.....	15, 229	varenicline tartrate (starter)	
TRICITRASOL.....	62	TWINRIX.....	50	.....	51, 55
tricitrates	137	TWIRLA.....	176, 185, 197	varenicline tartrate(continue)	
triderm	248	TYBLUME.....	176, 185, 197	.....	51, 55
trientine hcl	163	TYBOST.....	225	VARIVAX.....	50
tri-estarylla	175, 185, 196	tydemy	176, 185, 197, 264	VAXELIS.....	46, 50
trifluoperazine hcl	120	TYVASO.....	93, 234, 237	VAXNEUVANCE.....	50
trifluridine	148	TYVASO DPI MAINTENANCE		VCF VAGINAL	
trihexyphenidyl hcl	54, 97	KIT.....	93, 234, 237	CONTRACEPTIVE.....	226
TRIJARDY XR.....	169, 177, 199	TYVASO DPI TITRATION KIT		VECAMYL.....	88
TRIKAFTA.....	230, 231	.....	93, 234, 237	velivet	176, 185, 197
tri-legest fe	175, 185, 196	TYVASO REFILL.....	93, 234, 237	VELPHORO.....	140
tri-linyah	175, 185, 197	TYVASO STARTER..	93, 234, 237	VELTASSA.....	140
tri-lo-estarylla	175, 185, 197	UBRELVY.....	109	VENCLEXTA.....	43
tri-lo-marzia	175, 185, 197	UDENYCA.....	65	VENCLEXTA STARTING	
tri-lo-mili	175, 185, 197	ULTANE.....	112	PACK.....	43
tri-lo-sprintec	175, 185, 197	UNIFINE PROTECT PEN		VENELEX.....	257
trimethobenzamide hcl	155	NEEDLE.....	134	venlafaxine hcl	123
trimethoprim	35	UNISTRIP CONTROL.....	134	venlafaxine hcl er	123
tri-mili	175, 185, 197	unithroid	201	VENTAVIS.....	93, 234, 237
trimipramine maleate	125	UPTRAVI.....	237, 238	VEOZAH.....	110
TRINATE.....	70, 260, 263	UPTRAVI TITRATION....	237, 238	verapamil hcl	80, 81, 85, 93
tri-nymyo	175, 185, 197	urea	250	verapamil hcl er	80, 81, 85, 93
TRIPLE COMPLEX FORMULA		urea nail	250	VERELAN.....	80, 81, 85, 94
3 KIT.....	242, 252, 257	URELLE.....	35, 54, 96, 225	VERELAN PM.....	80, 81, 85, 94
TRIPLE PMB.....	148, 151, 153	UREMEZ-40.....	250	VERIFINE INSULIN PEN	
TRIPLE PMK.....	148, 151, 153	uretron d/s	35, 54, 96, 225	NEEDLE.....	134
tri-sprintec	175, 185, 197	URIMAR-T.....	35, 54, 96, 225	VERIFINE INSULIN SYRINGE	
TRISTART DHA		urin ds	35, 54, 96, 225	.....	134
.....	70, 143, 225, 260, 263	UROCIT-K 10.....	137	VERIFINE PLUS PEN	
TRIUMEQ.....	26, 29	UROCIT-K 15.....	137	NEEDLE.....	134
TRIUMEQ PD.....	27, 29	UROCIT-K 5.....	137	VERIFINE SAFE LANCET	
TRI-VI-FLOR		UROGESIC-BLUE.....	35, 54, 225	MINI 21G.....	134
.....	209, 260, 261, 264, 265	ursodiol	158	VERIFINE SAFE LANCET	
TRI-VI-FLORO		URSODIOL+SYRSPEND SF..	158	MINI 23G.....	134
.....	209, 260, 261, 264, 265	valacyclovir hcl	31	VERIFINE SAFE LANCET	
tri-vite/fluoride		VALCHLOR.....	257	MINI 28G.....	134
.....	209, 260, 261, 265	valganciclovir hcl	31	VERIFINE SAFE LANCET	
trivora (28)	175, 185, 197	valproic acid	99, 102, 104	MINI 30G.....	134
tri-vylibra	176, 185, 197	VALSARTAN.....	74	VERIFINE SHARPS	
tri-vylibra lo	176, 185, 197	valsartan	74	CONTAINER.....	134
tropium chloride	257	valsartan-		VERKAZIA.....	152
TRUE FOLIC ACID.....	264	hydrochlorothiazide	74, 144	VERSAPENN (AL) ANHYD	
TRUE METRIX LEVEL 1.....	133	VALTOCO.....	107	LIPID.....	227
TRUE METRIX LEVEL 2.....	133	VANCOGIN.....	23	VERZENIO.....	43
TRUE METRIX LEVEL 3.....	134	vancomycin hcl	23	VFEND.....	22
TRULICITY.....	187	VANCOMYCIN+SYRSPEND		VIBERZI.....	161
TRUMENBA.....	50	SF.....	23	VIBRAMYCIN.....	19, 34
TRUVADA.....	29	VANDAZOLE.....	17, 240	VICTOZA.....	187
TUKYSA.....	43	VANFLYTA.....	43	vienna	176, 185, 197
TURALIO.....	43	VAQTA.....	50	vigabatrin	99

vigadrone	99	WAKIX	126	XPOVIO (60 MG TWICE	
vigpoder	99	warfarin sodium	63	WEEKLY)	44
VIJOICE	225	WEGOVY	187	XPOVIO (80 MG ONCE	
vilazodone hcl	124	WELIREG	44	WEEKLY)	44
VILEVEV MB	35, 54, 96, 225	wera	176, 185, 197	XPOVIO (80 MG TWICE	
VIMPAT	99	WESCAP-C DHA		WEEKLY)	44
VINATE ONE	70, 260, 264	.....	71, 225, 261, 264	XTAMPZA ER	116
VIOKACE	145, 158	WESCAP-PN DHA		XTANDI	44
viorele	176, 185, 197	.....	71, 143, 225, 261, 264	xulane	176, 186, 197
VIRACEPT	30	WESNATAL DHA COMPLETE		XURIDEN	226
VIRAZOLE	31	.....	71, 143, 226, 261, 264	YASMIN 28	176, 186, 197
VIREAD	29	WESNATE DHA	71, 226, 261, 264	YAZ	176, 186, 197
VISTARIL	15, 104	wes-phos 250 neutral	143	YUPELRI	54
VISTOGARD	203	WESTGEL DHA		yuvaferm	186, 206
VITAFOL FE+		.....	71, 143, 226, 261, 264	ZACARE	243, 252
.....	70, 143, 225, 261, 264	wheat germ oil	265	ZACLIR CLEANSING	252
VITAFOL STRIPS	261	WIDE-SEAL DIAPHRAGM 60	226	zafemy	176, 186, 197
VITAFOL-NANO	70, 261, 264	WIDE-SEAL DIAPHRAGM 65	226	zafirlukast	232
VITAFOL-OB+DHA		WIDE-SEAL DIAPHRAGM 70	227	zaleplon	104
.....	71, 143, 225, 261, 264	WIDE-SEAL DIAPHRAGM 75	227	ZANAFLEX	56
VITAMEDMD ONE		WIDE-SEAL DIAPHRAGM 80	227	ZARONTIN	125
RX/QUATREFOLIC		WIDE-SEAL DIAPHRAGM 85	227	ZARXIO	65
.....	71, 143, 225, 261, 264	WIDE-SEAL DIAPHRAGM 90	227	ZAVZPRET	109
VITAMIN C BRIGHTENING		WIDE-SEAL DIAPHRAGM 95	227	ZEGALOGUE	186, 203
SERUM	243	WILATE	68	ZEJULA	44
vitamin d (ergocalciferol)	265	wixela inhub	60, 166	ZELBORAF	44
vitamins acd-fluoride		wymzya fe	176, 186, 197	ZEMPLAR	265
.....	209, 261, 265	XACIATO	240	zenatane	257
VITAPEARL	71, 225, 261, 264	XARELTO	63	ZENPEP	145, 158
VITATHELY WITH GINGER		XARELTO STARTER PACK	63	ZEPATIER	25
.....	71, 261, 264	XATMEP	44, 214, 220, 222	ZEPOSIA	220
VITRAKVI	43	XDEMVY	151	ZEPOSIA 7-DAY STARTER	
VIVJOA	22	XELJANZ	214	PACK	220
VIZIMPRO	43	XELJANZ XR	214	ZEPOSIA STARTER KIT	220
volnea	176, 185, 197	XELPROS	154	ZETONNA	151
VONJO	44	XELSTRYM	95	zidovudine	29
VONVENDI	68	XENICAL	161	ZIMHI	117, 203
voriconazole	22	XEPI	240	ZIOPTAN	154
VORTEX VALVED HOLDING		XERMELO	155	ziprasidone hcl	102, 106
CHAMBER	134	XIIDRA	152	ZIRGAN	148
VOSEVI	24, 25	XOFLUZA (40 MG DOSE)	22	ZITHROMAX	32
VOWST	225	XOFLUZA (80 MG DOSE)	22	ZITHROMAX TRI-PAK	32
VOXZOGO	225	XOLAIR	235	ZITHROMAX Z-PAK	32
VP FC KIT	56, 252, 257	XOPENEX HFA	60, 236	ZOKINVY	226
VP GKL KIT	242, 252, 257	XOSPATA	44	ZOLINZA	44
VRAYLAR	106	XPOVIO (100 MG ONCE		zolmitriptan	123
VTAMA	241, 257	WEEKLY)	44	zolpidem tartrate	105
VUITY	153	XPOVIO (40 MG ONCE		zolpidem tartrate er	105
vyfemla	176, 185, 197	WEEKLY)	44	ZOMIG	123
VYLEESI	110, 164	XPOVIO (40 MG TWICE		ZONISADE	99
vylibra	176, 185, 197	WEEKLY)	44	zonisamide	99
VYNDAMAX	82, 110, 225	XPOVIO (60 MG ONCE		ZONTIVITY	72
VYNDAQEL	82, 225	WEEKLY)	44	ZORYVE	257

zovia 1/35 (28)	176, 186, 197
ZTALMY	99
ZTLIDO	202
ZUBSOLV.....	117, 118
ZURZUVAE.....	100
ZYDELIG.....	44
ZYLET	148, 151
ZYVOX.....	32